

‘The patronising disposition of unaccountable power’

A report to ensure the pain and
suffering of the Hillsborough families
is not repeated

The Right Reverend James Jones KBE

Return to an Address of the Honourable
the House of Commons
dated 1 November 2017
for

**‘The patronising disposition of
unaccountable power’**
A report to ensure the pain and suffering of the
Hillsborough families is not repeated

The Right Reverend James Jones KBE

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Letter to the Prime Minister and Home Secretary

Dear Prime Minister and Home Secretary,

Home Secretary, following the conclusion of the fresh Hillsborough inquests in April last year your predecessor, now the Prime Minister, commissioned me to produce a report on the experiences of the Hillsborough families so that their 'perspective is not lost'. In doing so, she expressed the hope that we might learn from what the families had experienced. It is my privilege to now present this report to you, Home Secretary, in my role as your adviser on Hillsborough and to you, Prime Minister. I believe the report demonstrates that there remains much to learn.

I have known many of the families and survivors of the Hillsborough disaster for nearly twenty years. First, as the Bishop of Liverpool I presided at the 10th, 15th, and 20th anniversary services at Anfield. Second, as Chair of the Hillsborough Independent Panel I oversaw the publication of the Panel's report in September 2012 that set in train the quashing of the original inquests and the setting up of new inquests that led to the jury's majority determination of 'unlawful killing'. Third, in my role as the Home Secretary's adviser on Hillsborough I have chaired the forum that has enabled families to meet regularly with the criminal and disciplinary investigations. Furthermore, over the last year I have met with the families both in group sessions and in one-to-one conversations to produce this report.

In this report I do not pretend to speak for the families. But I have listened to what they have said to me. I urge you to help ensure that those responsible for our national institutions listen to what the experiences of the Hillsborough families say about how they should conduct themselves when faced by families bereaved by public tragedy. I want therefore to begin by inviting you to read these opening examples of what the Hillsborough families have said, in their own words.

'I was taken to the mortuary. This was cruel. This was my brother, who I knew inside out; who I had slept with. It was just through a window... I asked if I could go in and see him. There was a kerfuffle. They said no, he was the property of the coroner. I said "he is not, he is my mother's property".'

'Police officers visited my mum shortly after the disaster... They brought my dad's belongings in a bin liner and just tipped them on the floor. They said, "What was an old man doing going to a game like that?''

'[There was] no care or compassion for those who died. The dead were degraded by the police and media. Testing for blood alcohol was one example of this including for children. They were treated as though they didn't matter.'

'I felt the families were conned. We were told that our questions would be answered at the "generic" inquest, but they weren't.'

'The first inquest was dehumanising. The deceased were numbers not names. That dehumanisation impacted on my mental and physical health.'

'After Lord Justice Taylor's report I truly believed truth and justice would prevail, however what happened subsequently was a complete systematic degradation and humiliation of the 96, families, survivors and all the good I was raised to believe in.'

'I had a telephone call from the then South Yorkshire Chief Constable Med Hughes in the stages before the HIP was set up in 2009. During the call he said "I am under no obligation to disclose anything and the papers belong to me. If I wanted to I could take them into the yard and have a bonfire with them". I replied if he did we would turn him into a guy and chuck him on the top of the fire.'

'After the Panel report, I took the report to the cemetery and said, "Look, Mum, he was not a hooligan." The Panel found out the truth.'

'The second inquest gave me my children back.'

'I only hope my father can rest in peace knowing that I did everything that I possibly could to be his voice and make sure his truth was heard.'

Finally, the mother of one of those who died told me, – 28 years after the disaster took place – that: *'Grief is just beginning as we have been fighting to get to the truth.'*

Over the last two decades as I have listened to what the families have endured, a phrase has formed in my mind to describe what they have come up against whenever they have sought to challenge those in authority – 'the patronising disposition of unaccountable power'. Those authorities have been in both the public and the private sectors.

The Hillsborough families are not the only ones who have suffered from 'the patronising disposition of unaccountable power'. The families know that there are others who have found that when in all innocence and with a good conscience they have asked questions of those in authority on behalf of those they love the institution has closed ranks, refused to disclose information, used public money to defend its interests and acted in a way that was both intimidating and oppressive. And so the Hillsborough families' struggle to gain justice for the 96 has a vicarious quality to it so that whatever they can achieve in calling to account those in authority is of value to the whole nation.

