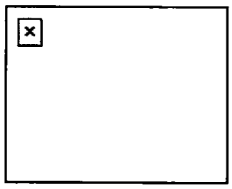


[e1]

# OPINION OF LORD MACKAY OF DRUMADOON

## PETITIONS

**BY**

GRO-A **and** GRO-A

**FOR**
**JUDICIAL REVIEW OF DECISIONS OF**

**THE LORD ADVOCATE AND**
**SCOTTISH MINISTERS**

## SUMMARY

5th February 2008

**These petitions were raised by the relatives of two people, who died after they had become infected with the Hepatitis C virus. That infection occurred whilst they were under the care of the National Health Service in Scotland. The Lord Advocate refused to hold Fatal Accident Inquiries into the deaths of the deceased. The petitioners seek the judicial review of those decisions. The petitioners also seek review of the refusal of the Scottish Ministers to set up public inquiries into those deaths.**

**Lord Mackay of Drumadoon has held that both the Lord Advocate and the Scottish Ministers have acted in a manner incompatible with the Convention rights of the deceased. Lord Mackay has quashed the decisions of the Lord Advocate refusing to hold Fatal Accident Inquiries into the deaths of the deceased. He has also held that both the Lord Advocate and the Scottish Ministers have statutory powers under which they could set up public inquiries into the deaths of the deceased and that such enquiries would satisfy the Convention rights of the deceased.**

**Before making any further orders, Lord Mackay has arranged a further hearing in respect of each petition to allow the Lord Advocate and the Scottish Ministers a period of time within which to consider what action they intend to take in the light of his rulings.**

The two petitions for judicial review were raised by Mrs. GRO-A, the daughter of Mrs. GRO-A who died on 7 May 2003, and Mrs GRO-A the widow of the GRO-A GRO-A who died on GRO-A 2003. Some years prior to their deaths both Mrs. GRO-A and Mr. GRO-A became infected with the Hepatitis C virus. In each instance, that occurred as a consequence of the medical treatment they received whilst patients of the National Health Service in Scotland.

The petitions were raised against the Lord Advocate and the Scottish Ministers. It is accepted on

behalf of both the Lord Advocate and the Scottish Ministers that Mrs. GRO-A's death was contributed to by her having become infected with the Hepatitis C virus as a consequence of blood transfusions. It is also accepted that Mr. GRO-A's death was contributed to by his having become infected with the Hepatitis C virus as a consequence of blood transfusions and treatment with blood products. Mrs. GRO-A and Mr. GRO-A became infected because some of the blood donations used in blood transfusions and for the preparation of blood products had been contaminated with the Hepatitis C virus (paras. [4] - [7]).

Mrs. GRO-A and Mr. GRO-A were amongst more than 4000 individuals who became infected with the Hepatitis C virus during the 1980s, as a consequence of their being transfused with blood or blood products contaminated with the Hepatitis C virus. The circumstances in which those individuals became infected with the Hepatitis C virus have given rise to public concern. The Scottish National Blood Transfusion Service and the National Health Service in Scotland did not introduce any form of heat treatment of blood products until April 1987. Such heat treatment could have eliminated the possibility of patients being treated with blood products being infected with the Hepatitis C virus. The Scottish National Blood Transfusion Service did not introduce any screening test for blood donations to determine whether they were contaminated with the Hepatitis C virus until 1 October 1991 (paras [8] - [19]).

The petitioners have never made any criticisms of any of the doctors and other medical staff who were directly involved in the care of their relatives. Their concerns relate to the circumstances in which blood donations from donors infected with the Hepatitis C virus came to be used in the blood transfusions, which Mrs. GRO-A and Mr. GRO-A both received, and in the blood products with which Mr GRO-A was treated.

Over several years, the petitioners have called for public inquiries to be held into the deaths of their relatives. On 18 April 2006, the Health Committee of the Scottish Parliament called upon the Scottish Ministers to set up an inquiry into matters pertaining to Hepatitis C in Scotland.

On 15 June 2006, the Lord Advocate decided not to seek Fatal Accident Inquiries into the deaths of Mrs. GRO-A and Mr. GRO-A On 16 June 2006 the Health Minister of the Scottish Executive issued a press release giving notice of the decision of the Scottish Ministers refusing to hold a full judicial inquiry into the infection of patients with Hepatitis C in Scotland through NHS treatment (paras [18] - [29]).

Lord Mackay of Drumadoon has held that since the deaths of Mrs. GRO-A and Mr. GRO-A both the Lord Advocate and the Scottish Ministers have acted in a manner incompatible with the Convention rights of the deceased. Article 2 of the European Convention of Human Rights provides that " everyone's right to life shall be protected by law...".

When a person dies following upon treatment in hospital, obligations arise under Article 2 which require the United Kingdom to have in place a system that is capable of providing a practical and effective investigation of the facts relating to the death of that person and the determination of any civil liability relating to their death. That system can include the possibility of criminal, civil or disciplinary proceedings and the initiation of an investigation by the State, which in respect of a death in Scotland could include the Lord Advocate seeking a Fatal Accident Inquiry before the Sheriff or the setting up of a public inquiry by the Scottish Ministers.

In the present cases, factual issues arise as to when each of Mrs. GRO-A and Mr. GRO-A became infected with the Hepatitis C virus and whether the Scottish National Blood Transfusion Service and the National Health Service in Scotland could have introduced the heat treatment of blood products and the screening of blood donations by earlier dates than they did (paras. [91] - [97]).

On the basis of the submissions he received, Lord Mackay has reached the conclusion that there has never been any possibility of criminal proceedings founded upon the circumstances leading up to the death of either Mrs. GRO-A or Mr. GRO-A No disciplinary proceedings have ever been taken against any individual involved in the collection of blood donations or the supply of blood and blood products for the transfusion of Mrs. GRO-A and Mr. GRO-A (paras. [102] - [105])

Lord Mackay has also reached the conclusion that whilst it would have been open to the each of the

petitioners to have raised civil proceedings seeking damages, in the particular circumstances leading up to the deaths of Mrs. GRO-A and Mr GRO-A there has never been any realistic prospects that such civil proceedings would have led to practical and effective investigations of the facts relating to those deaths (paras. [106] - [125]).

In the particular circumstances of these cases, Lord Mackay has reached the conclusion that the only means by which a practical and effective investigation into the death of either Mrs. GRO-A or Mr. GRO-A could be achieved would be if the State were to initiate a public inquiry. That could be done by the Lord Advocate seeking the holding of a Fatal Accident Inquiry before a Sheriff or by the Scottish Ministers setting up a public inquiry under the provisions of the Inquiries Act 2005.

Given the continuing refusal of the Lord Advocate and the Scottish Ministers to set up such public inquiries, Lord Mackay has reached the conclusion that, in the particular circumstances relating to the deaths of Mrs. GRO-A and Mr GRO-A the system in place to meet the State's obligations under Article 2 has not proved capable of providing a practical and effective investigation into either death. As a consequence both the Lord Advocate and the Scottish Ministers have acted in breach of the Convention rights of the deceased (paras. [126] - [128])

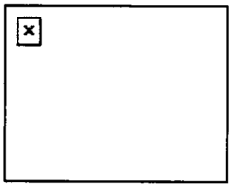
Lord Mackay quashed the decisions of the Lord Advocate not to hold Fatal Accident Inquiries into the deaths of Mrs. GRO-A and Mr GRO-A He did so because the Lord Advocate had acted in breach of the Convention rights of the deceased and also on account of errors of law on the part of the Lord Advocate that were apparent in the letter of 15 June 2006 giving notice of the Lord Advocate's decisions (paras [127] - [134]) .
Lord Mackay refrained from setting aside the decision of the Scottish Ministers of16 June 2006, on account of the fact that the decision of the Scottish Ministers had been taken as being their response to a call for a public inquiry made by the Health Committee of the Scottish Parliament, rather than their reply to calls from the petitioners for inquiries into the deaths of Mrs. GRO-A and Mr. GRO-A In reaching that decision Lord Mackay also had regard to the fact that on 16 June 2007 the Scottish Government re-affirmed its commitment to hold a "general public inquiry" to "find out why people were infected with Hepatitis C through NHS Treatment". The remit, scope, and form of that inquiry have yet to be determined (paras. [16] and [146])

Lord Mackay took the view that it would be premature to grant any further orders against the Lord Advocate and the Scottish Ministers. He continued the petitions to a further hearing, to allow the Lord Advocate and the Scottish Ministers the opportunity to consider what action they intend to take in light of the terms of his Opinion.

A date for this hearing will be fixed in due course.

**NOTE**

**This summary is provided to assist in understanding the Court's decision. It does not form part of the reasons for that decision. The full opinion of the Court is the only authoritative document.**



**OUTER HOUSE, COURT OF SESSION**

**[2008] CSOH 21**

OPINION OF LORD MACKAY OF DRUMADOON

in the petitions of

GRO-A

Petitioner;

against

THE LORD ADVOCATE AND SCOTTISH MINISTERS

Respondents:

---

GRO-A

Petitioner;

against

THE LORD ADVOCATE AND SCOTTISH MINISTERS

Respondents:

---

**Petitioners: O'Neill, QC, Caskie; Thompsons**
**Respondents: Dewar, QC, Ennis; Solicitor to the Scottish Executive**

5 February 2008

*Introduction*

[1] This Opinion follows upon continued first hearings in two petitions for judicial review. Dealing with those petitions in the order in which they were raised, the petitioner in the first petition is Mrs. GRO-A. She is the daughter of Mrs. GRO-A, who lived in Scotland and died here on 7 May 2003, at the age of 72. In the first petition the Lord Advocate is the first respondent and the Scottish Ministers are the second respondent.

[2] The petitioner in the second petition is Mrs. GRO-A . She is the widow of the GRO-A GRO-A , who lived in Scotland and died here on GRO-A 2003, at the age of 66. In the second petition the Lord Advocate is the first respondent and the Scottish Ministers are the second respondent.

[3] In this Opinion, I will refer to Mrs. GRO-A as "the first petitioner", to Mrs GRO-A as "the second petitioner", to the Lord Advocate as "the first respondent" and to the Scottish Ministers as "the second respondent".

[4] In her petition the first petitioner summarises the medical history of the late Mrs. GRO-A. During 1985 and again on 24 July 1991, Mrs. GRO-A received blood transfusions, whilst she was under the care and treatment of the National Health Service in Scotland ("the NHS in Scotland"). During November 1990, it was recorded in Mrs. GRO-A's medical notes that the functioning of her liver was giving rise for some concern, but that her blood had tested negative when screened for Hepatitis C. In October 1994 Mrs. GRO-A underwent further liver function tests. In March 1995 she was diagnosed as having screened positive for the Hepatitis C virus and she was advised of that diagnosis. It is averred on behalf of the first petitioner that when that diagnosis was made, it was ascribed by Mrs. GRO-A's consultant as having "presumably" been caused by the blood transfusions she had received.

[5] When Mrs. GRO-A died on 7 May 2003 no post-mortem examination was carried out. Her death certificate contained no reference to Hepatitis C. Mrs. GRO-A's death was not reported to the Procurator Fiscal until 26 May 2004, when the first petitioner's solicitor wrote to the Procurator Fiscal requesting that a Fatal Accident Inquiry ("FAI") be held. In her petition the first petitioner avers that her late mother's death was caused, or materially contributed to, by her infection with the Hepatitis C virus in the course of the blood transfusions. For the purposes of these proceedings both respondents accept that Mrs. GRO-A's death was contributed to by her becoming infected with the Hepatitis C virus during the blood transfusions she received whilst under the care of the NHS in Scotland.

[6] In her petition the second petitioner summarises the medial history of her late husband, the GRO-A . Mr. GRO-A was a haemophiliac. During the late 1980s and subsequently, he received treatment by way of Factor VIII blood products and blood transfusions, whilst he was under the care of the NHS in Scotland. It is averred by the second petitioner that during a medical examination in 1985 Mr. GRO-A was found to be generally well. In October 1987, however,

he was found to have ulcers on his oesophagus, consistent with infection with hepatitis. Around 1989 he was diagnosed as having Non A Non B Hepatitis. Prior to the development of a test for the isolation and identification of the Hepatitis C virus during the Spring of 1989, that was how the medical profession referred to the virus that subsequently came to be known as the Hepatitis C virus. The history of the identification and naming of the Hepatitis C virus is summarised in *A and others* v *National Blood Authority and another* [2001] 3 All E R 289, (per Burton J. at pages 300-1). Around 1990 Mr GRO-A was diagnosed as suffering from Hepatitis C.

[7] When Mr GRO-A died a post-mortem examination was instructed by the Procurator Fiscal at Falkirk. The consultant pathologist, who carried out the post-mortem examination, certified that the cause of Mr GRO-A s death was Hepatocellular carcinoma in his liver; due to Hepatitis C; due to the transfusion of blood products; due to haemophilia. A copy of the post-mortem report was sent to the Procurator Fiscal. For the purposes of these proceedings both respondents accept that Mr GRO-A s death was contributed to by his having been infected with the Hepatitis C virus during treatment with blood products and blood transfusions, whilst he was under the care of the NHS in Scotland. It is averred on behalf of the petitioner that Mr. GRO-A was infected with the Hepatitis C virus during the course of blood transfusions and Factor VIII treatment he received between 1985 and 1987.

*Infection with the Hepatitis C virus in Scotland*

[8] It is a matter of public record that over a period of years from around 1980 a large number of individuals, who had been under the medical care of and receiving treatment from the National Health Service in Scotland, received blood transfusions, blood products and tissue transfer, which infected them with the Hepatitis C virus. Over 4000 individuals were infected. Some of those individuals were haemophiliacs. Others were not. A number of those individuals have died, including Mrs. GRO-A and Mr. GRO-A Amongst those who remain alive, some have developed serious medical conditions, which have caused continuing pain and disability and have led to reduction of life expectancy.

[9] It is also a matter of agreement that the circumstances in which those individuals came to be infected with Hepatitis C virus, the consequences of their infection and the National Health Service's handling of the public health issues involved have given rise to public concern, including continuing calls in the Westminster Parliament, in the Scottish Parliament and in the media for the holding of a public inquiry in Scotland. Those calling for an inquiry have included Mr. Frank Maguire, a principal in the firm of solicitors that acts for both petitioners. Those calling for a public inquiry have

maintained that a number of issues of public concern should be investigated at a public inquiry. These include (a) the failure of the Scottish National Blood Transfusion Service ("SNBTS") and the NHS in Scotland to introduce any screening test for blood donations used in the preparation of blood products and for blood transfusions in Scotland until 1 October 1991, (b) the failure on the part of the NHS in Scotland to introduce prior to April 1987 any form of heat treatment in the preparation of blood products for routine clinical use; and (c) alleged systemic failures on the part of the NHS in Scotland in (i) investigating the reasons why the widespread infection of individuals with the Hepatitis C virus from blood and blood products occurred, (ii) locating and diagnosing those individuals who might have been infected with the Hepatitis C virus, (iii) ensuring that the individuals concerned received the appropriate treatment, counselling and support and (iv) taking steps to minimise the risk of such individuals cross-infecting others with the Hepatitis C virus.

[10] The SNBTS has always been a public body. It is currently a division of the Common Services Agency, which is a Non-Departmental Public Body constituted under the provisions of the National Health Service (Scotland) Act 1978. The Common Services Agency is known as NHS National Services Scotland and is accountable to the Scottish Government. Its statutory duties include the provision of supplies of human blood for blood transfusion and the production of blood products (see Article 3(a) of the National Health Service (Functions of the Common Services Agency) (Scotland) Order 1974).

[11] There was, as I have indicated, no dispute during the hearing before me as to the existence of a level of public concern about the circumstances in which individuals had come to be infected with the Hepatitis C virus and the consequences for such individuals of having developed such infection. That public concern is also clear from the contents of certain of the productions placed before me, including the "Report on Hepatitis C and the heat treatment of blood products for haemophiliacs in the mid-1980s" prepared by officials within the Scottish Executive's Health Department during 1999-2000, the "Report of the Expert Group on financial and other support" dated 2003, which was commissioned by the Scottish Executive and prepared by a group chaired by Lord Ross, the retired Lord Justice Clerk, and Official Reports of meetings of the Health Committee of the Scottish Parliament (and papers placed before that Committee). On 18 April 2006, the Committee took a decision calling upon the Scottish Executive to hold a public inquiry into matters pertaining to Hepatitis C in Scotland, with particular reference to the adequacy of the steps taken, once the

screening of blood donors had been introduced in 1991, to trace those patients in Scotland who had previously been supplied by the SNBTS and the NHS with blood transfusions and blood products derived from infected donors.

[12] The first of these reports was published in October 2000, after the Minister for Health and Community Care in the Scottish Executive had asked Scottish Executive officials to investigate the facts surrounding the heat treatment of blood products for haemophiliacs in the mid 1980s. The officials were asked to examine the evidence available to assess, amongst other issues, "whether patients in Scotland with haemophilia were exposed to the risks of the Hepatitis C virus longer than they should have been, given the state of knowledge at the time". The findings of the group of officials included that the SNBTS had been around 18 months behind the Bio Products Laboratory in England in producing a heat-treated product which was subsequently found to have eliminated the Hepatitis C virus but that "there were understandable technical reasons why that was the case".

[13] From these papers it would appear that amongst the principal issues that give rise to general public concern are (i) why the NHS in Scotland did not introduce heat treatment for blood products in Scotland until April 1987, which was approximately 18 months later than the Bio Products Laboratory in England had introduced such treatment for blood products in England, and (ii) why the SNBTS had delayed the introduction of screening blood donations in Scotland for the Hepatitis C virus until September 1991, in particular when such screening had been introduced in certain parts of England with effect from 1 July 1991. Later in this Opinion, in para. [130], I refer to the factual issues as to when Mrs. GRO-A and Mr. GRO-A may have become infected with the Hepatitis C virus.

[14] I should also refer briefly to an inquiry that is currently underway in England. On 19 February 2007 Lord Morris of Manchester announced that a privately funded independent public inquiry was being set up under the chairmanship of a former Solicitor General, Lord Archer of Sandwell QC. The terms of reference of this inquiry are:-

> "To investigate the circumstances surrounding the supply to patients of contaminated NHS blood and blood products; its consequences for the haemophilia community and others afflicted; and further steps to address both their problems and needs and those of bereaved families".

[15] Lord Archer is being assisted in the inquiry by Lord Turnberg, immediate past President of the Royal College of Physicians, as Medical Assessor, by Dr Judith Willetts, Chief Executive Officer of

The British Society for Immunology and by Dr Norman Jones, Emeritus Consultant Physician at St Thomas's Hospital. Lord Archer has called on patients, bereaved dependants, former health ministers and others to assist the inquiry, and hopes to receive the co-operation of the relevant Government departments. He has of course no power to compel witnesses and any findings or recommendations will have no binding or legal force. The parties setting up this inquiry have noted that "independent Public Inquiries have already been conducted into this very important issue of public health concern in Canada, Ireland and New Zealand, which have all achieved the unravelling of the facts surrounding this tragedy". It was originally envisaged that Lord Archer's inquiry would be concluded by November 2007, but there remains a measure of uncertainty as to when the report will be ready.

[16] Some time after the hearings before me concluded, the media carried reports that the second respondent had given a commitment to set up a public inquiry relating to the infection of individuals with the Hepatitis C virus. I arranged a By Order hearing so that I could be fully informed what the second respondent's intentions are. These were explained to me at the By Order hearing on 22 August 2007 and subsequently confirmed in writing on behalf of each of the first and second respondents. It is clear that the Scottish Government, which assumed office in May 2007, has given a commitment to hold a public enquiry to "find out why people were infected with Hepatitis C through NHS treatment". That commitment was re-affirmed at a meeting on 16 August 2007 between the Cabinet Secretary for Health and Wellbeing and members and representatives of the Scottish Haemophilia Forum and the Haemophilia Society, including Mr. Maguire, the solicitor who acts for the petitioners in the present petitions. It was explained to me that the proposed inquiry is to be a "general public inquiry". However, the remit, scope and form of the inquiry have yet to be determined. These matters will be considered further by the second respondent after the conclusion of Lord Archer's enquiry.