In your recent manifesto you made a commitment to 'stand up to those in positions of power who abuse that privilege'. This commitment has application here, in the need to tackle this patronising disposition wherever it is found. Because this report is not simply about how things were. The concerns that it deals with are both historic and contemporary. In your manifesto you also set out your plans to confront and overcome a number of 'burning injustices'. In doing so, I suggest that the way in which families bereaved through public tragedy are treated by those in authority is in itself a burning injustice which must be

addressed. That is why the points of learning I have identified in this report are essential. Not just to contribute to the process of justice for the 96 but so that the experience of the families and survivors of Hillsborough informs future much needed reform. It is because it is essential to look forward and not just backwards that the perspective of the families must not be lost.

One way in which the families' perspective is already leading to reform is through your commitment to introduce an 'independent public advocate' to 'act for bereaved families after a public disaster and to support them at public inquests'. I warmly welcome this undertaking, which will fill a real gap in the provision of support to bereaved families. I believe that this report confirms the need for an independent public advocate in these circumstances, but to ensure that the pain and suffering of the Hillsborough families is not repeated I would caution against the adoption of too narrow a definition of 'public disaster'. As this report shows, many of the experiences of the Hillsborough families are very sadly also reflected in the experience of families bereaved through other forms of public tragedy where the state has fallen short. I stand ready to work with the government to develop and deliver this commitment, alongside the other points of learning identified in this report.

I also wanted to set on record a recurrent theme that has been present, either implicitly or explicitly, in many personal conversations that I have had with families and survivors over the past 20 years. It is one that they have often been reluctant to raise not least because of public and political indifference to the subject and perhaps out of fear that it would add to the lack of empathy that they experienced. The disaster, the aftermath, and the struggle to be heard for over quarter of a century have had an adverse effect on the mental and physical wellbeing of both families and survivors. Depression, marital breakdown, family division, mental illness, unemployment, premature death and even suicide have featured in the Hillsborough narrative. Hopefully society's increasing awareness of the issues of mental health will lead to a more sympathetic understanding of what they have endured.

People talk too loosely about closure. They fail to realise that there can be no closure to love, nor should there be for someone you have loved and lost. Furthermore, grief is a journey without a destination. The bereaved travel through a landscape of memories and thoughts of what might have been. It is a journey marked by milestones, some you seek, some you stumble on. For the families and survivors of Hillsborough these milestones have included the search for truth, accountability and justice. But even these are not the end of the road. They are still travelling. And this report is another step along the way.

It is my privilege now to present this report. It is my hope that we will indeed act upon what the families have shared with us so that they might continue their own journey 'with hope in their heart' and we might be a better nation for having listened to them.

Yours sincerely,

The Right Reverend James Jones KBE

The names of those unlawfully killed

| | | | |
|------------------------------|----------|-----------------------------|----------|
| John Alfred Anderson | 62 years | Christopher Barry Devonside | 18 years |
| Colin Mark Ashcroft | 19 years | Christopher Edwards | 29 years |
| James Gary Aspinall | 18 years | Vincent Michael Fitzsimmons | 34 years |
| Kester Roger Marcus Ball | 16 years | Thomas Steven Fox | 21 years |
| Gerard Bernard Patrick Baron | 67 years | Jon-Paul Gilhooley | 10 years |
| Simon Bell | 17 years | Barry Glover | 27 years |
| Barry Sidney Bennett | 26 years | Ian Thomas Glover | 20 years |
| David John Benson | 22 years | Derrick George Godwin | 24 years |
| David William Birtle | 22 years | Roy Harry Hamilton | 34 years |
| Tony Bland | 22 years | Philip Hammond | 14 years |
| Paul David Brady | 21 years | Eric Hankin | 33 years |
| Andrew Mark Brookes | 26 years | Gary Harrison | 27 years |
| Carl Brown | 18 years | Stephen Francis Harrison | 31 years |
| David Steven Brown | 25 years | Peter Andrew Harrison | 15 years |
| Henry Thomas Burke | 47 years | David Hawley | 39 years |
| Peter Andrew Burkett | 24 years | James Robert Hennessy | 29 years |
| Paul William Carlile | 19 years | Paul Anthony Hewitson | 26 years |
| Raymond Thomas Chapman | 50 years | Carl Darren Hewitt | 17 years |
| Gary Christopher Church | 19 years | Nicholas Michael Hewitt | 16 years |
| Joseph Clark | 29 years | Sarah Louise Hicks | 19 years |
| Paul Clark | 18 years | Victoria Jane Hicks | 15 years |
| Gary Collins | 22 years | Gordon Rodney Horn | 20 years |
| Stephen Paul Copoc | 20 years | Arthur Horrocks | 41 years |
| Tracey Elizabeth Cox | 23 years | Thomas Howard | 39 years |
| James Philip Delaney | 19 years | Thomas Anthony Howard | 14 years |