[17] At the By Order hearing it was also made clear that the parties wished me to finalise my Opinion, notwithstanding the second respondent's commitment to hold a public inquiry.

*Steps taken by the petitioners to obtain public inquiries into the deaths of Mrs.* GRO-A *and Mr.* GRO-A

[18] I now turn to the history of events as far as the calls made for inquiries into the deaths of Mrs. GRO-A and Mr. GRO-A and the raising of the present petitions are concerned. On 26 May 2004, the first petitioner's solicitor wrote on her behalf to the Lord Advocate calling upon him to request that a FAI be held in terms of section 1(1)(b) of the Fatal Accidents and Sudden Deaths Inquiry

(Scotland) Act 1976 ("the 1976 Act") into the circumstances of the death of the Mrs. GRO-A The letter indicated that the first petitioner's solicitor would regard the holding of a FAI as sufficient to fulfil the State's obligation in terms of Article 2 of the EU Charter of Fundamental Rights. The letter gave notice to the Lord Advocate that if he failed to respond to the letter within 14 days, or in the event that he decided that a FAI should not be held, the solicitor would seek instructions to raise proceedings for judicial review. Prior to the date of the letter, 26 May 2004, there had been no contact between the first petitioner and the Procurator Fiscal at Glasgow or the Crown Office.

[19] On 30 April 2004 the second petitioner's solicitor had written in similar terms on her behalf to the Lord Advocate. The second petitioner had had no contact with the Procurator Fiscal at Falkirk, following upon the post-mortem examination of the body of her late husband.

[20] Following dispatch of the letters of 30 April 2004 and 26 May 2004, correspondence ensued between the petitioners' solicitor on the one hand and officials of the Procurator Fiscal at Glasgow, the Crown Office and the Minister for Health and Community Care on the other hand. In that correspondence the petitioners continued to press the first respondent to hold FAIs into the deaths of Mrs. GRO-A and Mr GRO-A and the second respondent to hold a public inquiry into the deaths of Mrs. GRO-A and Mr. GRO-A and indeed the deaths of other individuals, who had become infected with the Hepatitis C virus, whilst there were under the care of the NHS in Scotland. That correspondence was continuing when the petitions for judicial review were lodged and served on the respondents during May 2005. As at that date the first respondent has not intimated to the petitioners whether any decisions had been reached in respect of the requests to hold FAIs into the deaths of Mrs. GRO-A and Mr GRO-A and the second respondents remained unwilling to hold any public inquiries into those deaths.

[21] By letter dated 5 July 2005, Jim Brisbane, the Deputy Crown Agent, advised the petitioner's solicitor that he anticipated that the Lord Advocate would have made his decisions on whether or not to hold FAIs into the deaths of Mrs. GRO-A and Mr GRO-A by September 2005.

[22] First hearings in the petitions took place on 7 July 2005. The petitioners and respondents were represented by counsel. At these first hearings the Court was advised that the first respondent expected to take his decisions on the matters raised in the petitions by September 2005. The respondents were ordained to lodge answers to the petitions within 21 days and the petitioners were given a period of 7 days to adjust the petitions in response to these answers. Answers were intimated

on 29 July 2005.

[23] Continued first hearings were held on 24 August 2005 and were further continued, in part to enable the first respondent to take decisions within the timescale indicated to the Court by his counsel on 7 July 2005. No decisions were made (or in any event intimated) by the end of September 2005.

[24] Continued first hearings were then fixed to enable the Court to consider the question of whether the Court should make orders in relation to the potential liability for expenses of the petitioners. The orders that were sought were comparable to the protective costs orders which are available in public interest litigation in England and Wales (see *R (on the application of Corner House Research)* v *Secretary of State for Trade and Industry* [2005] 1 WLR 2600). The motions were heard by Lord Glennie and refused by him on 15 December 2005 (*McArthur* v *Lord Advocate* 2006 SLT 170), on the grounds that on the basis of the information placed before him it would not have been reasonable for him to have held, in respect of either petitioner, (a) that having regard to the financial resources of the petitioner and the respondents it was fair and just to make an order and (b) that if an order was not made the petitioner would probably discontinue with her petition and would be acting reasonably in so doing. It is clear from what was said by Lord Glennie in para. [15] of his Opinion that only a limited amount of information was placed before the Court as to the financial position of either petitioner.

[25] In January and February 2006 the Health Committee of the Scottish Parliament held public hearings into the question of whether a public inquiry should be held into the infection of individuals with the Hepatitis C virus whilst they were in the care of NHS in Scotland. On 18 April 2006 the Health Committee came to the decision to call upon the second respondent to cause an independent public inquiry to be held. Details of the Health Committee's deliberations are to be found in the Official Reports of the Scottish Parliament for 31 January 2006 and 18 April 2006.

[26] During April 2006 further first hearings were fixed in these cases for 29 and 30 June 2006. By letter dated 15 June 2006 sent by the Deputy Crown Agent to the petitioners' solicitor, intimation was given of the Lord Advocate's refusal to seek FAIs under the 1976 Act into the deaths of *inter alia* Mrs. GRO-A and Mr GRO-A

[27] The letter dated 15 June 2006 was in the following terms:-

"

GRO-A v LORD AVOCATE AND SCOTTISH MINISTERS
GRO-A v THE LORD ADVOCATE AND SCOTTISH MINISTERS

PETITIONS FOR JUDICIAL REVIEW

I refer to the above matter and to the concurrent enquiry that has been made by the Crown into the circumstances of each of these deaths.

The Lord Advocate is deeply conscious of the extent of loss and suffering that has been caused through the transmission of the Hepatitis C virus over many years through blood products and the transfusion of blood. It is a matter of deep regret that so many individuals became innocent victims at a point prior to full screening for the virus becoming available and he would wish to extend his condolences to the next-of-kin in these cases and others who have been similarly affected. He also recognises that there has been continuing interest in the fate of those so affected and the deep and lingering sense of dissatisfaction that they may feel about the past events.

The Lord Advocate has, however, in the exercise of his duty to investigate deaths, decided that a Fatal Accident Inquiry is not merited in respect of any of these deaths. In reaching that conclusion, he has had regard to inquiries carried out by the Procurator Fiscal, a further consideration of the issues by Crown Office personnel, and a review by Crown Counsel of that material, and other relevant information available on the issue of Hepatitis C infection. Regard has also been had to the representations which have been made by the next of kin, and by you on their behalf, during the discussions with the Procurator Fiscal, in correspondence, and indeed in the pleadings.

The circumstances of each of these deaths have been examined individually. None of them falls into the category of being sudden, suspicious, accidental, unexpected or unexplained. In the light of the representations that you have made, consideration has focused on the relevance of Hepatitis C infection and the possibility that that may have occurred as a result of receiving infected blood.

In respect of the late GRO-A, it is known that he was a haemophiliac who received blood products over an extensive period of his life. The issue of Hepatitis C in heat treatment of blood products for haemophiliacs has already been the subject of substantial investigation both in terms of the Scottish Executive Health Department's report of October 2000 and the investigation into allegations of criminality conducted by Crown Office in 2004.

In relation to the late GRO-A, it appears from the information available, that she contracted Hepatitis C as a result of a blood transfusion but at a point in time when no

practical, preventative measures were available. Transfusion would have been appropriate at a point when it was believed to be essential for the patient's care.

In relation to the late Mr. GRO-A , although it can be established that he became infected with Hepatitis C, this does not appear to have contributed to his death.

The deaths of these three individuals came under tragic circumstances, and naturally I would like to express our sincere condolences to the families and friends of all three. That said, none of the deaths falls into a category in which a Fatal Accident Inquiry is mandatory. Accordingly, the Lord Advocate could only order an Inquiry if it appeared to him to be expedient in the public interest to do so, on the grounds that the death occurred in circumstances such as to give rise to serious public concern. There are no issues surrounding the circumstances of these individual deaths which can be said to have caused such public concern, or which would otherwise necessitate a rehearsal of the relevant facts in a public forum.

Any wider issues of public concern surrounding the prevalence of the Hepatitis C virus, its isolation, the development of a screening test, and the management of infected patients, would be unlikely, in any event, to receive consideration within the remit of a Fatal Accident Inquiry. In addition, any such consideration would be a historical exercise which would be unlikely to produce any recommendations of relevance to modern circumstances. Any public concern that there may be in relation to the issue of Hepatitis C appears to relate to broader areas and to the circumstances of infection generally.

Having regard to the extent of the inquiry that has already been carried out into the issue of Hepatitis C infections, both within Scotland and elsewhere, to the examination of the individual circumstances of these deaths, and to the existence of other mechanisms available to affected parties, the Lord Advocate is satisfied that, insofar as Article 2 of ECHR may be engaged, the obligations of the State have been discharged. The actual nature of the process required, if Article 2 rights are engaged, varies according to context. There is no suggestion here of any use of force, lethal or otherwise, or of any other circumstances which would suggest an enhanced level of responsibility on the part of the State such as to justify any wider investigation than has taken place. The duty to make inquiry in respect of any death notified to the Procurator Fiscal as a result of Hepatitis C infection is particularly acute if there is

uncertainty as to the circumstances of infection and a prevailing consequential risk to others as a result of these deaths. Neither factor is present in these cases.

Intimation of this decision would normally be made directly to the next-of-kin but, standing your position in this matter, and the fact that they are currently litigants against the Crown, I thought it appropriate to give intimation through you."

[28] By press release dated 16 June 2006 the second respondent made public their decision to refuse to hold an inquiry into the deaths of persons such as Mrs. GRO-A and Mr. GRO-A who had died consequent upon their infection with the Hepatitis C virus whilst under the care and treatment of the National Health Service in Scotland. By 16 June 2006 the provisions of the Inquiries Act 2005 ("the 2005 Act") were in force.

[29] That press release was in the following terms:-

"News Release

**No public inquiry on Hepatitis C**

16/06/2006

A public inquiry into infection with Hepatitis C through NHS treatment would be unlikely to uncover any new relevant evidence or information and would bring little benefit to the patients involved, Health Minister Andy Kerr said today.

The Minister has written to the Health Committee in response to their call in April for a full judicial inquiry. Mr. Kerr's detailed response sets out:

- the background to the UK-wide 'look back' exercise carried out between 1995-1997 to trace as many patients as possible who had contracted Hepatitis C through blood transfusions'
- continuing Scottish National Blood Transfusion Services (SNBTS) investigations of new cases;
- testing for Hepatitis C;
- communication with patients;
- the case for a public inquiry.

He said:

'I have put on record on a number of occasions our sympathy for those who have contracted Hepatitis C through NHS treatment. I want to reiterate those comments again today.

This has had serious consequences for the lives of many people, and we do not underestimate them. It is for this reason that the Scottish Parliament and Scottish Ministers took the lead in ensuring that payments were made under the Skipton Fund to those patients affected, recognising the suffering and hardship involved. The creation of a UK payments scheme has been a significant achievement and step forward.

The UK-wide look-back exercise was decided by UK Ministers prior to devolution, based on professional advice, and reflected considerations of proportionality and practicability. There can be no case for reopening these issues now. This exercise was a complex undertaking which was carried out in a targeted and robust way.

The look-back exercise was fully communicated at the time to the public and to doctors. There was advice available through a helpline to those who were concerned about the risks from transfusion, and advice to doctors on counselling for people at risk and how to arrange for testing. I would like to emphasise that testing and counselling are still available for anyone who considers they are at risk as a result of a transfusion before 1991. Anyone who has concerns can raise those with their GP and request testing.

A full judicial inquiry would be a major and time-consuming exercise which would depend on the recollections of witnesses about events which took place twenty or more years ago. This would make it difficult to construct a clear and detailed picture of what took place.

An inquiry would not add significantly to our understanding of how the blood supply became infected with Hepatitis C, or the steps needed to deal with problems of this kind now or in the future. The transmission of Hepatitis C through the blood supply took place in the period before testing was introduced in 1991, and at a time when there was limited scientific and medical knowledge about the condition and the outlook for patients. There is already substantial published evidence on how the understanding of Hepatitis C and its implications for blood donation, blood products and blood transfusion developed over time. A public inquiry would not add to this.

Practice in terms of communication between health professionals and patients, and assessing and communicating the risks of medical treatment, has changed significantly since the 1980s when these infections occurred and important lessons have been learned. It is highly unlikely

that an inquiry would identify new issues or areas for improvement in practice for the future which have not already been discussed or implemented.

I have considered very carefully the points which were put before the Committee, and discussed by it on 18 April. I do not believe a public inquiry would either uncover any new evidence or information that is relevant to the causes of the infection of NHS patients through blood and blood products, or lead to significant lessons for the future.

It would be a diversion of effort from delivering and improving health services today. I cannot see that there is any possible justification for the efforts and costs that would be involved, or that this would bring any benefit to the patients involved. "

[30] After the letter of 15 June 2006 was received and the press release dated 16 June 2006 was issued, all the parties to the petitions engaged in extensive revisal of their written pleadings, in preparation for the continued first hearings which in due course came before me.

[31] Whilst that process was underway, by interlocutor dated 27 June 2006, the parties were ordered to lodge lists of the issues which they considered would require to be determined by the Court. The respondents did so, in respect of each of the petitions, in the following terms:-

"1. Whether, having regard to section 1(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, Article 2 of the European Convention on Human Rights, section 57(2) of the Scotland Act 1998 and section 6(2) of the Human Rights Act 1998, the first respondent was obliged to order a fatal accident inquiry (FAI) in the circumstances of this case.

2. Whether, in exercising his decision not to hold a FAI in the circumstances of this case, the first respondent exercised his discretion reasonably.

3. Whether, having regard to section 48(5) of the Scotland Act 1998, the Second Respondents had any power to order any such inquiry or an analogous inquiry (it not being clear what type of inquiry the petitioner seeks).

4. Whether, having regard to section 28(2) of the Inquiries Act 2005, the second respondent has any power to order any such inquiry or an analogous inquiry."

[32] The petitioners refrained from doing so. By letter dated 31 January 2007, addressed to the solicitor to the Scottish Executive (now the Scottish Government), who acts for both respondents, the solicitors for the petitioners intimated that senior counsel for the petitioners considered that the only issue that should be debated at the continued first hearings was whether or not the actions of the

respondents since the deaths of Mrs. GRO-A and Mr GRO-A had been compatible with the obligations on them under Article 2 of the European Convention on Human Rights in relation to the each of the petitioners. It was explained that senior counsel took the view that the other issues raised by the respondents were premature and/or academic, pending a ruling by the Court as to whether the respondents had acted in breach of Article 2.

[33] As set out in their written pleadings the orders sought by the petitioners in each of the petitions are in the following terms: -

> "(a) Reduction of the decision of the first respondent intimated by letter dated 15 June 2006 from the Deputy Crown Agent to the petitioner's solicitor to refuse to order an inquiry under the 1976 Act into the death of the late GRO-A (GRO-A).
>
> (b) Reduction of the decision of the second respondents intimated by press release dated 16 June 2006 and circulated in the name and under the authority of the Health Minister, Mr. Andy Kerr MSP, to refuse to order an inquiry under the 2005 Act into the death of persons such as the late GRO-A (GRO-A) who died consequent upon her infection with Hepatitis C through NHS treatment in Scotland;
>
> (c) Declarator that the petitioner is entitled to an independent, effective, and reasonably prompt public inquiry into the death of GRO-A (GRO-A), and at which her (*his*) next of kin can be legally represented, provided with the relevant material and able to cross-examine the principal witnesses, and that a failure on the part of the respondents to provide such an inquiry is incompatible with Article 2 of the European Convention on Human Rights and accordingly *ultra vires* of section 57(2) of the Scotland Act 1998;
>
> (d) An order ordaining the respondents to cause such an inquiry to be held, by such procedure, and within such period, as the Court may determine."

[34] In the event, in the written submissions which were lodged on behalf of the petitioners, to which senior counsel for the petitioners referred during his submissions before me, the motions made on behalf of the petitioners were as follows:-

> (1) Under and in terms of plea in law 4 in each petition for an order repelling the defences of each of the respondents on the grounds of their fundamental irrelevance and lack of specification;
>
> (2) Under and in terms of plea in law 1 and 4 in each petition, for an order for reduction of the

decision of the first respondent, the Lord Advocate, intimated by letter dated 15 June 2006 from the Deputy Crown Agent to the petitioners' solicitor to refuse to order an inquiry under the 1976 Act into the deaths of the late GRO-A *et separatim* of the late GRO-A respectively;

(3) under and in terms of Plea in law 2 and 4 in each petition, for reduction of the decision of the second respondents, the Scottish Ministers, intimated by press release dated 16 June 2006 and circulated in the name and under the authority of the Health Minister, Mr. Andy Kerr MSP, to refuse to order an inquiry under the Inquiries Act 2005 into the death of persons such as the late GRO-A *et separatim* of the late GRO-A respectively who died consequent upon their infection with the Hepatitis C virus ("Hepatitis C virus") through NHS treatment in Scotland; and

(4) Under and in terms of Plea in law 3 and 4 in each petition, for an order ordaining the respondents to hold inquiries into the deaths of the late GRO-A *et separatim* of the late GRO-A under procedure which is compliant with the minimum requirements of Article 2 of the European Convention on Human Rights."

[35] During the continued first hearings senior counsel for the respondents invited me to deal with all the issues specified in the Lists of Issues previously lodged on behalf of the respondents.

[36] Before the continued first hearings got underway, however, another preliminary issue arose. This was whether the Advocate General should be represented during the continued first hearings. That issue had first been raised by Lord Clarke, who presided over By Order hearings in both petitions, which took place on 21 February 2007. At the outset of the hearings before me, I raised the issue again. I was advised by senior counsel for the respondents that the Advocate General was fully aware of the continued first hearings and of the terms of the parties' written pleadings and that he did not intend to be represented during the hearings before me. He was not.

[37] During the hearings, and again during the preparation of this Opinion, I was much assisted by the extensive written submissions which counsel for the parties prepared and which were lodged in process and exchanged, in anticipation of the continued first hearings getting underway. I am very grateful to senior and junior counsel for the parties, and indeed to their solicitors, for the considerable effort that must have gone into the preparation of those documents.

*Statutory framework*

[38] Article 2 of the European Convention on Human Rights provides:-

"1. Everyone's right to life shall be protected by law. ....."

[.....]

The Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the 1976 Act") provides that:-

"Investigation of death and application for public inquiry

1. - (1) Subject to the provisions of any enactment specified in Schedule 1 to this Act and subsection (2) below, where-

(a) .....

(b) it appears to the Lord Advocate to be expedient in the public interest in the case of a death to which this paragraph applies that an inquiry under this Act should be held into the circumstances of the death on the ground that it was sudden, suspicious or unexplained, or has occurred in circumstances such as to give rise to serious public concern, the procurator fiscal for the district with which the circumstances of the death appear to be most closely connected shall investigate those circumstances and apply to the sheriff for the holding of an inquiry under this Act into those circumstances.

(2) .....

(3) An application under subsection (1) above-

(a) shall be made to the sheriff with whose sheriffdom the circumstances of the death appear to be most closely connected;

(b) shall narrate briefly the circumstances of the death so far as known to the procurator fiscal;

(c) may, if it appears that more deaths than one have occurred as a result of the same accident or in the same or similar circumstances, relate to both or all such deaths."

.....

Sheriff's determination etc.

6. - (1) At the conclusion of the evidence and any submissions thereon, or as soon as possible thereafter, the sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction-

(a) where and when the death and any accident resulting in the death took place;

(b) the cause or causes of such death and any accident resulting in the death;

(c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;

(d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and

(e) any other facts which are relevant to the circumstances of the death."