| | | | |
|----------------------------|----------|----------------------------------|----------|
| Eric George Hughes | 42 years | Graham John Roberts | 24 years |
| Alan Johnston | 29 years | Steven Joseph Robinson | 17 years |
| Christine Anne Jones | 27 years | Henry Charles Rogers | 17 years |
| Gary Philip Jones | 18 years | Colin Andrew Hugh William Sefton | 23 years |
| Richard Jones | 25 years | Inger Shah | 38 years |
| Nicholas Peter Joynes | 27 years | Paula Ann Smith | 26 years |
| Anthony Peter Kelly | 29 years | Adam Edward Spearritt | 14 years |
| Michael David Kelly | 38 years | Philip John Steele | 15 years |
| Carl David Lewis | 18 years | David Leonard Thomas | 23 years |
| David William Mather | 19 years | Patrick John Thompson | 35 years |
| Brian Christopher Matthews | 38 years | Peter Reuben Thompson | 30 years |
| Francis Joseph McAllister | 27 years | Stuart Paul William Thompson | 17 years |
| John McBrien | 18 years | Peter Francis Tootle | 21 years |
| Marian Hazel McCabe | 21 years | Christopher James Traynor | 26 years |
| Joseph Daniel McCarthy | 21 years | Martin Kevin Traynor | 16 years |
| Peter McDonnell | 21 years | Kevin Tyrrell | 15 years |
| Alan McGlone | 28 years | Colin Wafer | 19 years |
| Keith McGrath | 17 years | Ian David Whelan | 19 years |
| Paul Brian Murray | 14 years | Martin Kenneth Wild | 29 years |
| Lee Nicol | 14 years | Kevin Daniel Williams | 15 years |
| Stephen Francis O'Neill | 17 years | Graham John Wright | 17 years |
| Jonathon Owens | 18 years | | |
| William Roy Pemberton | 23 years | | |
| Carl William Rimmer | 21 years | | |
| Dave George Rimmer | 38 years | | |

Executive summary

1. This report aims to provide an insight into what the bereaved Hillsborough families have experienced over the 28 years which have passed since April 1989, and to place that insight on the official public record. In doing so, I hope that the truth of their experience will bring its own pressure to bear, delivering necessary changes to the way in which public institutions treat the bereaved.
2. The common thread to the experiences set out in this report is what I describe in the letter to the Prime Minister and Home Secretary which opens this report as ‘the patronising disposition of unaccountable power’. This does not just describe the families’ experience of the police, but also of other agencies and individuals across the criminal justice system and beyond. And it does not simply describe a historic state of affairs, but instead one that stretches forward to today, including aspects of the most recent inquests. Neither is it an experience of those in positions of power which is unique to the Hillsborough families, as my conversations with other bereaved families make clear.
3. So this report is not about a perspective on simply about ‘how things were’. The families’ experiences demonstrate a real and continuing need for change, and this report sets out proposals for how to bring about that change.
4. What this report describes as a ‘patronising disposition’ is a cultural condition, a mindset which defines how organisations and people within them behave and which can act as an unwritten, even unspoken, connection between individuals in organisations. One of its core features is an instinctive prioritisation of the reputation of an organisation over the citizen’s right to expect people to be held to account for their actions. This represents a barrier to real accountability.
5. As a cultural condition, this mindset is not automatically changed, still less dislodged, by changes in policies and processes. What is needed is a change in attitude, culture, heart and mind. To bring this about, I first ask that those in positions of leadership listen seriously to the experiences of the Hillsborough families described in this report. I ask that they note too the perspectives of other families bereaved by public tragedy who I have listened to in the writing of this report, and whose experiences echo those of the Hillsborough families.

6. Having heard the families' experiences, I ask that those in positions of leadership take action in order that – as my terms of reference put it – the families' 'perspective is not lost'.
7. My report contains 25 points of learning across a range of subjects, describing the changes which I believe are necessary. I consider each to be vitally important, but three in particular are crucial.

8. **First, I propose the creation of a Charter for Families Bereaved through Public Tragedy – a charter inspired by the experience of the Hillsborough families.**

The experience of the Hillsborough families demonstrates the need for a substantial change in the culture of public bodies. To help bring about that cultural change, I propose a charter drawn from the bereaved families' experiences and made up of a series of commitments to change – each related to transparency and acting in the public interest. I encourage leaders of all public bodies to make a commitment to cultural change by publicly signing up to the charter. The text of the charter is as follows:

Charter for Families Bereaved through Public Tragedy

In adopting this charter I commit to ensuring that [this public body] learns the lessons of the Hillsborough disaster and its aftermath, so that the perspective of the bereaved families is not lost.

I commit to [this public body] becoming an organisation which strives to:

1. In the event of a public tragedy, activate its emergency plan and deploy its resources to rescue victims, to support the bereaved and to protect the vulnerable.
2. Place the public interest above our own reputation.
3. Approach forms of public scrutiny – including public inquiries and inquests – with candour, in an open, honest and transparent way, making full disclosure of relevant documents, material and facts. Our objective is to assist the search for the truth. We accept that we should learn from the findings of external scrutiny and from past mistakes.
4. Avoid seeking to defend the indefensible or to dismiss or disparage those who may have suffered where we have fallen short.
5. Ensure all members of staff treat members of the public and each other with mutual respect and with courtesy. Where we fall short, we should apologise straightforwardly and genuinely.
6. Recognise that we are accountable and open to challenge. We will ensure that processes are in place to allow the public to hold us to account for the work we do and for the way in which we do it. We do not knowingly mislead the public or the media.

9. More details on the charter can be found in chapter 1 of this report.

10. **Second, there is a pressing need for what I describe in this report as ‘proper participation’ of bereaved families at inquests.** There are four strands to ‘proper participation’, each of which is necessary. They are:

I. Publicly funded legal representation for bereaved families at inquests at which public bodies are legally represented.

II. An end to public bodies spending limitless sums providing themselves with representation which surpasses that available to families.

III. A change to the way in which public bodies approach inquests, so that they treat them not as a reputational threat, but as an opportunity to learn and as part of their obligations to those who have died and to their family.

IV. Changes to inquest procedures and to the training of coroners, so that bereaved families are truly placed at the centre of the process.

11. Each strand is discussed in more depth in chapter 2 of this report.

12. **Third, I call for the establishment of a ‘duty of candour’ for police officers.** I believe that there is at present a gap in police accountability arrangements and propose a duty of candour which addresses the unacceptable behaviour of police officers – serving or retired – who fail to cooperate fully with investigations into alleged criminal offences or misconduct. The government should also explore how a wide ranging police duty of candour would operate, and should work with key policing bodies to publish detailed proposals. This issue is discussed in greater detail in chapter 2.

13. Further points of learning are identified throughout this report and collated in chapter 5. In addition, as set out in my letter to the Prime Minister and Home Secretary, I warmly welcome the commitment in the recent Conservative Party manifesto and in the Queen’s Speech to create an independent public advocate to act for bereaved families after a public disaster and to support them at public inquests. I encourage those who have been bereaved through public tragedy to work with the government as this commitment is developed and delivered. I stand ready to assist in this important work.

The structure of this report

The purpose of this report is to provide an insight into the experiences of the Hillsborough families over the past 28 years since 1989 and to identify where those experiences illustrate an ongoing need for change. The report's structure reflects this purpose.

The report is divided into the following thematic chapters:

- **Chapter 1** – Treatment of the bereaved families in the aftermath of the Hillsborough disaster
- **Chapter 2** – Inquests
- **Chapter 3** – Public inquiries
- **Chapter 4** – Criminal and disciplinary investigations

I am grateful to all those family members who spoke to me in the course of writing this report and who have given me permission to publish their personal and powerful accounts.

Each chapter begins with a number of quotations from those accounts, providing an introduction to the families' experiences. Those experiences are then developed and discussed in further detail, making use of extensive quotations. Each chapter then considers what has changed since the events the families have described, followed by outstanding points of learning. After the final thematic chapter, all of the report's points of learning are presented together in chapter 5.