.....

(3) The determination of the sheriff shall not be admissible in evidence or be founded on in any judicial proceedings, of whatever nature, arising out of the death or out of any accident from which the death resulted.

[.....]

The Scotland Act 1998 ("the Scotland Act") provides:

" 48(5) Any decision of the Lord Advocate in his capacity as head of the systems of criminal prosecution and investigation of deaths in Scotland shall continue to be taken by him independently of any other person.

.....

57(2) A member of the Scottish Executive has no power to make any subordinate legislation, or to do any other act, so far as the legislation or act is incompatible with any of the Convention rights or with Community law. "

[.....]

The Human Rights Act 1998 ("the Human Rights Act") provides:

"6(1) It is unlawful for a public authority to act in a way which is incompatible with a Convention right.

(2) Subsection (1) does not apply to an act if -

(a) as the result of one or more provisions of, or made under, primary legislation, the authority could not have acted differently; or

(b)in the case of one or more provisions of, or made under, primary legislation that cannot be read or given effect to in a way which is compatible with the Convention rights, the authority was acting so as to give effect to or enforce those provisions.

.....

(6) "An act" includes a failure to act ...."

[.....]

The Inquiries Act 2005 provides:-

"Power to establish inquiry

1. (1) A Minister may cause an inquiry to be held under this Act in relation to a case where it appears to him that-

(a) particular events have caused, or are capable of causing, public concern, or

(b) there is public concern that particular events may have occurred.

(2) In this Act 'Minister' means-

(a) a United Kingdom Minister;

(b) the Scottish Ministers;

(c) a Northern Ireland Minister;

and references to a Minister also include references to the National Assembly for Wales.

(3) References in this Act to an inquiry, except where the context requires otherwise, are to an inquiry under this Act.

No determination of liability

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

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

.....

Setting-up date and terms of reference

5 (1) In the instrument under section 4 appointing the chairman, or by a notice given to him

within a reasonable time afterwards, the Minister must-

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

(b) before that date-

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

(ii) state whether or not the Minister proposes to appoint other members to the inquiry panel, and if so how many.

(2) An inquiry must not begin considering evidence before the setting-up date.

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

(4) Before setting out or amending the terms of reference the Minister must consult the person he proposes to appoint, or has appointed, as chairman.

(5) Functions conferred by this Act on an inquiry panel, or a member of an inquiry panel, are exercisable only within the inquiry's terms of reference.

(6) In this Act 'terms of reference', in relation to an inquiry under this Act, means-

(a) the matters to which the inquiry relates;

(b) any particular matters as to which the inquiry panel is to determine the facts;

(c) whether the inquiry panel is to make recommendations;

(d) any other matters relating to the scope of the inquiry that the Minister may specify.

.....

United Kingdom inquiries

27 (1) This section applies to an inquiry for which a United Kingdom Minister is responsible.

(2) The Minister may not, without first consulting the relevant administration, include in the terms of reference anything that would require the inquiry-

(a) to determine any fact that is wholly or primarily concerned with a Scottish matter or a Welsh matter;

(b) to determine any fact that is wholly or primarily concerned with a matter which is, and was at the relevant time, a transferred Northern Ireland matter;

(c) to make any recommendation that is wholly or primarily concerned with a Scottish matter, a Welsh matter or a transferred Northern Ireland matter.

(3) Unless the Minister gives written permission to the chairman, the powers conferred

by section 21 are not exercisable-

(a) in respect of evidence, documents or other things that are wholly or primarily concerned with-

(i) a Scottish matter or a Welsh matter, or

(ii) a matter which is, and was at the relevant time, a Northern Ireland matter;

(b) so as to require any evidence, document or other thing to be given, produced or provided by or on behalf of the Scottish Ministers, the National Assembly for Wales or a Northern Ireland Minister.

(4) Before granting permission under subsection (3) the Minister must consult the relevant administration.

(5) Permission under subsection (3) may be granted subject to such conditions or qualifications as the Minister may specify.

(6) Permission under subsection (3) is not required for the exercise of powers in circumstances in which subsection (6) of section 30 would prevent the powers from being exercised in the case of an inquiry to which that section applies.

(7) In this section-

.....

'the relevant administration' means whichever of the following the case requires-

(a) the Scottish Ministers;

(b) the National Assembly for Wales;

(c) such one or more Northern Ireland Ministers as appear to the Minister to be appropriate;

'the relevant time' means the time when the fact or event in question occurred (or is alleged to have occurred);

'Scottish matter' means a matter that relates to Scotland and is not a reserved matter within the meaning of the Scotland Act 1998 (c. 46);

.....

Scottish inquiries

28 (1) This section applies to an inquiry for which the Scottish Ministers are responsible.

(2) The terms of reference of the inquiry must not require it to determine any fact or to

make any recommendation that is not wholly or primarily concerned with a Scottish matter.

(3) The powers conferred by section 21 are exercisable only-

(a) in respect of evidence, documents or other things that are wholly or primarily concerned with a Scottish matter, or

(b) for the purpose of inquiring into something that is wholly or primarily a Scottish matter.

(4) Those powers are not exercisable so as to require any evidence, document or other thing to be given, produced or provided by or on behalf of Her Majesty's Government in the United Kingdom, the National Assembly for Wales or a Northern Ireland Minister.

(5) In this section 'Scottish matter' means a matter that relates to Scotland and is not a reserved matter (within the meaning of the Scotland Act 1998).

.....

Joint inquiries

32 (1) The power under section 1 to cause an inquiry to be held, or to convert an inquiry under section 15, is exercisable by two or more Ministers acting jointly.

(2) In this Act 'joint inquiry' means an inquiry for which by virtue of this section, or section 34, two or more Ministers are responsible.

(3) In the case of a joint inquiry-

(a) powers conferred on a Minister by any provision of this Act (except section 41) are exercisable by the Ministers in question acting jointly;

(b) duties imposed by this Act on a Minister are joint duties of those Ministers.

(4) Subsection (3)(b), so far as relating to obligations under section 39, is subject to any different arrangements that may be agreed by the Ministers in question.

Inquiries involving more than one administration

33 (1) This section applies to a joint inquiry for which the Ministers responsible ('the relevant Ministers') are not all United Kingdom Ministers and are not all Northern Ireland Ministers.

(2) A limitation imposed by section 27(2), 28(2), 29(2) or 30(2) or (3) on the terms of reference of an inquiry for which a particular Minister is responsible has effect only to the extent that it applies in relation to all of the relevant Ministers.

(3) A limitation imposed by section 27(3), 28(3) or (4), 29(3) or (4) or 30(4) or (5) on the powers conferred on the chairman of an inquiry for which a particular Minister is responsible has effect only to the extent that it applies in relation to all of the relevant Ministers.

(4) Subsections (6) and (7) of section 30 do not apply if at least one of the relevant Ministers is a United Kingdom Minister."

[.....]

*Submissions on behalf of the petitioners*

[39] The petitions are brought by the petitioners as the relatives of two individuals who died after they had become infected with the Hepatitis C virus, whilst under the care of the NHS in Scotland. It is argued that in terms of Strasbourg jurisprudence the petitioners have the status of victims. The petitioners thus have sufficient title and interest to raise the present proceedings, which seek to found on the failures of the respondents to order inquiries into the deaths of their relatives. Those failures are alleged to be incompatible with the Convention rights of Mrs. GRO-A and Mr. GRO-A under Article 2 and, as a consequence, outwith the powers of the respondents under the Scotland Act. As such they constitute a failure to comply with the obligations placed on the United Kingdom under Article 2.

[40] Senior counsel for the petitioners explained that the petitioners sought public inquiries into the deaths of their relatives. They had no private financial or other legal interest in the outcome of the petition proceedings. Whilst at an earlier stage following upon the deaths of Mrs. GRO-A and Mr. GRO-A it would have been open to the petitioners to have raised civil proceedings against individuals employed within the NHS, or against statutory bodies or agencies operating as parts of the NHS in Scotland, the petitioners had never had the inclination nor the financial resources to do so. Any rights to claim compensation they might have had were now time-barred and, in any event, at least in the case of the first petitioner, any compensation that might have been recoverable would have been minimal. What the petitioners now sought were orders from the Court that would require the respondents to respect the Convention rights of Mrs. GRO-A and Mr. GRO-A by holding inquiries into

the circumstances in which Mrs. GRO-A and Mr GRO-A came to be infected with the Hepatitis C virus and of their subsequent deaths. Those circumstances included the acts and omissions of those responsible for the collection and subsequent supply of the blood donations with which Mrs. GRO-A and Mr GRO-A had been transfused and in the preparation of the blood products with which Mr. GRO-A had been treated.

[41] Senior counsel for the petitioners explained that there were no non-governmental organisations or other interest groups, which could be accorded the status of victims in respect of the deaths of Mrs. GRO-A or Mr GRO-A or which could otherwise establish sufficient title and interest to raise judicial review proceedings challenging the respondents' refusal to hold public inquiries into those deaths. In presenting this branch of his submissions, senior counsel for the petitioners freely acknowledged that the petitioners also consider that they have raised their petitions in the public interest. That is because many other persons were infected with the Hepatitis C virus in similar circumstances to Mrs. GRO-A and Mr GRO-A Some of those individuals have died and others remain under the care of the NHS in Scotland.

[42] Senior counsel for the petitioners submitted that the effect of section 57(2) of the Scotland Act 1998 was that the respondents did not have power to act in a manner incompatible with any of the Convention rights of Mrs. GRO-A and Mr GRO-A and the petitioners. Any purported actings (or failures to act) on the part of either of the respondents in contravention of a Convention right were *ultra vires*. That included situations when the respondents had been taking discretionary decisions in the exercise of their statutory powers.

[43] The submissions advanced on behalf of the petitioners in respect of Article 2, were extensive. It was stressed, amongst other points, that the Strasbourg Court has held (a) that an individual's rights under Article 2 to have his life protected by law can impose a correlative duty on the State to provide for a public inquiry into his death (see *McCann v United Kingdom* (1995) 21 EHRR 97, *Anchovy and others v Bulgaria* (2006) 42 EHHR 43, and *Öneryildiz v Turkey* ECtHR (Grand Chamber), 30 November 2004); (b) the persons responsible for carrying out such an investigation require to be independent in practice, as well as in theory, from those implicated in the events relating to the death (*Trubnikov v Russia,* ECtHR (Grand Chamber), 5 July 2005 and *Edwards v United Kingdom* (2002) 35 EHRR 487, (c) that is so even where there was no direct or indirect State responsibility for the death (see *Menson and others v United Kingdom* (Application no.47916/99) ECtHR non-admissibility

decision of 6 May 2003 (2003) 37 EHRR CD 220 and *Pereira Henriques v Luxembourg,* ECtHR, 9 May 2006); and (d) a State's obligations under Article 2 include the obligation to investigate the death of an individual who had been under the care and responsibility of the medical profession (see *Erickson v Italy* 29 EHRR CD 152, 156 (ECtHR 26 October 1999), *Powell v United Kingdom* (2000) 30 EHRR CD 362, Reports of Judgments and Decisions 2000-V, p.397, *Sieminska v Poland* App No. 37602/97 (29 March 2001, unreported), *Calvelli and Ciglio v Italy* ECtHR 17 January 2002 and *Vo v France* (2005) 40 EHRR 259, ECtHR (Grand Chamber), 8 July 2004).

[44] When referring to Strasbourg jurisprudence, senior counsel for the petitioners founded in particular on the case of *Öneryildiz v Turkey*. It was an important part of his submission that in the particular circumstances of the present cases the absence of any inquiry initiated by the respondents meant that the obligations of the United Kingdom under Article 2 had not been fulfilled.

[45] The case of *Öneryildiz v Turkey* arose out of a methane explosion at a household refuse tip which was operated by a local authority and in respect of which other municipal authorities had responsibilities. The explosion caused a landslide, which engulfed the applicant's house and killed his close relatives. Relying on Articles 2 and 8 of the European Convention on Human Rights, the applicant claimed that the local authorities had been responsible for the deaths of his relatives and for the destruction of his home and property. In para. 92 of its Judgment the Grand Chamber distinguished the case on its facts from cases such as *Calvelli and Ciglio v Italy* and *Vo* v *France*, in which the Court had previously held that, if the infringement of the right to life or to physical integrity has not been caused intentionally, the positive obligation to set up an effective judicial system did not necessarily require criminal proceedings to be brought in every case and could be satisfied if civil, administrative, or even disciplinary remedies were available to the victims. Having regard to the dangerous activities of the operations carried out at the refuse tip, the level of risk those activities posed to human life, and the fact that the true circumstances of the deaths were, or might be largely confined within the knowledge of state officials and authorities, the Grand Chamber held that the principles applicable to the procedural requirement of Article 2 were those identified as being appropriate for cases in which death had occurred on account of lethal force. That was justified not only because such deaths normally give rise to criminal liability, but also because what often occurs is that the true circumstances of the death are, or may be, largely confined within the knowledge of state officials and authorities (para. 93 of the Court's Judgment).

[46] The submissions advanced on behalf of the petitioners also dealt with how that line of Strasbourg jurisprudence had been considered in recent cases before courts in England and Scotland. Detailed reference was made to *R (Wright)* v *Secretary of State for the Home Department* [2001] Lloyd's Rep Med 478, [2001] UKHRR 1399, [2002] HRLR 1; *R (Khan)* v *Secretary of State for Health* [2004] 1 WLR 971; *R (Amin)* v *Secretary of State for the Home Department* [2004] 1 AC 653; *R (Middleton)* v *West Somerset Coroner and another* [2004] 2 AC 182; (HL) (11 March 2004); *R (Sacker)* v *West Yorkshire Coroner* [2004] 1 WLR 796; *Al Fayed* v *Lord Advocate* 2004 SC 568; *R (Plymouth CC)* v *HM Coroner* [2005] 2 FLR 1279, *R (Takoushis)* v *Inner North London Coroner* [2006] 1 WLR 461; *R (on the application of D)* v *Secretary of State for the Home Department (Inquest intervening)* [2006] 3 All E R 946; *R (Lin and Others)* v *Secretary of State for Transport* [2006] EWHC 2558; *Scholes* v *Secretary of State for the Home Department* [2006] HRLR 44; *R (JL)* v *Secretary of State for the Home Department* [2006] EWHC 2558; and *R (Gentle and another)* v *Prime Minister and others* [2006] All E R (D) 147(Dec).

[47] From these authorities senior counsel sought to draw certain propositions, which he submitted were relevant to the issues that arise in the present cases:- (a) Article 2 is one of the most fundamental provisions of the Convention and is underpinned by a profound respect for the sanctity of human life; (b) the Court's approach to Article 2 should be guided by the fact that the object and purpose of the Convention as an instrument for the protection of individual human beings requires its provisions to be interpreted and applied so as to make its safeguards practical and effective; (c) Article 2 imposed on the State a procedural obligation to initiate an effective public investigation following upon the death of an individual where an agent of the State has been, or may have been in some way, implicated in the factual circumstances relating to that death; (d) such an obligation arose when the individual who had died had been under the care of the National Health Service and had died in circumstances which give rise to reasonable grounds for thinking that the death may have been caused or contributed to by a wrongful act on the part of an employee of the National Health Service; (e) the procedural obligation introduced by Article 2 has three interlocking aims: to minimise the risk of future deaths, to give the beginning of justice to the bereaved, and to assuage the anxieties of the public; (f) any investigation required to satisfy Article 2 should be carried out by a person independent from those implicated in the events, should be reasonably prompt and should allow the involvement of the next-of-kin of the deceased to an appropriate extent; (g) any investigation required

to satisfy Article 2 must be practicable, in the sense of being capable of establishing (1) the factual circumstances of the death, (2) whether the death was caused by any action or inaction complained about, (3) any steps which could have been taken, but which were not taken, to prevent the death and (4) any precautions which ought to be taken to prevent future deaths; (h) any investigation required to satisfy Article 2 should also be capable of ensuring a sufficient element of public scrutiny to secure accountability; (i) decisions as to the holding of, and the procedures for the conduct of, an inquiry to satisfy any obligation under Article 2 should be kept separate from the merits and possible outcome of the inquiry; and (j) the holding of an FAI under the 1976 Act would satisfy any procedural obligation on the United Kingdom (or the respondents) under Article 2 to carry out effective investigations into the deaths of Mrs. GRO-A and Mr. GRO-A

[48] Applying those propositions to the facts of the present cases, it was argued that the obligations on the United Kingdom, and in turn on the first and second respondents, under Article 2 were directly engaged in relation to deaths such as those of Mrs. GRO-A and Mr GRO-A which had occurred in Scotland since the coming into force of the Scotland Act. Section 100 of the Scotland Act envisaged proceedings being taken against the Scottish Ministers (including the Lord Advocate) in respect of their acts, or failures to act, in a manner that had been incompatible with the Convention rights specified as such in Schedule 1 to the Human Rights Act.

[49] Article 2 enjoined the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate legislative and administrative steps to safeguard the lives of those within its jurisdiction. The State's obligation in this respect also implied, in "certain well-defined circumstances", a positive obligation on the State's authorities to take preventive operational measures to protect an individual whose life is at risk from the acts of another individual.

[50] Article 2 could therefore be relied upon as imposing a duty on a State's authorities to provide for an effective official investigation into a death, when agents of the State had been responsible for it, and also when there was insufficient evidence to establish (or where it would be otherwise inappropriate to hold) that the death had been caused by such agents. The essential purpose of such an investigation was to secure the effective implementation of the domestic laws which protect the right to life and, in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility.

[51] It was acknowledged that the form of investigation required to achieve that purpose would vary

in different circumstances. There required to be a measure of flexibility in selecting the means of conducting the investigation. The choice of method was essentially a matter for decision by the contracting State within its own domestic legal order. The manner in which the investigation should take place depended upon the context of the death in question. Whatever mode of investigation was employed, the authorities must act of their own motion, once the matter had come to their attention. They could not leave it to the initiative of the next-of-kin to lodge a formal complaint or to take responsibility for the conduct of any investigative procedures.

[52] It was argued that the case of *Öneryildiz* v *Turkey* illustrated how even in the field of refuse disposal Article 2 may be engaged. The engagement of Article 2 was all the more appropriate in respect of deaths which followed upon the receipt of blood transfusions given at a time when the State may have been aware about, and in any event should have been aware of, the risk of infection with a Hepatitis virus. The judicial system required by Article 2 placed an obligation on the respondents, as the competent authorities in Scotland, to act with exemplary diligence and promptness. They had not done so. The deaths which had given rise to the petitions had occurred some years ago. The respondents should have initiated independent investigations capable of (a) ascertaining the circumstances in which blood transfusions and treatment with blood products contaminated with the Hepatitis C virus had taken place, (b) identifying any shortcomings in the operation of the regulatory system relating to blood transfusions and the supply of blood products, (c) identifying the public officials and authorities constituting, associated with or employed within the NHS in Scotland, who had been involved in whatever capacity in the chain of events giving rise to Mrs. GRO-A and Mr. GRO-A having become infected with the Hepatitis C virus, (d) establishing what those officials and authorities did, or refrained from doing, over the relevant periods and (e) holding them accountable for their actings. No steps to achieve that had been taken by the respondents.

[53] Senior counsel for the petitioners also advanced supplementary submissions relating to the terms of the letter dated 15 June 2006 and the adequacy of the reasons set out in that letter as justifying the Lord Advocate's refusal to seek FAIs. Under reference to *Wordie Property Co Ltd.* v *Secretary of State for Scotland* 1984 SLT 345, *R (Hurst)* v *London Northern District Coroner* [2005] 1 WLR 3892, *South Bucks District Council and another* v *Porter* (No 2) [2004] 1 WLR 1953 and *Koca* v *Secretary of State for the Home Department* 2005 SC 487, it was submitted that the decisions of the first respondent refusing to hold FAIs into the deaths of Mrs. GRO-A and Mr GRO-A were

unsustainable. It was argued that the terms of the letter of 15 June 2006 disclosed that the Lord Advocate had failed to reach a concluded view as to whether or not Article 2 had been engaged, in respect of the deaths of Mrs. GRO-A and Mr GRO-A It had been. That error having been made, the Lord Advocate had failed to give proper consideration to what bearing Article 2 should have upon the exercise of his statutory powers under the 1976 Act as to whether to order FAIs in relation to the deaths of Mrs. GRO-A and Mr GRO-A

[54] It was also argued that the Lord Advocate had misdirected himself as to the scope of FAIs under the 1976 Act. That was illustrated by the following passage in the letter dated 15 June 2006:-

> "Any wider issues of public concern surrounding the prevalence of the Hepatitis C virus, its isolation, the development of a screening test and the management of infected patients, would be unlikely, in any event, to receive consideration within the remit of a Fatal Accident Inquiry."

It was pointed out that the scope of any FAI held under the 1976 Act and of any recommendations made at the conclusion of the FAI were matters for the Sheriff, who would himself, by virtue of the provisions of section 6 of the Human Rights Act, require to have regard to the requirements of Article 2.

[55] The terms of the letter indicated that the Lord Advocate had allowed his own prediction as to the likely outcome of any inquiry to play a part in his decision as to whether an inquiry should take place. That was a further error on his part (see *R (Amin)* v *Secretary of State for the Home Department* [2004] 1 AC 653, per Lord Steyn at para. 52).

[56] There was also a factual inaccuracy in the letter relating to the death of Mrs. GRO-A, when the author of the letter had asserted that it appeared "from the information available that she had contracted Hepatitis C as a result of a blood transfusion but at a point in time when no practical, preventive measures were available". Mrs. GRO-A underwent two blood transfusions, the first during 1985 and the second on 24 July 1991, by which date a test for the Hepatitis C antibody testing was available. During 1990 Mrs. GRO-A underwent a Hepatitis C test that proved negative. On that basis, it appeared that Mrs. GRO-A may not have contracted the Hepatitis C virus from the blood transfusion she received during 1985.

[57] It was argued that it had not been open to the Lord Advocate to reach the conclusion that there were "no issues surrounding the circumstances of (*the*) deaths (*of Mrs.* GRO-A *and Mr.* GRO-A which

could be said to have caused (*serious*) public concern, or which would otherwise necessitate a rehearsal of the relevant facts in a public forum". The letter dated 15 June 2006 had made no reference to the numerous calls there had been for a public inquiry in Scotland into deaths arising from infection with the Hepatitis C virus following blood transfusions. The letter had referred to the Lord Advocate's reliance upon inquiries carried out within Scotland, which were understood to be those carried out by the Scottish Executive Health Department, the Expert Group and the Crown Office. However, neither of those inquiries had been Article 2 compliant inquiries in respect of the deaths of Mrs. GRO-A and Mr GRO-A In particular neither of them had allowed for the participation of the families of the deceased. Furthermore the letter dated 15 June 2006 indicated that the Lord Advocate had relied on "the existence of other mechanisms available to affected parties", without specifying what those mechanisms were and how individual procedures, which might fall within that general description, such as criminal proceedings, disciplinary procedures and civil claims for damages, could provide a practical and effective means of allowing for the investigation of concerns that systemic failures within the National Health Service in Scotland had caused or contributed to the deaths of Mrs. GRO-A and Mr GRO-A The Lord Advocate had therefore been in error when he had reached the conclusion that he was "satisfied that, insofar as Article 2 of ECHR may be engaged, the obligations of the State have been discharged." That was not a conclusion he had been entitled to reach. In any event, his reasons for doing so were inadequate and flawed.

[58] In anticipation of submissions that were to be advanced on behalf of the respondents, to the effect that it would not have been competent for the second respondents to have ordered any inquiries into the deaths of Mrs. GRO-A and Mr GRO-A senior counsel for the petitioners argued that the provisions of section 48(5) of the Scotland Act merely confirmed the independence of the first respondent, as Lord Advocate, in reaching decisions in her capacity as head of the system of investigation of deaths in Scotland. Those statutory provisions did not confer on the first respondent a sole and exclusive jurisdiction in the investigation of deaths that have occurred in Scotland. That had not been the position pre-devolution, when a number of public inquiries into deaths, which had occurred in Scotland, had been set up by Ministers of the Crown, other than the Lord Advocate. There was no reason why it should be the position post-devolution, where the Scottish Ministers are intended to stand in the place of the Secretary of State for Scotland in relation to functions that were within devolved competence. The setting up of statutory inquiries into deaths fell within devolved

competence, because it was not a reserved matter within the meaning of section 30 and schedule 3 to the Scotland Act. In any event, such inquiries into the deaths of Mrs. GRO-A and Mr GRO-A could be set up by the second respondents under the Inquiries Act 2005.

*Submissions on behalf of the respondents*

[59] In responding to those submissions, senior counsel for the respondents dealt initially with the submissions on behalf of the petitioners which had been directed against the first respondent. It was submitted that any decisions of the first respondent into the investigation of the deaths in Scotland required to be carried out within the framework of the 1976 Act. Having regard to the provisions of section 48(5) of the Scotland Act, the Lord Advocate retained her capacity as head of the system of investigation of deaths in Scotland. As head of that system, the Lord Advocate was bound by historical constitutional precedent, as continued by section 48(5) of the Scotland Act, to make any decisions independently of any other person.

[60] Any FAIs into the deaths of Mrs. GRO-A and Mr GRO-A could only have been sought under the provisions of section 1(1)(b) of the 1976 Act. The exercise of the Lord Advocate's discretion under section 1(1)(b) was unfettered, other than by considerations arising out of Article 2. Senior counsel argued that the decisions of the first respondent not to order FAIs had been soundly based in law and that they had fallen within the discretion of the first respondent. He had not failed to have regard to the relevant legislative framework. He had not failed to take into account any relevant or material consideration, nor had he taken into account any irrelevant consideration. He had not fettered his discretion by the inflexible application of any rigid policy, without having regard to the particular circumstances relating to each of the deaths of Mrs. GRO-A or Mr GRO-A He had not acted in bad faith. Nor had he displayed "Wednesbury unreasonableness".

[61] Under reference to the detail of the provisions of section 1(1)(b) of the 1976 Act, senior counsel for the respondents pointed out that the only category into which the deaths of Mrs. GRO-A and Mr. GRO-A might have fallen would be that the deaths had occurred in circumstances such as to give rise to public concern. If they had done so, the Lord Advocate would have required to consider whether inquiries into the deaths would be in the public interest. As the letter of 15 June 2006 made clear, it was recognised that there may be wider issues of public concern surrounding the prevalence of the Hepatitis C virus, its isolation, and the development of screening and the management of infected patients. However, the Lord Advocate had taken the view that it was unlikely that such issues

would receive consideration within the remit of FAIs into the deaths of Mrs. GRO-A and Mr. GRO-A He had also taken the view that any FAIs would be of an historic nature and would be unlikely to produce any recommendations of relevance to modern circumstances. It had been entirely appropriate for the Lord Advocate to have regard to the practical benefits and drawbacks of holding FAIs and it had been open to him to reach the conclusion that it would not be expedient in the public interest to do so. Account had also be taken of the particular investigations into the circumstances of the deaths of Mrs. GRO-A and Mr GRO-A which had been carried out by the Procurator Fiscal in consultation with the petitioners and other family members, the investigations into potential criminal proceedings undertaken following the death of Mr. GRO-A and "the many and varied investigations into the questions of Hepatitis C contamination of blood and blood products".

[62] Turning to Article 2, senior counsel for the respondents did not dispute that Article 2 was engaged following the deaths of Mrs. GRO-A and Mr. GRO-A He argued, however, that in the circumstances relating to the deaths of Mrs. GRO-A and Mr GRO-A it was not open to the petitioners to argue that there had been any breach by the respondents of the substantive obligations on them (a) not to take the lives of Mrs. GRO-A or Mr GRO-A and (b) to establish a system of laws, precautions, procedures and means of enforcement which would, to the greatest extent reasonably practicable, protect life. There had not been any systemic failures on the part of the NHS in Scotland, or on the part of any agency or person employed within the NHS in Scotland, to protect the lives of individuals, such as Mr GRO-A who suffered from haemophilia. Nor had there been any gross negligence such as would have founded a prosecution. Any possible breach of such a substantive obligation could only have arisen once it had become known, from around 1989 onwards, that there was a risk of persons becoming infected with the Hepatitis C virus. Only then could it be said that it would have been reasonably practicable for the State to have taken additional steps to protect human life and prevent Mrs. GRO-A and Mr. GRO-A from becoming infected with the Hepatitis C virus. In the cases of Mrs. GRO-A and Mr GRO-A the actings of the NHS in Scotland, at the time they were taken, had been as reasonably practicable as they could have been.

[63] Senior counsel for the respondents argued that Article 2 only imposed a procedural obligation on a State, to initiate an effective public investigation by an independent official body, in respect of a death occurring in circumstances in which it appeared that one of the substantive obligations within Article 2 had been or may have been violated and (emphasis added) that agents of the State had been,

or may have been, implicated, in some way, in any such violation. The question as to whether there had been a breach of the procedural obligation imposed by Article 2 accordingly involved a two-stage test. The first stage involved addressing whether or not the State, or one of its agents, had arguably acted in breach of one of the substantive obligations arising under Article 2. The second stage, namely that of considering whether there had been a breach of the procedural obligation to initiate an inquiry, only arose in the event that the party seeking to establish a failure to comply with Article 2 had satisfied the first stage of the two-stage test and had demonstrated that the State or one of its agents had potentially been in breach of one of the substantive obligations arising under Article 2.

[64] Having regard to what was said by Lord Bingham in *R (Middleton)* (at para.3), it would require to have appeared to the first respondent that the substantive obligation under Article 2 had been or may have been, violated and that agents of the State had been, or may in some way have been, implicated in such violation, before he was required to implement the State's procedural obligation by initiating an effective public investigations into the death. Accordingly, the test upon the first respondent, imposed by the State's obligations under Article 2, was in two stages: (i) consideration of whether there had been or may have been a breach the substantive obligation on the State by agents of the State; and (ii) if so, implementation of the procedural obligation imposed on the State by Article 2.

[65] Looking at the first stage, the question that arose was whether there had been any reason for the Lord Advocate to consider that the substantive obligations under Article 2 had been or might have been violated in a way that implicated agents of the State, who could have included those employed within the SNBTS and the NHS in Scotland (see *R (Khan)* (*supra*)). It was submitted that on the basis of the very considerable body of information before the Lord Advocate it would not have been reasonable for him to have concluded that there had been any gross negligence or any suggestion of a cover up such as to render the deaths of Mrs. GRO-A and Mr. GRO-A exceptional cases as identified in *R(Khan)*. For that reason the first stage of the test had not been satisfied.

[66] Accordingly the Court did not require to consider whether the second part of the test had been met. That meant that all the Court was engaged in, in respect of each petition, was a review of the decision not to hold a FAI, which had been a decision made by the first respondent in the exercise of his discretion under the 1976 Act. Accordingly, the question that the Court required to consider in the present cases was not whether the State, as represented by the respondents, had acted in a way that

was inconsistent with its substantive obligations under Article 2, but rather whether or not the decisions of the first respondent had been reasonable, having regard to all of the facts and circumstances of the deaths of Mrs. GRO-A and Mr. GRO-A

[67] Senior counsel for the respondents submitted that, even if it were to be concluded by the Court that the first stage of the two-stage test had been satisfied, as far as the second stage of the test was concerned, the Court should be satisfied that the first respondent had been entitled to take the view that the wide variety of information available to him, whose recovery had been initiated by the State, had collectively amounted to effective public investigations into the circumstances of the deaths of Mrs. GRO-A and Mr. GRO-A

[68] Senior counsel for the respondents submitted that the statutory framework set out in the 1976 Act for the holding of FAIs met the procedural obligations imposed upon the United Kingdom by Article 2. However, senior counsel for the respondents also stressed that it was not necessary for the State to hold an Article 2 compliant investigation following the death of every individual who had received treatment from, or was under the care of, the NHS in Scotland. The jurisprudence relating to Article 2, both Strasbourg and domestic, made it clear that there is a "sliding scale" of procedural obligations incumbent upon a State in the event that the substantive obligation has been or might have been violated, with the implication that agents of the State had been or might have been implicated in that violation. Furthermore not every investigation need amount to a full public inquiry within the scope of the 1976 Act, before Article 2 can be complied with. In addition to the possibility of a FAI taking place, the State had provided for remedies to be sought in the civil courts by relatives of a deceased who wished to make allegations of professional negligence, albeit that it was understood that in the present cases no such allegations were actually being advanced by the petitioners against any identified individuals. Against that, however, it should not be ignored that over 80 actions for damages had been raised in the Court of Session and the Sheriff Court following upon patients having become infected with the Hepatitis C virus, whilst under the care of the NHS in Scotland. Those actions had proceeded on the grounds of negligence and product liability. Certain of those cases remained current. Others had settled, including some in which a payment of damages had been made. None had proceeded to proof.

[69] It was pointed out that the jurisprudence flowing from Article 2 required that there be a prompt and reasonably expeditious investigation into any actual or potential breaches of the substantive

obligations on the State. The purpose of that investigation was to effect a practical, preventive and accountable response, in order to support the substantive obligations on the State. In the circumstances of the present cases, there could be no "prompt and reasonably expeditious investigation" at this late stage. However such investigations had already been undertaken in respect of each death. The holding of further inquiries would be neither prompt nor reasonably expeditious. Furthermore such inquiries would be unlikely to provide any information or advice that would have any practical effect in ending any activity on the part of the State or agents of the State which might have been in breach of the United Kingdom's obligations under Article 2. The discovery, isolation and subsequent screening of blood and blood products for this virus were now undertaken routinely. For that reason the implementation of any procedural obligation on the State into the circumstances of the deaths of Mrs. GRO-A and Mr GRO-A would have no practical result.

[70] It was submitted that having regard to the nature of the procedural obligation incumbent upon the State, the first respondent's decisions not to arrange for the holding of FAIs were not open to challenge. The first respondent had implemented the procedural obligation of the State in a manner entirely consistent with Article 2.

[71] Before concluding his submissions, senior counsel for the respondents pointed out that the petitioners gave no specification of the statutory basis or framework under which the second respondents might convene any inquiry the Court might order them to hold. What was sought by the petitioners was the reduction of the decision of the Health Minister of 16 June 2006 to refuse to order an inquiry under the Inquiries Act 2005 into the death of persons such as Mrs. GRO-A and Mr GRO-A declarator that the petitioners were entitled to independent, effective and reasonably prompt public inquiries into the deaths of Mrs. GRO-A and Mr GRO-A at which their next of kin could be legally represented; and an order ordaining the second respondents to cause such inquiries to be held, by such procedure, and within such period, as the Court may determine.

[72] It was submitted on behalf of the second respondents that the orders sought by the petitioners in respect of the second respondents could not be competently granted by the Court. That was because the sole and exclusive jurisdiction for investigating deaths in Scotland lies in the hands of the first respondent, by virtue of her appointment as the Lord Advocate. That exclusive jurisdiction had been maintained by section 48 (5) of the Scotland Act 1998. It was submitted that standing the terms of that statutory provision the second respondents could not order or hold any inquiry into the deaths of

Mrs. GRO-A or Mr. GRO-A It would be *ultra vires* for them to do so, in that setting up such inquiries would exceed the powers conferred on them by the Scotland Act, from which legislation they derive their competence and authority. Moreover, were the second respondents to hold any inquiry that would amount to an act usurping and interfering with the independence of the first respondent and her decision-making powers as head of the systems of criminal prosecution and investigation of deaths in Scotland.

*Discussion*

[73] In paras. [31] - [35] of this Opinion, I outlined the remedies the petitioners seek and the issues that the respondents wish the Court to determine. In light of the very carefully prepared and delivered submissions I have received, I intend to address the following issues:-

i. *Is Article 2 engaged following the deaths of Mrs.* GRO-A *and Mr.* GRO-A

ii. *Whether the actings of the respondents since the deaths of Mrs.* GRO-A *and Mr.* GRO-A *have been compatible with Article 2?*

iii. *If the first respondent has failed to act in a manner compatible with Article 2 whether such failure constitutes grounds for reducing the decisions of 15 June 2006 refusing to order FAIs into the deaths of Mrs.* GRO-A *and Mr.* GRO-A

iv. *Are there any other grounds for reducing the decisions of the first respondent of 15 June 2006 refusing to order FAIs into the deaths of Mrs.* GRO-A *and Mr.* GRO-A

v. *Whether, having regard to the provisions of section 1(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, Article 2 of the European Convention on Human Rights, section 57(2) of the Scotland Act 1998 and section 6(2) of the Human Rights Act 1998, the first respondent is obliged to order FAIs into the circumstances of each of the deaths of Mrs.* GRO-A *and Mr* GRO-A

vi. *If the actings of the second respondent have not been compatible with Article 2, are there are grounds for reducing their decision, intimated by the press release dated 16 June 2006, refusing to order a full judicial inquiry into the infection of patients of the NHS with the Hepatitis C virus?*

vii. *Having regard to the provisions of section 48(5) of the Scotland Act 1998 and section 28(2) of the Inquiries Act 2005 does the second respondent have any power to order*

*inquiries into the circumstances of the deaths of Mrs.* GRO-A *and Mr* GRO-A *at which their next of kin could be legally represented, be provided with the relevant material and be able to cross-examine the principal witnesses?*

viii. *Should a declarator be pronounced in favour of the first petitioner that she is entitled to an independent, effective and reasonably prompt public inquiry into the death of Mrs.* GRO-A *at which her next of kin could be legally represented, be provided with the relevant material and be able to cross-examine the principal witnesses, and that a failure on the part of the respondents to provide such an inquiry would be incompatible with Article 2 of the European Convention on Human Rights and accordingly ultra vires of the respondents in terms of section 57(2) of the Scotland Act 1998?*

ix. *Should a declarator be pronounced in favour of the second petitioner that she is entitled to an independent, effective and reasonably prompt public inquiry into the death of Mr* GRO-A *at which his next of kin could be legally represented, be provided with the relevant material and be able to cross-examine the principal witnesses, and that a failure on the part of the respondents to provide such an inquiry would be incompatible with Article 2 of the European Convention on Human Rights and accordingly ultra vires of the respondents in terms of section 57(2) of the Scotland Act 1998?*

x. *Should an order be pronounced in favour of the first petitioner ordaining the respondents or one of other of them to cause such an inquiry to be held, by such procedure, and within such a period, as the Court may determine?*

xi. *Should an order be pronounced in favour of the second petitioner ordaining the respondents or one or other of them to cause such an inquiry to be held, by such procedure, and within such a period, as the Court may determine?*

*Is Article 2 engaged following the deaths of Mrs.* GRO-A *and Mr.* GRO-A

[74] For the purposes of considering the application of Article 2 to the deaths of Mrs. GRO-A and Mr. GRO-A the parties are agreed that the employees of the NHS in Scotland and the SNBTS during the periods when Mrs. GRO-A and Mr. GRO-A must have become infected with the Hepatitis C virus fall to

be treated as having been agents of the State. They are also agreed that following upon the deaths of Mrs. GRO-A and Mr GRO-A questions have arisen about the circumstances leading up to each of them having become infected with the Hepatitis C virus, as a consequence of the actings of agents of the State, and when such infection occurred. On that basis, they are agreed the provisions of Article 2 are engaged and that the petitioners are, in relation to the deaths of their respective relatives, "victims" who are entitled to raise proceedings of the nature they have done.