In speaking to the families and producing this report I have been mindful of the fact that everybody affected by the disaster at Hillsborough will have had a unique experience. As BBC journalist Judith Moritz expressed it in her submission to me:

'...the families hadn't had a universal experience, but rather multiple experiences. There is much commonality, but there are also many differences... In disasters in which there are multiple victims, it is a mistake to assume that relatives will all have the same priorities and needs.'

The report should be read with this important fact in mind.

Chapter 1 – Treatment of the bereaved families in the aftermath of the Hillsborough disaster

‘The start of my journey will be very similar to all of the families – hearing news of the disaster, trying desperately to trace Vincent and finally being told, at 1 pm the following day that he had perished. My parents had waited in Sheffield all night hoping for positive news and it was only at my dad’s insistence that the police allowed him to view photographs of the dead and we found Vincent. Dad was not allowed to touch him or be near to him. It broke his heart and his spirit and he never recovered from Vincent’s death.’

Dorothy Griffiths, sister of Vincent Fitzsimmons

‘...then that dreadful day [he] went to a football match and never came home. We waited till 12.30 on that day phoning all day, but no answer. So we went to Sheffield hoping he was at a hospital. But he was at the gym. They would not let me touch him and said he belongs to us, I shouted at them and said he does not belong to you – Anthony is my son. I was so out of it I just sat there crying. There was a couple of Salvation Army people, they came over to us, and started to speak to us. We then made our way to the medical centre. We identified Anthony and still couldn’t hold him. They were so stern with us.’

Betty Almond, mother of Anthony Kelly

‘Maureen and I left home about 2100hrs and drove to Sheffield calling the help line from the car but could not get through. I drove straight to the Northern General Hospital...

We were informed that Gary was not at the NGH but there was clothing that might be associated with Gary and that we should report to Hammerton Road police station. Maureen and I were taken there. We had to register that our son was missing which we duly did despite the noise and chaos, we were then informed that we had to go to a club close by and await further direction, the scene that greeted us was again noise and chaos and no information.

Eventually we were taken by double decker bus to SWFC ground. On arrival a ranking police officer boarded and we were told not to leave the bus in what I considered to be an over forceful manner. I will never forget that man.

We were taken off the bus in small groups and made to wait outside a building the time was approx. 0200hrs. It was very cold and a clergyman offered us a blanket from a large pile, we refused.

We were taken into a room in the building and there we found one wall covered in polaroid photographs and we were asked to make an ID if possible. We looked and could not see Gary until we reached photo number 86. It was of our son and we went into deep shock, there was much grief being expressed in that room by other families as they found their loved ones.

We were asked to make a formal ID and were taken into what was a temporary mortuary. Two police brought a trolley in and I made the formal ID. It was approximately 0230hrs.'

Phil Jones, father of Gary Philip Jones

'[I] had just come out from identifying [my] husband when they started asking questions about alcohol consumption and travel arrangements.'

Wendy Hamilton, wife of Roy Hamilton

'Our friend Steve had to go and identify the bodies [of Inger Shah and her friend Marian McCabe] and give a statement early on Sunday 16th April – just hours after the disaster. He told me South Yorkshire police officers asked if he was “shagging my mum”.'

Becky Shah, daughter of Inger Shah

'We had a phone call to say that [the police] were in Liverpool for a couple of days and they had Paul's clothing. I explained that it was Paul's funeral on the Thursday. I was told “Well if you want them you will have to attend a police station near Liverpool city centre”. I felt at that time, why are they not being more compassionate? We hadn't even buried Paul. Surely, they would bring them to your house.

We had Paul's funeral, then I was taken by an uncle to the police station. I had to leave my family on one of the saddest days of my life. I needed to be with them. I was met by an officer and taken into a room. I could see Paul's clothes in a bag behind the officer. I just wanted them in my arms. To smell my brother, one last time. But before I could do this the officer then asked me about Paul. “Did Paul like a drink?”... That was my first experience of the police. No, “I'm sorry for your loss”. No, “I know how difficult this must be”. I just cried and said “I've just buried my brother, I want his clothes”.'

Donna Miller, sister of Paul Carlile

'Police officers visited my mum shortly after the disaster. Their behaviour was uncaring, arrogant and insulting – it reduced my mum to tears. They brought my dad's belongings in a bin liner and just tipped them on the floor. They said, “What was an old man doing going to a game like that?”... They were in the house for about 15 minutes and said nothing to comfort my mum.'