[75] In my opinion, the parties are correct in agreeing that Article 2 is engaged, following upon the deaths of each of Mrs. GRO-A and Mr. GRO-A The circumstances in which they came to be infected with the Hepatitis C virus are such that there are reasonable grounds for taking the view that the deaths of both of them may have resulted from wrongful actings on the part of those responsible for providing supplies of blood for the blood transfusions they both received and the blood products with which Mr GRO-A was treated. That such a view can be taken follows from, amongst other considerations, the medical history of Mrs. GRO-A and Mr GRO-A which I summarised earlier, in paras. [4] and [6], and the factual issues to which I referred in para. [13]. The remedies, if any, the petitioners are entitled to depend on the nature and extent of those obligations and whether the respondents have fulfilled them. It is accordingly necessary to consider the extent of the obligations that arose following the deaths of Mrs. GRO-A and Mr GRO-A and whether the respondents have acted in a manner compatible with them.

*Whether the actings of the respondents since the deaths of Mrs. GRO-A and Mr. GRO-A have been compatible with Article 2?*

[76] In addressing this question, there are a number of preliminary matters that require to be borne in mind. The first is that the provisions of the Scotland Act are intended to ensure that the first respondent in her capacity as head of the systems of criminal prosecution and investigation of deaths in Scotland and the second respondents, who include the Lord Advocate, have no power to do anything, whether by act or omission, that would involve their acting in a manner which was incompatible with Convention rights and that would place the United Kingdom in violation of its obligations under Article 2. That is, of course, accepted on behalf of both respondents.

[77] Secondly it is important to remember that the submissions before me proceeded on the basis that it would be for the respondents, and in particular for the first respondent, as opposed to the Secretary of State for Scotland or any other Minister of the Crown in the United Kingdom Government, to order

any inquiry to which either of the petitioners was entitled and which was necessary to prevent any violation of the obligations arising under Article 2. None of the parties to the proceedings, and in particular the respondents, have sought to convene the Secretary of State for Scotland as an additional party to the proceedings. And, as I have already indicated, the Advocate General for Scotland, although aware of the continued first hearings before me, intimated that he did not intend to be represented during them.

[78] Thirdly, it is important to keep in mind that the second respondent also argues that it would not be competent for them to hold or to order any statutory or other form of public inquiry into the deaths of Mrs. GRO-A and Mr. GRO-A I shall deal with that argument in due course. Accordingly, whilst it is conceded that the first respondent could hold or ordering a public inquiry, it was not argued on behalf of the respondents that it falls to the United Kingdom Government to fulfil any obligations arising in the present cases under Article 2.

[79] The nature and extent of the Convention rights under Article 2, which arose following upon the deaths of Mrs. GRO-A and Mr. GRO-A and whether those Convention rights have been respected by the respondents are obviously at the heart of these petitions. They are issues on which I received extensive submissions and was referred to numerous authorities.

[80] Of the many authorities to which I was referred, *R (Takoushis)* v *Inner North London Coroner and another* [2006] 1 WLR 460 has been the case I have found to be of greatest assistance. It sets out an approach to the application of Article 2 in cases where death has followed upon treatment in hospital which I have found to be both highly persuasive and of considerable practical benefit. I intend to quote certain passages from the Judgment of the Court in *R (Takoushis)*, which was delivered by the Sir Anthony Clarke MR. But before I do so, I should summarise briefly the facts of the case and also those in the earlier decision of Richards J in *R (Goodson)* v *Bedfordshire and Luton Coroner* [2006] 1 WLR 432, to which detailed reference was made by the Master of the Rolls when delivering the Judgment in *R (Takoushis)*.

[81] In *R (Goodson)* the claimant's father had died within 24 hours of having undergone an operation for the removal of gall-stones. Following a post-mortem, the cause of death was certified as being (a) organising peritonitis (due to or as a consequence of); (b) traumatic perforation of the duodenum and colon (due to or as a consequence of); (c) operative procedure for exploration of the bile duct. At an inquest into the death of the claimant's father, the coroner decided that he would only call a

pathologist and the relevant hospital consultant as witnesses. The claimant applied to the coroner to adjourn the hearing for expert evidence to be prepared and for the inquest to be conducted as an inquiry for the purposes of Article 2. The coroner refused the claimant's application and, having completed the inquest, returned a verdict of death by misadventure.

[82] The claimant sought judicial review of the coroner's decision. Richards J held that simple negligence in hospital care and treatment, which resulted in death, was not of itself a breach of the State's duty under Article 2 to protect life, but that where State agents potentially bore responsibility for the death, including potential liability in negligence, the events relating to the death should be subject to an effective investigation. He also held that whether it was preferable to regard the requirement for an effective investigation as being a positive obligation on the State to establish a framework of legal protection, including an effective judicial system for determining the cause of death and questions of liability, rather than a separate procedural obligation on the State to investigate under Article 2, the actual nature of the investigation required would vary according to the context in which the death had occurred. Accordingly where a death in hospital raised no more than a potential liability in negligence there was no separate procedural obligation on the State to investigate and the holding of an inquest would only play a part in the discharge of the State's positive obligation under Article 2. It would only be in exceptional cases, where the circumstances gave rise to the possibility of a breach of the positive obligation on the State under Article 2 to protect life, that an inquest might require to perform the function of discharging a separate investigative obligation upon the State. In the circumstances of the case before him, Richards J held that having regard to the totality of the available procedures, which had included the possibility of a civil claim in negligence, and also criminal and disciplinary procedures, the coroner's decision could not be challenged on the ground that, by itself, the inquest had been insufficient to meet the State's positive obligation under Article 2.

[83] Turning to the facts of *R (Takoushis)*, the case arose following the suicide of an individual with a long history of mental illness. He had been taken to hospital by the emergency services, after having been seen by a member of the public apparently preparing to commit suicide by jumping into a river. The hospital to which the individual was taken operated an emergency triage system for the assessment of patients with mental health problems, under which he should have been seen by a doctor within ten minutes of his arrival at hospital. He was not. Before any doctor came to see him he absconded. He returned to the river and jumped in. His body was subsequently recovered from the

river.

[84] An inquest into the deceased's death was held by the coroner. The deceased's widow sought judicial review of the coroner's verdict. In those proceedings she challenged the procedure the coroner had followed and the verdict that he had reached. She did so partly on the basis that, because Article 2 had been engaged, the limited nature of the inquest, which the coroner had conducted, constituted an infringement of the obligation on the United Kingdom under Article 2 to investigate the death of her late husband.

[85] The judicial review was refused by the judge who first dealt with it. In due course the proceedings came before the Court of Appeal. The Court of Appeal allowed the appeal. It held that the coroner's decision-making had been flawed. It ordered that the coroner's verdict should be quashed and that a new inquest be held. Although it was not strictly necessary for it to do so, in its Judgment, which was delivered by Sir Anthony Clarke MR, the Court of Appeal dealt at some length with the scope of Article 2 following upon the death of an individual who has been in the care of a hospital. The Court of Appeal did so because it apprehended that the issue had the potential of being of some importance in the future.

[86] In paragraph 73 of the Judgment the Master of the Rolls referred to the fact that Article 2 is sometimes said to comprise both a positive obligation on the State to provide for the protection of life and a procedural or adjectival obligation on the State to investigate death. He then referred to the cases of *R (Amin)* and *R (Middleton)*, both of which figured in the submissions I received. Each of those cases concerned the extent of the United Kingdom's obligations under Article 2 in respect of deaths occurring in custody. In *R (Amin)* the deceased had been killed by a cellmate, who was subsequently convicted of his murder. In *R (Middleton)* the deceased had hanged himself in his cell. In both cases the House of Lords discussed the principles to be derived from Strasbourg jurisprudence in respect of the application of Article 2 to deaths which have occurred in custody. The House of Lords also set out the approach that is necessary to ensure that the United Kingdom's obligations under Article 2 are fulfilled in respect of such deaths. Following on a death in custody, the investigation required under Article 2 is intended to ensure the accountability of agents of the State for deaths occurring under their responsibility. Such investigation must be capable of leading to a determination of whether any force used was justified or the protection afforded to life was adequate and ought ordinarily to culminate in the jury at the inquest expressing its conclusions on the central

factual issues in the case.

[87] In *R (Takoushis)* the issue which arose was whether a similar approach required to be applied in cases where the deceased had been under the care and treatment of a hospital prior to his death. That question was considered in some detail by the Court, against the background of the earlier decision of Richards J in *R (Goodson)*. In delivering the Judgment of the Court the Master of the Rolls said:-

> "82 The question in the instant case is whether such an approach (*that applicable to deaths in custody)* applies in a case of this kind. Mr. Lewis *(who appeared for the coroner)* submitted that it does not. He submitted that a series of decisions of the European court show that the court has drawn a distinction between cases of death in custody and death in hospital. He recognised (without conceding it) that the same or similar principles might apply to mental patients who were compulsorily detained but submitted that they do not apply to a case like this where Mr. Takoushis was not detained in any way. He relied in particular upon *Erikson* v *Italy* (1999) 29 EHRR CD 152, Powell v United Kingdom (2000) 30 EHRR CD 362, *Calvelli and Ciglio* v *Italy* Reports of Judgments and Decisions 2002-I, p 1, *Sieminska* v *Poland* (Application No 37602/97) (unreported) 29 March 2001 and *Vo* v *France* (2005) 40 EHRR 259. Mr. Lewis also relied in particular upon the recent decision of Richards J in *R (Goodson) v Bedfordshire and Luton Coroner* [2006] 1 WLR 432.
>
> .....
>
> 84 Much of the debate in the course of the argument centred on the decision and approach of Richards J in the *Goodson* case. Mr. Lewis invited us to follow it, whereas Mr. Fitzgerald *(who appeared for the claimant)* invited us to say that it was wrong. Richards J directed himself by reference to paras 2 and 3 of the opinion of the Appellate Committee in the *Middleton* case [2004] 2 AC 182, 191, which we have quoted in para 73 above. He then observed [2006] 1 WLR 432, para 51:
>
> > 'On that formulation the substantive or positive obligations are (1) not to take life without justification, and (2) to establish a framework of laws, etc, which will, to the greatest extent reasonably practicable, protect life; and the separate, procedural obligation to investigate arises where it appears that one of those positive obligations has been or may have been violated and that agents of the State are or may be implicated. Thus the existence of the procedural obligation is linked with a breach or

possible breach of one of the positive obligations. If taken at face value that appears to limit very substantially the circumstances in which the investigative obligation will arise. In the case of deaths in hospital, a breach or possible breach of one of the positive obligations is likely to exist in only a small minority of cases.'

85 We agree that, if the procedural obligation is linked to the positive obligation in article 2, the investigative obligation would indeed be very limited. While it is true that there are a number of statements which link the two, the European court does not always do so. This can we think be seen from *Powell* v *United Kingdom* 30 EHRR CD 362, which is one of the cases relied upon by Mr. Lewis and referred to by Richards J. It is also one of three medical negligence cases referred to by the House of Lords in support of the principles set out in para 73 above; the others were *Sieminska* v *Poland* 29 March 2001 and *Calvelli and Ciglio* v *Italy* Reports of Judgments and Decisions 2002-I, p 1.

.....

95 Richards J expressed his conclusions derived from the Strasbourg cases as follows in the *Goodson* case [2006] 1 WLR 432, para 59:

'I have not found it at all easy to analyse those four Strasbourg authorities on the application of article 2 to cases of alleged medical negligence. The conclusions I have reached in relation to them, however, are as follows.

(i) Simple negligence in the care and treatment of a patient in hospital, resulting in the patient's death, is not sufficient in itself to amount to a breach of the state's positive obligations under article 2 to protect life. This is stated clearly in the *Powell* case 30 EHRR CD 362.

(ii) Nevertheless, where agents of the state potentially bear responsibility for the loss of life, the events should be subject to an effective investigation. Given (i) above and the general context, the reference here to potential responsibility for loss of life must in my view include a potential liability in negligence. Thus the need for an effective investigation is not limited to those cases where there is a potential breach of the positive obligations to protect life.'

96 We entirely agree with those conclusions but add this with regard to conclusion (i). It is important to note that Richards J refers to simple negligence. The position is or may be

different in a case in which gross negligence or manslaughter is alleged: see, e.g. *R (Khan)* v *Secretary of State for Health* [2004] 1 WLR 971. By gross negligence we mean the kind of negligence which would be sufficient to sustain a charge of manslaughter.

97 Richards J's conclusion (iii), in para 59, was in these terms:

> '(iii) There is a degree of confusion in the expression of how the need for an effective investigation fits within the structure of article 2. Some of the language used links the requirement of an effective investigation with the positive obligation to establish a framework of legal protection, including an effective judicial system for determining the cause of death and any liability on the part of the medical professionals involved. In other places, on the other hand, there is express reference to the separate procedural obligation to investigate. Two considerations lead me to the view that the former rather than the latter is the preferable analysis. First, in each of the cases the availability of a civil action in negligence and/or the applicant's settlement of such an action is central to the court's conclusion that there has been a sufficient investigation of the death: i e it is the existence of an effective judicial system that seems to be decisive. Secondly, *Calvelli and Ciglio* v *Italy* Reports of Judgments and Decisions 2002-I, p 1, is both the most recent decision and also a decision of the Grand Chamber; and the judgment in that case analyses the matter solely in terms of the positive obligation to set up an effective judicial system, without reference to the separate procedural obligation to investigate.'

98 We agree with those conclusions, subject to this. We recognise that the *Calvelli* case, and indeed the other cases, tend to refer to the state's positive obligation to set up an effective judicial system but it seems to us that central to the court's approach throughout is that the relevant events should be subject to an effective investigation. In order to comply with article 2, the state must set up a system which involves a practical and effective investigation of the facts. While we agree that the cases do not support the conclusion that there is an independent obligation on the state to investigate every case in which it is arguable that there was, for example, medical negligence, the system must provide for a practical and effective investigation. Thus, for example, in the

*Middleton* case [2004] 2 AC 182, para 8, the House of Lords said:

'The court has recognised (in *McCann* v *United Kingdom* 21 EHRR 97, para 146) that its approach to the interpretation of article 2 'must be guided by the fact that the object and purpose of the Convention as an instrument for the protection of individual human beings requires that its provisions be interpreted and applied so as to make its safeguards practical and effective.' Thus if an official investigation is to meet the State's procedural obligation under article 2 the prescribed procedure must work in practice and must fulfil the purpose for which the investigation is established.'

99. If, as in our opinion is the case, the system must be practical and effective, we are not persuaded that the mere fact that the State has made it possible in law for the family to begin a civil action against those said to be responsible is by itself a sufficient discharge of the State's obligation in every case. For example, it may not be practicable for the family to procure an effective investigation of the facts by the simple expedient of civil proceedings. Their claim may be for a comparatively small sum, as for example where the only claim is that of the estate of the deceased, such that it would not make practical or economic sense for civil proceedings to be begun, especially for a family who is not able to obtain legal aid.

100 Another possibility is that the facts may be such that liability has been admitted, with the result that, at any rate under the adversarial system in operation in England, there can be no trial and thus no independent investigation of the facts as part of the civil process.

101 Some light is we think thrown on this point by *Vo* v *France* 40 EHRR 259, which was decided in July 2004 but not cited to Richards J in the *Goodson* case. In *Vo* v *France*, following medical negligence at the hands of her doctor, the applicant suffered injury to her amniotic sac, which necessitated termination of her pregnancy. The foetus was between 20 and 24 weeks at termination. The doctor was charged with causing unintentional injury but was acquitted on the ground that the foetus was not at that stage a human person. The acquittal was upheld by the Cour de Cassation. The applicant alleged a breach of article 2. The court dismissed objections as to admissibility but held (by 14 to 3) that there was no violation of article 2.

102 The court said, at paras 88-91:

'88. The court reiterates that the first sentence of article 2, which ranks as one of the most fundamental provisions in the Convention and also enshrines one of the basic

values of the democratic societies making up the Council of Europe (see *McCann* v *United Kingdom* 21 EHRR 97, para 147), requires the State not only to refrain from the 'intentional' taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction (see, e g, *LCB* v *United Kingdom* (1998) 27 EHRR 212, para 36).

89. Those principles apply in the public health sphere too. The positive obligations require States to make regulations compelling hospitals, whether private or public, to adopt appropriate measures for the protection of patients' lives. They also require an effective independent judicial system to be set up so that the cause of death of patients in the care of the medical profession, whether in the public or the private sector, can be determined and those responsible made accountable (see *Powell* v *United Kingdom* 30 EHRR CD 362 and *Calvelli and Ciglio* v *Italy* Reports of Judgments and Decisions 2002-I, p 1, para 49).

90. Although the right to have third parties prosecuted or sentenced for a criminal offence cannot be asserted independently (see *Iribarne Pérez* v *France* (1995) 22 EHRR 153, para 70), the court has stated on a number of occasions that an effective judicial system, as required by article 2, may, and under certain circumstances must, include recourse to the criminal law. However, if the infringement of the right to life or to physical integrity is not caused intentionally, the positive obligation imposed by article 2 to set up an effective judicial system does not necessarily require the provision of a criminal law remedy in every case. In the specific sphere of medical negligence, 'the obligation may for instance also be satisfied if the legal system affords victims a remedy in the civil courts, either alone or in conjunction with a remedy in the criminal courts, enabling any liability of the doctors concerned to be established and any appropriate civil redress, such as an order for damages and for the publication of the decision, to be obtained. Disciplinary measures may also be envisaged' (see *Calvelli and Ciglio* v *Italy* Reports of Judgments and Decisions 2002-I, p 1, para 51, *Lazzarini* and *Ghiacci* v *Italy* (Application No 53749/00), 7 November 2002 and *Mastromatteo* v *Italy* (unreported) 24 October 2002, para 90).

91. In the instant case, in addition to the criminal proceedings which the applicant

instituted against the doctor for unintentionally causing her injury - which, admittedly, were terminated because the offence was covered by an amnesty, a fact that did not give rise to any complaint on her part - she had the possibility of bringing an action for damages against the authorities on account of the doctor's alleged negligence (see *Kress* v *France* (Application No 39594/98) (unreported) 7 June 2001, paras 14 et seq.). *Had she done so, the applicant would have been entitled to have an adversarial hearing on her allegations of negligence (*see *Powell's* case 30 EHRR CD 362*) and to obtain redress for any damage sustained.* A claim for compensation in the administrative courts would have had fair prospects of success and the applicant could have obtained damages from the hospital. That is apparent from the findings clearly set out in the expert reports in 1992 - before the action had become statute-barred - concerning the poor organisation of the hospital department in question and the serious negligence on the doctor's part, which none the less, in the Court of Appeal's opinion, did not reflect a total disregard for the most fundamental principles and duties of his profession such as to render him personally liable.' (Emphasis added.)

103 There was thus no violation of article 2 because there was an appropriate system in place. However, the passage we have italicised suggests to us that a factor in the court's conclusion was that, if the applicant had started civil proceedings in time, she would have been entitled to an adversarial hearing and thus an investigation of the relevant facts. If the position were, for example, that the doctor had admitted civil liability and that no independent investigation was possible as a result, the court might well not have held that the system sufficiently provided for the cause of death to be determined, as envisaged by para 89 of the judgment.

104 The fourth, fifth and sixth conclusions set out by Richards J in the *Goodson* [2006] 1 WLR 432, para 59, were:

'(iv) Whether the matter is analysed in terms of the positive obligation to set up an effective judicial system or in terms of the procedural obligation to investigate may not ultimately be of great significance. Although certain minimum criteria are laid down, the actual nature of an investigation required under article 2 varies according to context; and the Strasbourg cases on deaths resulting from alleged medical negligence show that, if the procedural obligation does apply, the range of remedies available

under the judicial system (criminal, civil and possibly disciplinary) can be sufficient to discharge it.

(v) On my preferred analysis, however, there is no separate procedural obligation to investigate under article 2 where a death in hospital raises no more than a potential liability in negligence. In such a situation an inquest does play a part, though only a part, in the discharge of the State's positive obligation under article 2 to set up an effective judicial system for determining the cause of death and questions of liability. But it does not need to perform the function of discharging a separate investigative obligation on the State under article 2. It will only be in exceptional cases, where the circumstances give rise to the possibility of a breach of the State's positive obligations to protect life under article 2, that the separate procedural obligation to investigate will arise and an inquest may have to perform the function of discharging that obligation.

(vi) It also seems to me to follow from my preferred analysis that an inquest cannot be challenged on the ground that it is insufficient to meet the State's positive obligations under article 2. The totality of available procedures, including most obviously the possibility of a civil claim in negligence, must be looked at in order to determine whether the State has complied with the positive obligation to set up an effective judicial system. Since an inquest forms only one part of the whole, its failure to provide the totality cannot be a ground for finding it incompatible with article 2. This is a sufficient reason for rejecting an alternative submission made briefly by [counsel for the claimant] in oral argument, which I have not otherwise mentioned, to the effect that the failure to hold an effective inquest constituted a breach of the State's positive obligations under article 2.'

105 Subject to what is said in paras 97-103 above, we agree with those conclusions. It seems to us that, however it is analysed, the position is that, where a person dies as a result of what is arguably medical negligence in an NHS hospital, the State must have a system which provides for the practical and effective investigation of the facts and for the determination of civil liability. Unlike in the cases of death in custody, the system does not have to provide for an investigation initiated by the State but may include such an investigation. Thus the question in each case is whether the system as a whole, including both any investigation initiated by the

State and the possibility of civil and criminal proceedings and of a disciplinary process, satisfies the requirements of article 2 as identified by the European court in the cases to which we have referred, namely (as just stated) the practical and effective investigation of the facts and the determination of civil liability.

106 The question is whether the system in operation in England in this case meets those requirements. In our opinion it does. The system includes both the possibility of civil process and, importantly, the inquest. We can understand the point that the possibility of civil proceedings alone might not be sufficient because they do not make financial sense and may not end in a trial at which the issues are investigated. However, in the context of the other procedures available, an inquest of the traditional kind, without any reading down of the 1988 Act by giving a wider meaning to "how" as envisaged in the *Middleton* case [2004] 2 AC 182, and provided that it carries out the kind of full and fair investigation which is discussed earlier in this judgment and which (we hope) will now take place, in our opinion satisfies the requirement that there will be a public investigation of the facts which will be both practical and effective. Moreover, the family will be able to take a full part.

107 In these circumstances, while article 2 is engaged in the sense described above, the present system including the inquest does not fall short of its requirements in any way. On the contrary it complies with it."

[88] It will have been observed that in the passages I have quoted from the Judgment in *R (Takoushis)*, the Court of Appeal made reference to *Erickson* v *Italy*, *Powell* v *United Kingdom*, *Sieminska* v *Poland* and *Calvelli and Ciglio* v *Italy* and *Vo* v *France*, all of which were cited to me by senior counsel for the petitioners. None of these authorities support the argument that in every case in which an individual has died whilst in the care of, or following treatment in, a hospital, the State must itself initiate an investigation that is capable of ensuring the accountability of any agents of the State, whether individuals or authorities, that have been involved in any way in the care and treatment of the individual concerned. That is clear, for example, from what was said in para. 52 of the Court's Judgment in *Calvelli and Ciglio v Italy* and paras. 89 - 92 of the Court's Judgement in *Vo* v *France*.

[89] I have no difficulty in understanding why senior counsel for the petitioners sought to found on the decision of the European Court of Human Rights in *Öneryildiz* v *Turkey*. However, I have reached the conclusion that the factual circumstances in that case were of a significantly different nature to

those of the present cases. The deaths occurred because of an explosion within the refuse site, which led to a landside that engulfed those living outside the site. There was no question of those who were killed having been employed by, or having had any previous dealings with, the operators of the refuse site. The operation of any refuse site is an inherently dangerous operation. It can give rise to the emission of dangerous gases, which require to be collected and burnt off. The refuse site concerned was operated and supervised by a number of public authorities. It was badly constructed and poorly operated. The refuse site exposed humans and the environment to "all kinds of risks". It posed a major health risk to many who lived nearby. I consider those factual circumstances to be significantly different from those of the present cases, in which both Mrs. GRO-A and Mr. GRO-A had been patients of the NHS in Scotland.

[90] Having taken the view that *Öneryildiz* v *Turkey* can be distinguished on its facts, I see no reason why I should not reach my decisions in the present cases by applying the approach summarised in para. 105 of the Judgment of the Court of Appeal in *R (Takoushis)*. In my opinion, the general approach set out by the Court of Appeal in R (Takoushis) is a sound way of determining whether the respondents had in place a system which could provide in the circumstances relating to the deaths of Mrs. O'Hara and Mr. Black for the practical and effective investigation of the facts relating to the deaths and have acted in a manner compatible with Article 2. It is appropriate that I should indicate that I reached the decision to apply the approach set out by the Court of Appeal in *R (Takoushis)* before I had the opportunity of reading the Opinion of Lady Smith in *Emms, Petitioner* 2008 SLT 2, which was issued after I took the present cases to avizandum.

[91] The approach set out in *R (Takoushis)* takes account of the fact that the jurisprudence of the European Court of Human Rights does not require a State to initiate an investigation in every case in which an individual has died, after having been treated and cared for in hospital. However, a State requires to put in place a system that provides for the practical and effective investigation of the facts of such a death and the determination of civil liability (see paras. 98-99 and 105).

[92] The deaths of Mrs. GRO-A and Mr. GRO-A have given rise to a number of issues, including determining when they became infected with the Hepatitis C virus, establishing the factual circumstances in which their treatment involved the use of blood and blood products contaminated with the Hepatitis C virus, and identifying the public officials and authorities who were responsible for the systems that were in place for the collection of blood donations and the use of the blood thus

collected for blood transfusions and the preparation of blood products for clinical use. The issues that arise also include reaching a conclusion as to whether any of those public officials or authorities should be held to account. That is the background against which I have to consider whether in the circumstances of each of the present cases "the system as a whole, including any investigation initiated by the State and the possibility of civil and criminal proceedings and of a disciplinary process, satisfies the requirements of Article 2 ..... namely ..... the practical and effective investigation of the facts and the determination of civil liability" (see para.105).

[93] There are a number of elements to the system on which the respondents rely as having constituted full compliance with Article 2. These are (a) the possibility of an investigation initiated by the State, (b) the possibility of criminal proceedings, (c) the possibility of a disciplinary process and (d) the possibility of civil proceedings. However, the overarching question in the case of each death is whether the system taken as a whole has in fact satisfied the requirement of Article 2 for "the practical and effective investigation of the facts and the determination of civil liability". Closely linked to that overarching question is the related issue of whether either or both of the respondents ever considered whether in relation to the deaths of Mrs. GRO-A and Mr. King that question could to be answered in the affirmative if the State did not itself initiate a public investigation. The position of the first respondents in relation to the overarching question has to be addressed under reference to the letter of 15 June 2006, which I will look at in detail later. That of the second respondent can be considered in light of the contents of the press release of 16 June 2006. The press release falls to be read, of course, in the context of the second respondent's contention that by virtue of the provisions of section 48(5) of the Scotland Act the sole and exclusive jurisdiction for the investigation of deaths in Scotland lies in the hands of the first respondent, in her capacity as Lord Advocate.

[94] As far as investigations initiated by the State in the present cases are concerned, when Mrs. GRO-A died on 7 May 2003 her death was not reported to the Procurator Fiscal by the hospital authorities. No post-mortem was carried out. No police investigation took place immediately following her death. The first respondent was not invited to hold an FAI until 26 May 2004. It is reasonable to assume that thereafter the procurator fiscal did carry out some investigations, but what they amounted to remains unknown and the first petitioner was not involved in them. The invitation to hold an FAI was eventually refused by the letter of 15 June 2006.

[95] Immediately following Mr. GRO-B death on GRO-A 2003, whilst the second petitioner was

still at the hospital where her husband had died, she was interviewed by two police officers. The purpose of that interview was not explained to her. Neither on that occasion, nor subsequently, has the second petitioner, or those who act for her, ever suggested that any criminal offence was committed by anyone involved in any way with the circumstances giving rise to Mr GRO-A's death. Mr. GRO-A death was, however, reported to the Procurator Fiscal by the hospital authorities. A post-mortem was carried out. Following upon that post-mortem, the first petitioner heard nothing from the Procurator Fiscal, until her solicitors received an initial response from the Crown Office to a letter they sent on 30 April 2004, inviting the Lord Advocate to hold a FAI. That invitation was subsequently refused by the letter of 15 June 2006.

[96] As far as the scope of the inquiries carried out by the first respondent are concerned, these are summarised in the third paragraph of the letter of 15 June 2006. The letter does not contain any specification as to the inquiries carried out by the Procurator Fiscal.

[97] Senior counsel for the respondents informed me that on 5 December 2002 a representative of the Scottish Haemophiliac Groups Forum wrote to the Chief Constable of Central Scotland Police Force. The letter requested that the police consider whether the supply of blood products infected with Hepatitis C virus or HIV to haemophiliacs merited investigation. The request was referred to Crown Office, who instructed the police to carry out an investigation. In due course a confidential police report was submitted to Crown Office. The nature of any allegations of criminality addressed in that report and the identities of those against whom any such allegations may have been directed have never been disclosed. In the event, having considered the terms of that report, Crown Counsel instructed that no proceedings should be taken.

[98] The letter of 15 June 2006 also indicates that the Crown Office's investigation took into account Crown Counsel's review of material gathered together by the Procurator Fiscal and Crown Office officials and "other relevant information available on the issue of Hepatitis C infection". It is reasonable to assume that information will have included, but may not have been limited to, the reports and other documents I have referred to in paras. [11] - [15] and which I have read. In so far as these reports and other documents were prepared or commissioned by the second respondents, the contents of them were shared with the first respondent. However, it remains unclear whether other written material, including research material, may have been before the respondents prior to the issue of the letter of 15 June 2006 and the press release of 16 June 2006.

[99] However, the terms of the letter of 15 June 2006 do make it possible to assess whether any investigations carried out on behalf of the first respondent addressed and reached appropriately reasoned conclusions on the issues of (a) when Mrs. GRO-A was first diagnosed as having been infected with the Hepatitis C virus, (b) when she was first infected with the Hepatitis C virus, and (c) whether, if such infection occurred on account of a blood transfusion given to Mrs. GRO-A on 24 July 1991 (or on any other date), the infection might have been avoided had a system for screening blood donations for the Hepatitis C virus been put in place by the SNBTS by the date in question. In my opinion, it is far from clear that they such investigations did so.

[100] Similarly in relation to the death of Mr. GRO-A there is no indication in the letter of 15 June 2006 that any investigations carried out on behalf of the first respondent addressed and reached appropriately reasoned conclusions on the issues of (a) when Mr. GRO-A was first diagnosed as having been infected by the Hepatitis C virus, (b) when he was first infected with the Hepatitis C virus, and (c) whether, if such infection could have occurred on account of Mr GRO-A having been treated with blood products and/or given blood transfusions on or between specific dates, such infection might have been avoided had a system for the heat treatment of blood products been introduced earlier than 1987 or a system for the screening of blood donations introduced prior to 1 October 1991.

[101] In my opinion, it is clear from the terms of the letter of 15 June 2006 that the investigations carried out by the first respondent prior to the issue of the letter were limited in scope. That letter intimated that the first respondent had decided not to order any FAIs. On the following day intimation was given of the second respondent's decision not to convene a public inquiry, which could have involved inquiring into the deaths of Mrs. GRO-A or Mr. GRO-A There is of course no suggestion that either of the respondents currently intends to carry out any further investigations into the circumstances giving rise to the deaths of Mrs. GRO-A and Mr GRO-A The inquiry that the second respondents propose to set up, which I referred to in para. [16], is stated to be of a very different character. Later in my Opinion, I will have a little more to say in respect of that inquiry. At the moment it is sufficient that I express my conclusion that any investigations carried out by the respondents and relied on by the first respondent, when the decisions were taken not to order the holding of FAIs, did not constitute a practical and effective investigation of the facts relating to the deaths of either Mrs. GRO-A or Mr. GRO-A

[102] In both *R (Goodson)* and *R (Takoushis)*, inquests had been held by the coroner following upon

the deaths that had given rise to the court proceedings. There is no procedure in Scotland similar to the holding of a coroner's inquest. However, in my opinion, as I shall discuss more fully later in this Opinion, both of the respondents have statutory powers that would enable them to initiate independent public inquiries into the circumstances of the deaths of Mrs. GRO-A and Mr GRO-A Their powers to do so form part of the system that is in place to ensure that the obligations arising under Article 2 following a death are complied with. However it is for the respondents to exercise their statutory powers to set up an independent public inquiry and neither has elected to do so. Nor, of course, is there any suggestion that the United Kingdom Government has taken or intends to take any steps to order such a public inquiry into the deaths of either Mrs. GRO-A or Mr. GRO-A

[103] Turning to the issue of criminal proceedings, nothing that has been placed before me, whether by way of the productions lodged or during the course of submissions, persuades me that there was ever any realistic possibility of any criminal proceedings arising out of the deaths of Mrs GRO-A or Mr GRO-A Whilst both deaths have been investigated by the Procurator Fiscal and reports were prepared for and considered by the first respondent, and Crown counsel considered the police report prepared following upon the intervention of the Scottish Haemophiliac Groups Forum, senior counsel for the respondents did not identify any possible offences, let alone the identities of any potential accused, who might have figured in any criminal proceedings arising out of the deaths of Mrs. GRO-A and Mr GRO-A In the event, no criminal proceedings have been initiated by the first respondent arising out of or related to the deaths of Mrs. GRO-A or Mr. GRO-A

[104] During his submissions, senior counsel for the respondents submitted that the reference to "the existence of other mechanisms available to the affected parties" in the Deputy Crown Agent's letter of 15 June 2006 encompassed the possibility of the petitioners initiating a private prosecution. I rather doubt whether the writer of that letter would have had such a possibility in mind. In any event, I discount it for a variety of reasons, not least of all because that I consider it inconceivable that any private citizen would be able to mount criminal proceedings following upon a death occurring after events such as those which preceded the deaths of Mrs. GRO-A and Mr GRO-A I also take in account the fact that neither petitioner has ever asserted that any crime has been committed.

[105] In these circumstances, the fact that it was theoretically possible that criminal proceedings might have been raised following the deaths of Mrs. GRO-A and Mr GRO-A has not made any meaningful contribution to the practical and effective investigation of those deaths.

[106] Likewise I reject the suggestion that disciplinary proceedings were ever a realistic possibility in these cases. It is not clear by which professional body or other organisation any such proceedings might have been initiated. Nor was it suggested against whom such proceedings might have been directed. In these circumstances I discount disciplinary proceedings as a possible mechanism for making any contribution towards satisfying the requirement of Article 2 for a practical and effective investigation of the facts and the determination of civil liability.

[107] The next topic to consider is the possibility of civil proceedings at the instance of the petitioners. In doing so it may be important to bear in mind what was said in the Judgment in *R (Takoushis)*, at para.99, where the Court indicated that they were not persuaded that the mere fact that the State has made it possible in law for the family of the deceased to begin a civil action against those said to be responsible for the death of the deceased was by itself a sufficient discharge of the State's obligations in every case. They instanced, by way of example, that it might not be practicable for the family to procure the effective investigation of the facts by the simple expedient of civil proceeding. The family's claim might be for a comparatively small sum, such that it would not make practical or economic sense for civil proceedings to be commenced, especially by a family which was not able to obtain legal aid.

[108] The issue that has caused me greatest difficulty in these petitions arises out the fact that following upon the deaths of their relatives it would undoubtedly have been open to the petitioners, as a matter of law, to have raised civil proceedings in the nature of actions seeking damages. Such proceedings would have been competent and any summons necessary to initiate such an action could have been framed. In theory any such action, if it had proceeded to proof, could have led to an investigation of the facts before a court of law and a determination of civil liability. In my opinion, however, the practicalities relating to such litigation also require to be looked at.

[109] It is likely such actions would now be time-barred. In relation to the death of Mrs. GRO-A, such proceedings would have become time-barred shortly before the date of the first respondent's letter of 15 June 2006 and in relation to the death of Mr GRO-A approximately 3 months after that date. If actions for damages had been founded upon the provisions of the Consumer Protection Act 1987 ("the 1987" Act), whose provisions implement the Council Directive on Product Liability (EEC) 85/374, it is arguable any obligation on the SNBTS, in terms of the 1987 Act would have been extinguished by lapse of time. That is because it would appear that any blood and blood products, with which Mrs.

GRO-A and Mr GRO-A were treated and which could have led to their infection with the Hepatitis C virus, were supplied by SNBTS more than 10 years before they died (cf. section 22A of the Prescription and Limitation (Scotland) Act 1973).

[110] For the purposes of testing whether the rights of the petitioners to raise civil proceedings could have led, or could still lead, to practical and effective investigations into the deaths of Mrs. GRO-A and Mr GRO-A it is appropriate to proceed on the basis that such civil proceedings would not be time-barred. In my opinion, where a relative of a deceased has allowed their right to raise civil proceedings to become time-barred, it would not be open to that relative to argue that the right to raise such proceedings should be left completely out of account during any consideration of whether the Convention rights of the deceased under Article 2 have been violated. Having said that, the strong probability that any proceedings based on product liability would have been defended, no matter when they had been raised, could constitute as factor relevant to the question of whether it was likely that any such proceedings would ever have proceeded to proof.

[111] In considering the possibility of actions for damages based on negligence, amongst the important questions that arise are (a) whose allegedly negligent acts and omissions could have been founded upon and (b) which parties the petitioners might have resolved to sue. No complaint of negligence has ever been made by either of the petitioners against any of the doctors or other medical staff who treated Mrs. GRO-A and Mr GRO-A when they were in hospital, or against any Health Board or other authority which managed the hospitals in which they received treatment. On the basis of the information placed before me, there would appear to have been very limited possibility indeed of the petitioners or anyone else having been in a position to attribute fault to any of the doctors and other medical professionals who actually treated and cared for Mrs. GRO-A and Mr GRO-A including those who transfused them with blood or treated them with blood products, which were supplied by others, in particular the SNBTS, for use with patients under the care of the NHS in Scotland.

[112] The concerns raised by the petitioners relate to the circumstances in which their relatives came to be infected with the Hepatitis C virus, which in turn involves issues relating to the procedures and systems for the collection and the screening of blood donations and the preparation and heat-treatment of blood and blood products that were in place over the relevant periods. Such matters were the responsibility of individuals and authorities, in particular the SNBTS, which, as I understood the information placed before me, did not have any direct part to play in the care and treatment of Mrs.

GRO-A and Mr GRO-A Accordingly even if the petitioners had wished to raise civil proceedings seeking to recover damages, which they maintain they have never been in a position to do and profess they have never wanted to do, it appears clear that any actions of damages founded on negligence could only have been directed against individuals and authorities who never had any practical involvement in the care and treatment of Mrs. GRO-A or Mr GRO-A

[113] Accordingly, any allegations of negligence upon which such actions could have been founded would in all probability have been of a very different nature to those commonly pled in actions for damages based on medical negligence, in which the pursuer seeks to found on an alleged failure or mistake in diagnosis, an alleged error in the prescribing of treatment or medication or an act or omission during the course of the carrying out a medical procedure. Such allegations of negligence relating to how Mrs. GRO-A and Mr GRO-A came to be infected with the Hepatitis C virus would almost inevitably involve consideration of (a) why the SNBTS, and possibly other public authorities and individuals involved in the NHS in Scotland, did not introduce or require until April 1987 any form of heat-treatment for blood products made available for clinical use, and (b) why the SNBTS did not introduce any screening of blood donations until 1 October 1991.