Gordon Baron, son of Gerard Baron

'Then we had a call from the headmistress, telling us that the reporters were stopping the kids as they went into school. We hadn't said anything to them – but stopping kids is not right. The kids wouldn't know anything... A lot of people had the same trouble... You are relying on them [the journalists] to see it's too traumatic.'

Tony Murray, father of Paul Murray

1 From an article for Amnesty, published at <https://www.amnesty.org.uk/blogs/campaigns/after-hillsborough-i-fought-justice-27-years>

'In the aftermath of the disaster I could not understand how the press got hold of my name. I thought that the only way his could have happened was either through the hospital admission records or from the police. I had no direct contact with the press. After the disaster I went to live with Arthur's widow, Susan, spending most of my time with her on the Wirrall. Little did I know that the press were also camped out at my place in Bootle. How did they get my address?'

Dave Golding, nephew of Arthur Horrocks

'We do have some friends in the press, the minority, but without them we would have been dead in the water.'

Trevor Hicks, father of Sarah and Victoria Hicks

'It is one of the most difficult things about this disaster. I struggle with the fact we never owned our own bereavement. Paul's death has been so public. We have had to battle for every bit of evidence or at times for people to listen to us.'

Donna Miller, sister of Paul Carlile

'Everyone assumes Hillsborough is a Liverpool disaster and only affected families from Liverpool. However, Hillsborough was and is a National Disaster. Out of the 96 who died, 35 were from Liverpool, 20 from the surrounding Merseyside area and 41 were from the rest of the UK. The survivors are also from all over the UK. Two of the lads who tried to save my brother were from Devon. Five out of the seven women who died were from London. When people refer to it only being a Liverpool disaster, it makes me feel like my brother is invisible.'

Louise Brookes, sister of Andrew Mark Brookes

'My teenage years were taken away from me. My childhood ended on 15th April 1989.'

Lynsey Barker, daughter of Eric Hankin

Events in the disaster's immediate aftermath

1.1 In its report, the Hillsborough Independent Panel described the disaster's immediate aftermath, as families sought information about the missing and identified those who had died. The Panel wrote:

'It was decided to continue using the gymnasium [within Hillsborough Stadium] as a temporary mortuary pending the identification of the dead... In the entrance area to the gymnasium notice boards were used to display polaroid photographs of the dead. Each photograph was given a number corresponding to a body on the gymnasium floor...

On the suggestion of a vicar, a disused Boys' Club, close to Hammerton Road Police Station, the police centre of operations, was opened as a reception centre for relatives and friends seeking information. It was an old, damp and unwelcoming place with no adequate amenities for receiving people....

Following consultation with the coroner, the police-led process was set in motion shortly after 9 pm. People were bussed from the Boys' Club to the gymnasium. There they waited in the car park, blankets around their shoulders, before being called to the entrance. They queued to view the unclear photographs of the dead.

When a face was recognised the number was called and the corresponding body was wheeled on a trolley to the gymnasium door. There was little time allowed for contemplation, touch was restricted and privacy denied. Relatives and friends of the deceased were then escorted to police officers sitting at tables, who took statements.'

The Report of the Hillsborough Independent Panel

1.2 Personal experiences of the disaster's immediate aftermath made up a very strong and recurring theme amongst the families I listened to and received written contributions from. I was told how, for many, grief was compounded by early experiences of institutions failing them and by what families considered to be thoughtless and degrading treatment of them and their loved ones. I was also told that the impact of this treatment endures.

'These are experiences which live with, and haunt very many families to this day, and persist like a running sore, leaving many wounds still unhealed.'

Written submission by Marcia Willis Stewart of Birnberg Pierce, solicitors to families who are members of the Hillsborough Family Support Group

1.3 A number of specific issues were raised repeatedly.

1.4 Family members spoke of a lack of information: of telephone information lines being constantly engaged and of inaccurate information being provided at Sheffield hospitals and at Hillsborough Stadium itself. In many instances, this included the heartbreak of being told that a loved one was safe and well, only to later learn that they had in fact died.

1.5 The situation in Sheffield was described by Louise Brookes, sister of Anthony Mark Brookes as 'absolutely chaotic and bedlam'. Other families spoke of travelling between the Northern General Hospital and the Hammerton Road Boys' Club, recalling that 'nobody seemed to know what was going on'.

1.6 Several people described the process of identifying their relative from polaroid photographs of the dead that had been pinned on a notice board, unsorted by gender or age. This process clearly caused great and lasting distress. One family member described the process to us as 'traumatic' and 'cruel'. Paul Robinson, brother of Steven Robinson, told us that 'no attempt had been made to make the process easy', describing the police as 'unprofessional' with apparently 'no training in bereavement counselling'.

1.7 Several people said that they were asked to look at the board of photographs even though their relative had already been identified by friends. In many cases personal identification was retrieved almost immediately from the bodies of the deceased. For some families the viewing of photographs was therefore not only painful, but also entirely unnecessary.

1.8 This and other aspects of processes followed on the day were described by families as dehumanising. In another example, families spoke of those who died having their faces covered with bin bags, and of police officer collar numbers being written on their bodies. These images – and the sense of disrespect they seemed to convey, had stayed with families since the day of the disaster and were felt deeply.

1.9 Many family members talked about being prevented from holding or touching the body of their loved one, and of the pain that this had caused. Several were told that their relative was now the ‘Property of the coroner.. Jenni Hicks, mother of Sarah and Victoria Hicks, told me ‘Property of the coroner? No they’re not, they’re your children’. Many of the families said that they were only asking for respect and courtesy. Instead, they ‘had been treated with not an ounce of compassion’.

1.10 This chapter begins with a number of quotes from family members. To give the reader the opportunity to understand more about families’ experiences in their own words, extracts from several further accounts are presented below:

‘...I tried to find out if he was at home. I rang my mother, then started to ring around the numbers quoted on the TV. The police assured me that all the dead had been identified. I told my mum this and relaxed.

But there was still no word. I tried the numbers again and then went to Sheffield on 16 April. I went to the Leppings Lane gate and had a confrontation with the policeman at the gate. He told me that all the dead had been identified. After an hour a policeman came across, took the social worker with me to one side. He then came and asked if I was prepared to look at some bodies. I asked him what he wanted me to do that for, all the dead had been identified. But they said that one man and one woman hadn’t...

I was taken then to the Medico Legal Centre where I met “the men in suits”. I went all through the process again. It was inhumane. I was sat at a table. The policeman was asking questions. These were people we trusted; they upheld the law, which I respected. This man then went into a drawer and threw a polaroid onto the table. It was like dealing a playing card. I had to turn the photo around in order to see it – it was Mike. I said “that’s him”. Instinctively I knew he was dead. A cold shiver ran through me. I went to put the picture in my pocket. I was told this was the property of South Yorkshire Police. I asked “what happens now?”

I was taken to the mortuary. This was cruel. This was my brother, who I knew inside out; who I had slept with. It was just through a window. The curtains opened. I felt like the cartoon character “Chad”, peering over the edge. I fell to my knees. I asked if I could go in and see him. There was a kerfuffle. They said no, he was the property of the coroner. I said “he is not, he is my mother’s property”. I swore. I was told again that he was the property of the coroner.’

Steve Kelly, brother of Michael Kelly

*'There was this big green board with all these little tiny photographs everywhere, and there was no compassion there... We were made to look at every photograph, and I couldn't see Sarah and the relief was enormous. I can remember the relief when I first looked at the board. I looked at Trevor and said "She is not here". And to me that meant that there was still some hope. So the policeman said "Look again, love." So, obviously he knew she was there: "Look again, love." And when I looked the second time, I saw her. I saw a picture. Sarah was number 67.'*²

Jenni Hicks, mother of Sarah and Victoria Hicks

'My brother Tommy was a taxi driver. Along with five more of my brothers he drove down to Sheffield. They were in the gymnasium when they were told to look for my son's photograph to identify him, which they did.

Then they were taken to where my son was laying in a body bag. PC Mason, a British Transport Policeman, started to point a stick towards my son, asking, "How many drinks did he have?" in an aggressive manner, and "What did he have to eat?" My brothers told him "He does not drink, he is only 17 years old", to which Mason replied, "That's what they all say", which is absolutely disgusting and disrespectful. As the night wore on I remained by the window praying my Keith would be alright and come home. I stood by the window until 04.10 Sunday morning until the police arrived to tell me about Keith followed by my brothers. A doctor had to be called to give me an injection for shock.'

Mary Corrigan, mother of Keith McGrath

'My son was identified with a bin liner over his head. Why did the police put a bin liner over his head?'