[114] During the course of the hearing, it occurred to me that the investigation and pursuit of allegations of negligence against the SNBTS might involve others, including former Ministers of the Crown and senior officials of the Scottish Office, who had responsibility for the development and implementation of health policy in Scotland and the funding and administration of the National Health Service in Scotland over the relevant period.

[115] That view was reinforced when I read the letter dated 27 September 2007, which an official of the Scottish Government wrote to my clerk following upon the By Order hearing on 22 August 2007, to which I have referred in para. [16]. The purpose of that letter was to provide written clarification of the intentions of the respondents as to the holding of a general public inquiry into infection with Hepatitis C through NHS treatment. The letter explained that the SNP election manifesto had stated that a SNP administration would "hold a public inquiry to find out why people were infected with Hepatitis C through NHS treatment". The letter also explained that on taking up office the Scottish Government had made it clear that they would honour that commitment. The letter stressed that the remit, scope and form of the inquiry remain to be determined and that the decisions of the first and second respondents, which are under challenge in the present proceedings, were considered to be

separate matters to the decision of the second respondents to hold a general public inquiry into why people became infected with Hepatitis C. However the letter went on to state that "the general public inquiry will be concerned with the general policies and decisions of government and professionals at the time and their consequences". In my opinion, that reinforces the possibility that the raising of civil proceedings against the SNBTS might well give rise to the investigation and leading of evidence about dealings during the relevant period between the SNBTS and its officials, on the one hand, and Ministers and senior officials in the Scottish Office, on the other. Where such lines of inquiry might lead can not be predicted. However the possibility that such lines of inquiry may prove to be necessary means that the evidence relevant to the factual issues the petitioners seek to have investigated at a public inquiry, and which might also be relevant to civil proceedings, may lie partly in the hands of authorities forming part of the NHS in Scotland, who were responsible for the collection of blood donations and the supply of blood and blood products for clinical use, and partly under the control of the Scottish Government itself. That could give to practical difficulties of some significance for the petitioners, were it necessary for them to identify, locate and recover such evidence for the purposes of civil proceedings.

[116] As I have indicated, during the submissions, reference was also made to the possibility of the petitioners raising actions for damages founded upon the provisions of the Consumer Protection Act 1987 ("the 1987 Act"). The 1987 Act implements the Council Directive on Product Liability (EEC) 85/374 (as amended). As I have indicated it is arguable that any proceedings under the provisions of the 1987 Act would face difficulty, in view of the fact that by the dates of their deaths 10 years had elapsed from when each of Mrs. GRO-A and Mr GRO-A had last been treated with any blood or blood products infected with the Hepatitis C virus (see section 22A of the Prescription and Limitation (Scotland) Act 1973 and section 4(2) of the 1987 Act).

[117] But even if any obligations on SNBTS under the 1987 Act have not been extinguished and could be founded upon by the petitioners in civil proceedings, the statutory regime brought into effect by the provisions of the 1987 Act, in terms of which a producer is liable for damage caused by any defect in his product, irrespective of any fault on the producer, makes it extremely unlikely that such proceedings could facilitate practical and effective investigations as to how Mrs. GRO-A and Mr GRO-A came to be infected with the Hepatitis C virus. Such an investigation would only take place were the defenders to any action to invoke the statutory defences that are available to them in terms of

the Council Directive. That is illustrated by the decision of Burton J in *A and another* v *National Blood Authority and another* [2001] 3 All E R 289, where the claimants had been infected with the Hepatitis C virus through transfusions using blood or blood products obtained from infected donors. Having heard evidence during a trial that lasted for over three months, Burton J rejected the attempts by the defendants to rely on certain statutory defences. Bearing in mind the potential value of any claims for damages at the instance of the present petitioners, and the costs that would be involved were the defenders to any actions for damages to seek to rely on the available statutory defences, I do not consider it likely that a statutory defence would be pled were such an action to be raised, or that if it were, the action would proceed to proof. It is also interesting to note from Burton J's Judgment in that case that the defendants admitted liability in respect of any claimant who was infected on or after 1 April 1991. The possibility of a similar approach being taken to the defence of any action for damages raised in respect of the death of Mrs. GRO-A would increase the likelihood that any action relating to her death would not proceed to proof. In these circumstances, I do not consider that there are any grounds for concluding that there has ever been any realistic possibility of civil proceedings based on the provisions of the 1987 Act leading to practical and effective investigations as to why the blood transfusions and blood products which Mrs. GRO-A and Mr. GRO-A received were infected by the Hepatitis C virus and whether their infection with the Hepatitis C virus could have been avoided.

[118] The information placed before me by senior counsel for the petitioner was to the effect that neither petitioner would be entitled to legal aid. Having regard to the limited details as the means of the petitioners that were before Lord Glennie, to which he referred in para.[15] of his Opinion, and the fact that the second petitioner has received a payment from the Skipton Fund, following upon the death of her husband, that information is probably correct. It was certainly not challenged on behalf of the respondents. However, neither petitioner placed full details of their financial means before me. For that reason, I am not in a position to reach a concluded view that neither of the petitioners is in a financial position to initiate civil proceedings seeking to recover damages.

[119] The Skipton Fund, to which I referred in the last paragraph, is an *ex gratia* payment scheme, which has been in operation since 25 March 2004. The Skipton Fund makes payments to individuals who were treated anywhere in the United Kingdom under the National Health Service before 1 September 1991 by way of the receipt of blood, tissue or blood product and, as a result of that treatment, became infected with the Hepatitis C virus. A first stage payment of £20,000 is available to

those who are eligible and a second stage payment is also payable to those whose infection has led to advanced liver disease. Payments can also be made under the provisions of the scheme into the estates of those who became infected with the Hepatitis C virus before 1 September 1991 and have subsequently died, if they died on or after 29 August 2003. The scheme was initially established by the Department of Health in England, on behalf of health administrations throughout the United Kingdom, including the second respondent. The scheme in Scotland now falls under the provisions of section 28 of the Smoking, Health and Social Care (Scotland) Act 2005 ("the 2005 Act") and the second respondent, the Scottish Ministers, have appointed the Skipton Fund to manage the scheme on their behalf. Having regard to the fact that payments can not be made in respect of persons who died before 29 August 2003, a payment under the scheme is payable to the estate of Mr GRO-A but not to that of Mrs. GRO-A

[120] Being in the financial position to initiate civil proceedings is one matter. Standing the financial risks of being involved civil litigation, a willingness to embark on an action seeking damages, and a determination to pursue such an action the length of a defended proof, are separate matters altogether. Even if the petitioners had wished to raise actions for damages based on negligence or the provisions of 1987 Act, which I am informed they never have, it is difficult to see how it would have made any financial sense for them to have done so. Having regard to Mrs. GRO-A's age, at the date of her death, the fact that she was the mother of the first petitioner, the age of Mr. GRO-A when he died, leaving the second petitioner as his widow, and the fact that he was a retired minister of religion, the quantum of the potential claim of either petitioner is unlikely to have been a sum of great significance. In such circumstances, however such civil proceedings could have been funded, there would have been little financial incentive for either petitioner to have embarked upon, let alone pursued the length of proof, a complicated action for damages, which would require to have been directed against public authorities.

[121] Furthermore, even if actions had been or were to be raised by the petitioners, experience suggests that there would be very limited prospects of such actions ever proceeding to proof. The irrecoverable expenses that either petitioner would inevitably incur, were an action arising out of the death of Mrs. GRO-A or of Mr GRO-A to proceed to proof, would be liable to make substantial inroads into any damages that would be recoverable in the event of success. The petitioners would also be bound to have some regard to the considerable financial liabilities that would arise in the event that

any actions they raised failed after proof. Equally importantly, looking at the position of expenses from the standpoint of any defender, the irrecoverable costs involved in such litigation, even in the event of a successful defence, would almost certainly encourage a defender to try and effect a settlement of any action, without making any admission of liability.

[122] As I have indicated, some actions for damages have been raised in the Court of Session in recent years, arising out of the infection of individuals with the Hepatitis C virus, whether from blood transfusions or treatment with blood products. Neither party laid before me copies of the pleadings in any of those cases, nor indeed did they dwell on the factual and legal grounds upon which such actions have been placed. I understood, however, that all of those actions have been defended. I was told that some of those actions have settled extra-judicially, certain of them following the payment of damages. None of the actions have proceeded to proof. That is hardly surprising, having regard to the nature of the factual and legal issues that must have been involved in, and the financial realties of, such litigation. Indeed the enactment of section 28 of the 2005 Act tends to support the view that it is widely recognised that any party embarking on civil proceedings for damages, based on a NHS patient having become infected with the Hepatitis C virus, would face very considerable difficulties.

[123] Having carefully considered all the information which the parties chose to place before me during the course of the continued first hearings, I am not persuaded there are any realistic prospects that any actions for damages, which could have raised by the petitioners, whether on the basis of allegations of negligence or product liability in terms of the 1987 Act, would have led to practical and effective investigations of the facts relating to the deaths of Mrs. GRO-A and Mr GRO-A or any determinations of civil liability based on such investigations of the facts.

[124] In my view the central factual issues which the petitioners seek to have investigated involve much more than considering whether there was any negligence on the part of those individuals involved in treating Mrs. GRO-A and Mr. GRO-A Those factual issues include the circumstances that led to Mrs. GRO-A and Mr GRO-A becoming infected with the Hepatitis C virus and, very importantly, whether those circumstances disclose the existence any systemic failures within the systems and procedures put in place by the SNBTS, or by any other individuals or authorities involved, for the collection of blood donations and the preparation and supply of blood and blood products for transfusion, during the periods when Mrs. GRO-A and Mr GRO-A were infected with the Hepatitis C virus.

[125] There is no dispute that Mrs. GRO-A and Mr GRO-A became infected with the Hepatitis C virus whilst they were under the care of the NHS in Scotland. Nor is there any dispute that such infection contributed to their deaths. Looked at in that narrow context it could be argued that there is nothing more to investigate. In my opinion, however, any practical and effective investigations of the facts, of the nature required by Article 2, must be capable of addressing when each Mrs. GRO-A and Mr GRO-A became infected with the Hepatitis C virus and whether any steps could have been taken by the SNBTS or by other individuals and public authorities involved in the NHS in Scotland that might have prevented such infection occurring. To restrict any investigations so as to exclude such lines of enquiry would, in my opinion, be incompatible with the provisions of Article 2, whether the requirement for an effective investigation is considered to be part of the positive obligation on the State to establish a framework of legal protection or a separate procedural obligation to investigate any death in respect of which Article 2 has been engaged.

[126] For all these reasons, on the basis of the information placed before me by the parties during the continued first hearings, I have reached the conclusion that the right of each of the petitioners to raise civil proceedings could not and would not, in the particular circumstances of the deaths of Mrs. GRO-A and Mr GRO-A satisfy the obligations arising under Article 2 following on their deaths.

[127] The petitioners do not allege that any crime was committed or that any individual or public authority involved in treating Mrs. GRO-A and Mr GRO-A has acted negligently. In my opinion, that does not deprive them of their rights to found on Article 2. Nor does the fact that the petitioners consider that the holding of public inquiries into the deaths of Mrs. GRO-A and Mr GRO-A would be in the wider public interest detracts from the validity of the arguments that have advanced on their behalf. In my opinion, it would be quite unrealistic, and in any event virtually impossible, to seek to divorce issues of public concern from the issues as to how and when Mrs. GRO-A and Mr. GRO-A came to be infected with the Hepatitis C virus and whether anything could and should have been done to prevent that occurring, by those in a position to do so. As observed by the Court of Appeal in *R (Khan)* v *Secretary of State for Health* [2004] 1 WLR 871 in para. 67 of the Judgment of the Court "the procedural obligation introduced by Article 2 has three interlocking aims: to minimise the risk of future like deaths, to give the beginnings of justice to the bereaved, and to assuage the anxieties of the public".

[128] In summary, therefore, returning to the question posed in para. 105 of the Judgment of the

Court of Appeal in *R (Takoushis)*, on the basis of the information before me, I have reached the conclusion that in the absence of the holding of a FAI or another form of independent public inquiry initiated by the respondents there are no options available to the first petitioner which offer any realistic prospects of a practical and effective investigation of the full facts relating to the death of her mother, Mrs. GRO-A, or the holding to account of those responsible for her becoming infected with the Hepatitis C virus or of a determination of civil liability relating to her death. I have reached a similar conclusion in relation to the second petitioner, in respect of the death of her husband, Mr GRO-A In these circumstances, whilst I am satisfied that the system the respondents have had in place since the coming into force of the Scotland Act would be capable of satisfying the requirements of Article 2 in relation to the majority of deaths that occurred following treatment in hospital, that has not been achieved in the present cases. For that reason, the continuing refusal of the respondents to initiate independent public inquiries into the deaths of Mrs. GRO-A and Mr GRO-A means that in the particular circumstances of their cases the respondents have failed to act in a manner compatible with the Convention rights of Mrs. GRO-A and Mr GRO-A under Article 2.

[129] In my opinion, it is also clear from the terms of the letter of 15 June 2006 that insofar as the first respondent's predecessor gave consideration to Article 2, before taking his decisions not to hold FAIs, such consideration did not involve his addressing whether the system the respondents had in place for investigating deaths would in the particular circumstances relating to the deaths of Mrs. GRO-A and Mr GRO-A meet the requirements of Article 2 for public examinations of the facts that would be both practical and effective. Looked at in another way, in respect of each of the deaths, the first respondent failed to apply the guidance provided by the Court of Appeal in *R (Takoushis)* in addressing the question of what Article 2 required. The decision of the Court of Appeal in *R (Takoushis)* predated the first respondent's own decisions not to hold FAIs. The second respondent, of course, have never addressed the relevant questions relating to Article 2 at all. That was because they have taken the view throughout that it has been a matter for the first respondent alone to decide whether or not any public inquiries should be held into the deaths of Mrs. GRO-A and Mr. GRO-A

*If the first respondent has failed to act in a manner compatible with Article 2 whether such failure constitutes grounds for reducing the decisions of 15 June 2006 refusing to order FAIs into the deaths of Mrs.* GRO-A *and Mr.* GRO-A

[130] I answer this question in the affirmative. In my opinion, if the first respondent acted in a

manner incompatible with Article 2 in reaching his decisions refusing to order FAIs, those decisions fall to be reduced. In particular, the first respondent's apparent failure to follow the guidance provided in *R (Takoushis)* warrants the reduction of those decisions

*Are there any other grounds for reducing the decisions of the first respondent of 15 June 2006 refusing to order FAIs into the deaths of Mrs.* GRO-A *and Mr.* GRO-A

[131] This question relates to the criticisms advanced on behalf of the petitioners about the terms of letter dated 15 June 2006, which gave notice of the decisions of the predecessor of the present Lord Advocate refusing to hold FAIs into the deaths of Mrs. GRO-A and Mr. GRO-A For convenience I refer to the present Lord Advocate's predecessor as "the first respondent". That is because the decisions which he took are defended by both respondents. I can deal with this question comparatively briefly.

[132] In my opinion, the decisions of the first respondent as communicated by the letter of 15 June 2006 are open to criticism on grounds additional to that the first respondent acted in a manner incompatible with Article 2. As I have already noted, it is would appear from the letter that before the first respondent made his decisions he failed to reach a concluded view as to whether Article 2 had been engaged, following the deaths of Mrs. GRO-A and Mr GRO-A It is now accepted on behalf of the respondents that it was. One practical manifestation of the first respondent's apparent failure to reach a concluded view that Article 2 had been engaged can be identified when the author of the letter seeks to pre-empt, at least to some extent, the scope of the issues that could be addressed at any FAI and, by implication, the scope of the findings that might be made following an FAI. In considering whether the provisions of Article 2 require the holding of an independent public inquiry, it is not appropriate to second guess what the findings of any inquiry are likely to be and whether those findings are liable to be useful. Any obligation arising under Article 2 to hold an inquiry into the circumstances of a death can not be satisfied by a representative of the State reaching the view that there would be only be a limited possibility of such an inquiry establishing that the death concerned had been caused by the act or omission of any individual or public body, who ought to be held publicly to account (per Lord Steyn in *Re(Amin)* at paras. 50 - 52).

[133] In my opinion the terms of the letter also disclose (a) a failure on the part the first respondent to give adequate notice of the documents and other materials and information upon which his decisions were based; (b) a failure on the part of the first respondent to indicate his view on the factual issue of when Mrs. GRO-A may have become infected with the Hepatitis C virus, resolution of that factual

issue being essential before the first respondent's assertion that Mrs. GRO-A s infection had occurred "at a time when no practical preventative measures were available" could be tested; (c) a failure on the part of the first respondent to identify that the factual issue as to when Mrs. GRO-A became infected with the Hepatitis C virus involved addressing the possibility that the infection occurred on account of the blood transfusion she received on 24 July 1991; (d) a failure on the part of the first respondent to indicate his view on the factual issue as to when Mr GRO-A may have become infected with the Hepatitis C virus; (e) a failure on the part of the first respondent to identify that the factual issue of when Mr GRO-A became infected with the Hepatitis C virus involved addressing the possibility of the infection having occurred between 1985 and 1987, whilst Mr GRO-A was being treated with blood products, which had not been heat-treated; (f) an error on the part of the first respondent when he prejudged the likely scope of any FAI so as to exclude from the possible remit of such an inquiry issues such as the introduction of the heat-treatment of blood products and the development of tests for the screening of blood donations for the Hepatitis C virus; (g) consequent on that particular error, a further error on the part of the first respondent in reaching the conclusion that there were no issues relating to the circumstances of the deaths of Mrs. GRO-A and Mr. GRO-A which could be said to cause serious public concern; (h) that the first respondent sought to pre-judge the likely outcome of any FAI; and (i) a failure on the part of the first respondent to make clear exactly what was encompassed within the use of the phrase "the existence of other remedies available to the parties".

[134] In my opinion those criticisms illustrate that the first respondent erred in law, when exercising his powers under the 1976 Act, by reason of his failure to recognise that the Article 2 was engaged and the erroneous view he took as to the potential scope of the remit of a FAI. They also illustrate that the first respondent failed to take into account relevant and material considerations, having taken his decisions without forming views as to when each of Mrs. GRO-A and Mr GRO-A may have become infected with the Hepatitis C virus; based his decision in relation to the death of Mrs. GRO-A on an erroneous understanding that she had contracted the Hepatitis C virus as a result of a blood transfusion "when no practical, preventative measures were available"; failed to identify certain of the sources of information on which his decisions were reached; and failed to make clear to what he was referring when he set out certain of his reasons for those decisions.

[135] In these circumstances I am persuaded that the first respondent's decisions refusing to hold

FAIs, as set out in the letter of 15 June 2006, disclose errors in law on his part. Standing the conclusion I have reached that the first respondent's actings since the deaths of Mrs. GRO-A and Mr. GRO-A have not been compatible with Article 2, it follows that such errors in law constitutes further grounds on which the decisions of the first respondent not to hold FAIs should be reduced.

*Having regard to the provisions of section 1(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, Article 2 of the European Convention on Human Rights, section 57(2) of the Scotland Act 1998 and section 6(2) of the Human Rights Act 1998, was the first respondent obliged to order FAIs into the circumstances of the deaths of Mrs.* GRO-A *and Mr.* GRO-A

[136] This question is one that the respondents invite the Court to address. The petitioners do not seek an order against the first respondent in such specific terms.

[137] During the hearings it was argued on behalf of the respondents that the first respondent had not acted in a manner incompatible with Article 2 and that his decisions refusing to hold FAIs had been reasonable. I have, of course, found against the respondents on both of those issues. This question focuses the related issue of whether there is anything in the provisions of section 1(1) of the 1976 Act, Article 2 of the European Convention on Human Rights, section 57(2) of the Scotland Act and section 6(2) of the Human Rights Act that obliged the first respondent to order FAIs into the deaths of Mrs. GRO-A and Mr GRO-A as opposed to the second respondent, or for that matter a Minister of the Crown in the Government of the United Kingdom, setting up inquiries into the deaths of Mrs. GRO-A and Mr GRO-A to meet the obligations on the United Kingdom arising under Article 2.

[138] It was agreed between the parties that, as a matter of legal competency, it would have been open to the first respondent to have reached the conclusion that he should order FAIs under the 1976 Act into the deaths of Mrs. GRO-A and Mr GRO-A It was also agreed that any FAI held under the provisions of the 1976 Act would satisfy any procedural obligation on the United Kingdom under Article 2 to carry out an investigation and would meet the minimum standards required of any such investigation (see *R (Amin)* v *Secretary of State for the Home Department*, per Lord Hope at para. [60]).

[139] Senior counsel for the respondents accepted that the exercise by the first respondent of her discretion under section 1(1)(b) of the 1976 Act was fettered by considerations arising from Article 2. On the other hand, it is clear that the provisions of Article 2 would not oblige the Lord Advocate to hold an FAI into the death of every person whose death had occurred in Scotland during the course of, or following upon, medical treatment provided by the NHS. Against that background, the question

arises whether, if it became clear to the first respondent, in relation to a particular death in Scotland, that the holding of a FAI would be one, but not the only, practical means of ensuring that the United Kingdom fulfilled its obligations under Article 2, the first respondent would be constrained by the provisions Article 2 to order an FAI.

[140] One purpose of the provisions of section 57(2) of the Scotland Act is to ensure that the first respondent, when exercising the retained functions of the Lord Advocate (see section 52(6) of the Scotland Act), acts compatibly with Convention rights. The provisions of section 6(1) of the Human Rights Act have a similar purpose. They apply to the first respondent because she is a public authority. In the circumstances of these cases, however, even when read with the provisions of section 6(2), the provisions of section 6(1) of the Human Rights Act add nothing to the provisions of section 57(2) of the Scotland Act.

[141] Turning to the detail of the provisions the 1976 Act, the respondents argued that in respect of deaths such as those of Mrs. GRO-A and Mr GRO-A FAIs could only have been ordered by the first respondent under section 1(1)(b) of the 1976 had it appeared to him that it would "be expedient in the public interest that an inquiry under (the) Act should be held into the circumstances of the death(s) on the ground that (they were) sudden, suspicious or unexplained, or (had) occurred in circumstances such as to give rise to serious public concern". It had not. Against that factual background, and standing the terms of section 1(1) of the 1976 Act, it was argued that it would not have been competent for the first respondent to have ordered FAIs into the deaths of Mrs. GRO-A and Mr GRO-A

[142] The contrary argument on behalf of the petitioners was that if, in respect of a particular death in Scotland, Article 2 requires a public investigation to be initiated by the United Kingdom, the first respondent was constrained to consider it expedient in the public interest to order an FAI into that death. In relation to such a death, the first respondent's exercise of her discretion under section 1(1) of the 1976 was fettered by her statutory obligation under the provisions of section 57(2) of the Scotland Act not to do any act incompatible with any Convention rights. Rephrasing the proposition in more practical terms, in a situation in which the Lord Advocate knew, or ought to have appreciated, that the holding of a FAI would be one way in which the United Kingdom could initiate the public inquiry necessary to provide a practical and effective investigation into the facts of a particular death in Scotland, and thereby ensure the United Kingdom's compliance with its obligations under Article 2 in respect of that death, it was the duty of the Lord Advocate to allow the exercise of her discretion to be

guided by the existence of those obligations.

[143] When advancing this line of argument, senior counsel for the petitioners accepted that there may be cases in which no FAI need be held into deaths that might be regarded as having occurred in "sudden, suspicious or unexplained" circumstances, or in circumstances which are "such as to give rise to serious public concern". In such cases a FAI may not be required because other proceedings are underway, such as criminal proceedings or contested civil proceedings that are liable to involve public hearings. Were that to be the position, the first respondent, could properly reach the view that the obligations that had arisen under Article 2 were being complied with and that in these circumstances it was not expedient in the public interest to hold a FAI. A similar view could be reached if some other form of statutory inquiry, which was compliant with Article 2, was going to take place.

[144] It is appropriate that I should address this question on the basis that I am correct in holding that the actings of each of the respondents to date have been incompatible with the obligations of the United Kingdom under Article 2. In reaching those decisions, I had regard to the fact that neither of the respondents nor the United Kingdom Government have decided to order public inquiries into the deaths of Mrs. GRO-A and Mr. GRO-A

[145] I agree with the submissions made on behalf of the respondents in relation to this particular question. Even if the first respondent is bound to proceed on the basis that the exercise of her discretion under the 1976 Act is constrained by obligations on the United Kingdom arising under Article 2 and by the provisions of section 57(2) of the Scotland Act, that does not require her to order FAIs unless and until she has reached the conclusion that the statutory criteria set out in the 1976 Act have been fully met and warrant her exercising her discretion to that effect. Such a conclusion is consistent with the fact that the holding of FAIs under the 1976 Act is not the only procedure by which the respondents could have complied with the obligations arising under Article 2. Setting up an Inquiry under the Inquiries Act 2005 is clearly an alternative procedure for doing so.

[146] For these reasons, I answer this question in the negative.

*If the actings of the second respondent have not been compatible with Article 2, are there are grounds for reducing their decision, intimated by the press release dated 16 June 2006, to refuse to order a full judicial inquiry into the infection of patients of the NHS with the Hepatitis C virus?*

[147] I have reached the conclusion that it would not be appropriate to answer this question. In the

first place it may be open to argument whether the petitioners fall to be treated as "victims" with the right to challenge the decision of 16 June 2006. That decision did not mention either Mrs. GRO-A or Mr GRO-A by name. More importantly, perhaps, the decision was taken by the second respondent in response to a call for a full judicial inquiry that had been made to the Scottish Executive on 16 April 2006 by the Health Committee of the Scottish Parliament. It is also appropriate that I take account of the recent decision of the Scottish Government to set up a general public inquiry, to which I referred in para. [16]. Taking all these factors into account, were the Court to express a concluded view as whether there are grounds for reducing the second respondent's decision of 16 July 2006 that might be construed as amounting to an unnecessary interference in the relationship between the Scottish Government and the Scottish Parliament.

[148] Senior counsel for the respondents suggested that if I reached the conclusion that it was appropriate to grant reduction of the first respondent's decisions of 15 June 2006 it would not be necessary for the Court to go further at this stage. That was because the respondents would wish to consider their position with a view to determining what further action they might take.

[149] Such an approach accords with the view attributed to senior counsel for the petitioners, prior to the continued first hearings getting underway. I dealt with that earlier in para. [32].

[150] In my opinion these overlapping positions are perfectly understandable. In these circumstances I do not intend to embark on any further analysis as to whether there are grounds for reducing the second respondent's decision of 16 June 2006.

*Having regard to the provisions of section 48(5) of the Scotland Act 1998 and section 28(2) of the Inquiries Act 2005 does the second respondent have any power to order inquiries into the circumstances of the deaths of Mrs.* GRO-A *and Mr* GRO-A *at which their next of kin could be legally represented, be provided with the relevant material and be able to cross-examine the principal witnesses?*

[151] I answer this question in the affirmative. The role of the first respondent as head of the system of investigation of deaths in Scotland is not a jurisdiction that prevents other Ministers of the Crown or public officials, who have been granted the appropriate statutory powers to do so, from exercising their statutory powers to set up public inquiries into deaths that are deemed to warrant such form of investigation In my opinion, that is clear from the provisions of the legislation under which FAIs were previously and are currently held in Scotland.

[152] The Fatal Accident Inquiry (Scotland) Act 1895 ("the 1895 Act") made provision for holding public inquiries into the causes of deaths due to accidents that had occurred in the course of industrial

employment or occupation. Section 4(2) of that Act provided that

> "(i)n any case in which it is competent for any official or department of Her Majesty's Government to cause public inquiry to be made into the ..... accident under the provisions of any statute in force for the time being, then such intimation *(by the Sheriff Clerk)* shall also be made to such official or department".

Section 3 of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1906 ("the 1906 Act") provided that in any case of sudden or suspicious death in Scotland, the Lord Advocate could direct that a public inquiry be held and that any such inquiry should take place according to the procedure prescribed by the 1895 Act.

[153] The 1895 Act and the 1906 Act were both repealed by the 1976 Act. Schedule 1 to the 1976 Act refers to a number of other statutes under which inquiries could be set up by Ministers of the Crown and officials into deaths that had occurred in Scotland. In terms of the provisions of certain of those statutes, no FAI could be held if an inquiry under the statute in question had already been held. Other of those statutes provided that the Lord Advocate could direct that a FAI should take place, even although another form of statutory inquiry had been ordered. Whilst certain of those statutory provisions have been repealed, they have been replaced by other provisions to similar effect. Furthermore the provisions of section 3(2)(a) of the 1976 Act and rule 4(2)(d) of the Fatal Accidents and Sudden Deaths Inquiry Procedure (Scotland) Act 1977 require that in the case of any death in which it is competent for a minister or government department to cause a public inquiry to take place under a statute other than the 1976 Act, notice of the holding of any FAI must be given to the minister or government department concerned.

[154] Since the 1976 Act came into force, a number of public inquiries have taken place into deaths in Scotland, which have not been FAIs held under provisions of the 1976 Act. Those inquiries have included the Piper Alpha Inquiry, the Dunblane Inquiry and the Bellgrove Train Crash Inquiry. Such inquiries have taken place under the provisions of several Acts of Parliament, including the Tribunals and Inquiries Act 1921 and legislation regulating health and safety in merchant shipping, the off-shore oil industry, the railways and aircraft. Over many years, those inquires have been set up Ministers in the United Kingdom Government, including the Secretary of State for Scotland, exercising their statutory powers, without any suggestion having been made that the setting up of such an inquiry amounted to any form of interference in the role of the Lord Advocate as head of the

system of investigating sudden deaths in Scotland. It is reasonable to assume that all such inquiries were set up after appropriate consultation with the Lord Advocate.

[155] In my opinion, it is clear from the provisions of the Inquiries Act 2005 that public inquiries under that Act can include inquiries into the circumstances of fatal accidents and deaths. As far as the holding of such inquiries in Scotland is concerned, if an inquiry is to take place into a "Scottish matter", it is the second respondent who has the power to cause the inquiry to be held (section 1). That power is exercisable in the name of the Scottish Ministers collectively, rather than in the name of the Lord Advocate on her own. The terms of reference of an inquiry under the Inquiries Act 2005, which had been set up by the second respondent on their own, could not require the inquiry to determine any fact or make any recommendation that was not wholly or primarily concerned with a "Scottish matter"(section 28(1) and (2)). The 2005 Act defines a "Scottish matter" as being a matter that relates to Scotland and is not a reserved matter within the meaning of the Scotland Act (section 28(5).

[156] If following the deaths of Mrs. GRO-A and Mr GRO-A any inquiry required to ensure compliance with Article 2 could be confined to Scottish matters, such an inquiry under the Inquiries Act 2005 could be set up by the second respondent. If, on the other hand, the view was taken that in order to comply with the obligations arising under Article 2 the scope of the inquiry should allow for the consideration of any reserved matters, within the meaning of the Scotland Act, the inquiry could be a "joint inquiry" within the meaning of sections 32 and 33 of the Inquiries Act 2005. That would involve the second respondent setting up the inquiry with a Minister of the United Kingdom Government. The ICL Factory Inquiry announced on 1 October 2007 is an example of a joint inquiry and has been established jointly by Scottish and United Kingdom Ministers under the Inquiries Act 2005.

*Should a declarator be pronounced in favour of the first petitioner that she is entitled to an independent, effective and reasonably prompt public inquiry into the death of Mrs.* GRO-A *at which her next of kin could be legally represented, be provided with the relevant material and be able to cross-examine the principal witnesses, and that a failure on the part of the respondents to provide such an inquiry would be incompatible with Article 2 of the European Convention on Human Rights and accordingly ultra vires of the respondents in terms of section 57(2) of the Scotland Act 1998?*

[157] I have reached the view that it would premature to grant the first petitioner a declarator in such extensive terms. Whilst I have held that the actions of the respondents to date have not been compatible with the obligations of the United Kingdom under Article 2, it is appropriate that the

respondents be given further time to consider what action they intend to take following upon my granting reduction of the decision of the first respondent dated 15 June 2006 not to hold a FAI into the death of Mrs. GRO-A

*Should a declarator be pronounced in favour of the second petitioner that she is entitled to an independent, effective and reasonably prompt public inquiry into the death of Mr GRO-A at which his next of kin could be legally represented, be provided with the relevant material and be able to cross-examine the principal witnesses, and that a failure on the part of the respondents to provide such an inquiry would be incompatible with Article 2 of the European Convention on Human Rights and accordingly ultra vires of the respondents in terms of section 57(2) of the Scotland Act 1998?*

[158] I answer this question in similar terms.

*Should an order be pronounced in favour of the first petitioner ordaining the respondents or one of other of them to cause such an inquiry to be held, by such procedure, and within such a period, as the Court may determine?*

[159] I am not prepared to pronounce such an order at this stage of the proceedings. On any view it would be premature to consider making such an order.

*Should an order be pronounced in favour of the second petitioner ordaining the respondents or one or other of them to cause such an inquiry to be held, by such procedure, and within such a period, as the Court may determine?*

[160] I am not prepared to grant such an order at this stage of the proceedings.

*Further procedure*

[161] For the reasons I have given, I shall, in respect of each petition, sustain the first plea in law for the petitioner, repel the third plea in law for the first respondent and grant decree reducing the decision of the first respondent of 15 June 2006 refusing to order an inquiry under the 1976 Act; and I shall also fix a By Order hearing at which I can be addressed by the parties on further procedure.

NEWS.scotsman.com

Tuesday, 26th February 2008

- **Published Date:** 06 February 2008
- **Source:** The Scotsman
- **Location:** Scotland

# Families win long fight for hepatitis C deaths inquiry

By CRAIG BROWN

FOR the last eight years of her life, GRO-A was in constant pain – all because a blood transfusion that was meant to save her life went wrong.

The grandmother was one of many innocent victims fatally infected with the debilitating hepatitis C virus by contaminated NHS blood stocks during the 1970s and 1980s.

After a long campaign, her relatives yesterday celebrated a judge's landmark decision that will force Scottish ministers to launch an inquiry into the scandal.

Lord Mackay overturned a 2006 ruling by Scotland's most senior law officer, the Lord Advocate, Elish Angiolini, who ruled there should not be fatal accident inquiries into the deaths of Mrs GRO-A 72, and the GRO-A, 66, a haemophiliac who died of hepatitis C in 2003. Lord Mackay held that Ms Angiolini's decision had breached their human rights.

It is thought to be the first time a Scottish judge has quashed a decision of the Lord Advocate.

Mrs GRO-A's daughter, GRO-A, said: "We knew we couldn't change what had happened. It's really been for us about finding out the truth, and always realising that there's hundreds of others out there that may still have this to go through. We didn't want anyone else to be in this position."

Another daughter, GRO-A, 39, from Bishopbriggs, said: "I'm delighted that at last we get an opportunity to find answers to the questions we've had for many years.

"It's been a struggle. It has been very difficult at times, but luckily we are a close-knit family and we've been able to support each other. It would have been easy to give in, but we just felt that we had to do it for our mother."

Mrs GRO-A, 42, from Scotstoun, Glasgow, described how her mother's illness had gone undiagnosed until 1995, when she was diagnosed with cirrhosis of the liver and subsequently hepatitis C. She contracted it during one of two operations on her heart in 1986 and 1991.

"It wasn't just one part that hurt – it was her whole body," she said. "Her stomach became swollen, her liver and spleen enlarged. Later on, she needed a wheelchair whenever she wanted to go out.

"She had always been a very active person. In the final weeks, she was bedridden in hospital."

A summary of Lord Mackay's findings said any investigation "could include the Lord Advocate seeking a fatal accident inquiry before a sheriff or the setting up of a public inquiry by the Scottish ministers".

The previous Labour administration at Holyrood had resisted calls from victims and their families for a public inquiry, but the SNP government has said one will be held. Its remit has yet to be established.

Frank Maguire, of Thompsons Solicitors, has campaigned on the family's behalf for more than three years.

He said that while the inquiry would focus on the deaths of Mr GRO-A and Mrs GRO-A, it would have implications for other sufferers. "There are still people out there who have had transfusions in the 1980s and early 1990s who don't know they have hepatitis C because nothing has really been done about tracing them and they may have never come back into contact with hospitals since then," he said.

Hepatitis C is spread mainly through contact with the blood of a person who isinfected. It can lead to liver failure, but it can take years, or even decades, for symptoms to appear.

ANXIOUS WAIT OVER 'TAINTED BLOOD' TESTS

BRITISH soldiers could face months of anxious waiting for tests to establish whether they were exposed to contaminated blood in Iraq and Afghanistan, it emerged yesterday.

All of the 18 military casualties given transfusions with blood that had not been tested properly have now been informed of the risk. But Derek Twigg, the defence minister, said some had still not had their tests completed because blood samples could not be taken for "some months" after the transfusion. It was revealed last month that seriously injured British troops had been given blood from the US military that had not been properly screened, meaning it could contain infections.

Mr Twigg added: "The MoD fully recognises the distress this will have caused."

Last Updated: 05 February 2008 9:29 PM
Page 1 of 1



## Chris James

**From:** Jane Matheson
**Sent:** 19 February 2008 14:36
**To:** GRO-A; GRO-A; GRO-A; GRO-A; GRO-A
**Cc:** Dan Farthing
**Subject:** FW: 1st European Rare Disease Day UK Event - 26th February
**Importance:** High
**Attachments:** invitation.pdf

Dear GRO-A, GRO-A, GRO-A and GRO-A
You have all offered to go to the event at the House of Commons next Tuesday 26th February 4-6pm for the 1st Rare Disease Day Parliamentary Drinks Reception. The details of the event stay the same as in the original attached 'invitation' document except that the room is now the Members Dining Room to accommodate the large number of people who want to attend. The background to the event is described in the email below mine.

As the event starts at 4pm the plan is to leave the office at 3.15pm.
GRO-A – you would be welcome to come to the office first for 3.15pm or you can meet the group at the Reception at 4pm. Please could you let GRO-A know which option you're taking!

I've just had this information from Melissa Hillier of GIG to say that the following MPs have agreed to attend. They are arranging for a photographer to take pictures of attendees with their local MP so if your MP is listed please could you let Melissa know if you want to be involved (melissa@ GRO-C ):

'I know that some of you have kindly invited your local MP's to attend the reception and we have had an extremely positive response. This is important as we need to raise awareness of Rare Diseases to MP's and Lords in order that they support the work that we currently do and hopefully encourage them to put pressure on government to improve services in the future and support our campaigns.

We will have a photographer at the day and I would very much like to take photos of anyone who lives in the following constituencies with their local MP (if you would be willing happy to do so). This may enable us to gain some coverage in the local press about Rare Disease Day following the reception.

As I will not recognise all the faces on the day, I would be really grateful if you could let me know if you would be happy to have a quick photo taken if your MP is listed below. I will then do my best to co-ordinate this on the day.

Southend West - David Amess
Blaydon(nr newscastle) - Dave Anderson
Daventry - Tim Boswell
Twickenham - Vince Cable
Heyward and Middleton - Jim Dobbin
St Ives - Andrew George
Luton North - Kelvin Hopkins
Middlesborough South and Cleveland - Ashok Kumar
Bristol North West - Doug Naysmith
Boston and Skegness - Mark Simmonds
Wyre Forest - Richard Taylor'

Enjoy the event!
Jane

GRO-A
Senior Information and Advice Officer
Direct line: GRO-C
Email: GRO-C
The Haemophilia Society Petersham House, 57a Hatton Garden, London, EC1N 8JG

26/02/2008