Teresa Glover, mother of Ian Glover

'It was absolutely chaotic and bedlam at the Boys' Club. Not one police officer came to me or my mom to see if we were ok. The only person who came to us was a female member of the public to offer us a cup of tea. There was no care or compassion by South Yorkshire Police.'

'I was physically assaulted by a retired social worker at the Boys' Club. He slapped me across the face. Absolutely disgraceful.'

'My dad attended the gymnasium with two of Andy's friends, whilst me and my mom remained at the Boys' Club. My dad was asked to view polaroid photos of the victims. They were not arranged in any order, i.e. all males together, all females together and all children together. After viewing the photos for the first time, my dad could not see Andy and told the police officer. The police officer replied back to him to "look again as your son will not look how you last remember him". My dad looked again and he still did not see Andy. The officer, told him for a third time to "take your time and look more closely at the photos". Again, my dad could not see Andy. The police officer then walked approximately six steps away to another policeman who was sat at a desk. The policeman who had been escorting my dad during the viewing of the photos then returned back to my dad and told him that Andy had already been identified at 10.55 pm (approximately four hours earlier). Absolutely disgraceful, cruel and wicked to put a father through that hell. My dad never recovered from seeing all those photographs of the victims.'

Louise Brookes, sister of Andrew Mark Brookes

2 ¹ 'The Day of the Hillsborough Disaster': Rogan Taylor, Andrew Ward and Tim Newburn

'It was pretty much impossible for relatives to obtain information from the disaster telephone line that was set up once. For future disasters multiple lines should be set up and other lines of communication for family members/relatives to get updates.

Respect for the bereaved – Allow families privacy and let them hug, kiss and talk to them if they so wish once they have identified them. The issue many families faced after identifying their loved ones was that the police in charge at the gym would not grant these wishes and responded very coldly to explain that this was not possible as they now were the “property of the coroner”. This protocol needs changing.

Photographs that were taken of the victims at the gymnasium for families to try and identify their loved ones were very poor quality and not arranged in any logical way i.e. splitting sexes, adults and children. This resulted in many families not being able to identify their relatives easily and putting them through unnecessary anguish and pain. In our case despite viewing the photos three times my parents were convinced that Steven was not there and was likely ok. They rang home to me to pass this news on to family and friends only to identify him later on which caused additional pain and distress in relaying this updated information and the impact this had on those receiving the updated news.'

Paul Robinson, brother of Steven Robinson

'The police's priority was to put a plan in place to protect officers and not families. I was told a bare-faced lie by the police that Christopher was not in the gym, even though he was. The police did not assist the families with finding the deceased.'

Barry Devonside, father of Christopher Devonside

'The more you tried [to get through to the given contact number] the more stress and anxiety inducing it was.'

Becky Shah, daughter of Inger Shah

'Believe me, the words are so emblazoned in our minds. We can recite them verbatim now, after all this time and through all of that. He [a police officer at the gymnasium] said, “There has to be post-mortems, they are the property of South Yorkshire and they are nothing more to do with you.”'³

Trevor Hicks, father of Sarah and Victoria Hicks

'The process for identifying Christopher and Kevin was inadequate. It wasted time.'

Theresa Arrowsmith, sister of Christopher and Kevin Traynor

'On the day of the 15th April we knew that Marian was at the match, we tried so many times on the emergency numbers but often unable to get through, I believe with technology now we should have some additional lines and some sort of priority to those numbers to stop the anguish that is experienced in such devastation...

Despite our best efforts on the 15th to no avail, we started to try again on the Sunday morning again no information. So we tried ringing her friends to be told by one family that Marian was dead.

3 'The Day of the Hillsborough Disaster': Rogan Taylor, Andrew Ward and Tim Newburn

So we travelled from Essex to Sheffield, a town which we were totally unfamiliar with. When we arrived at the medical legal centre and gave our details, we then had many hours to wait still not knowing for definite that Marian had died... Bearing in mind that this was more than 24 hours later, the organization and information available was appalling.'

Christine McEvoy, mother of Marian McCabe

'All you could do was look through the glass. Yes that's my son. I got him back three days later wrapped in a shroud.'

Brenda Fox, mother of Steven Fox

'Later Sunday afternoon, I along with my husband, mum and two of my brothers went down to Sheffield, courtesy of the Red Cross. When we got to the hospital, we were told to go into this room. I remember yellow curtains on a wall. No one told us what we were going to see. No one spoke to us. When we were in the room these yellow curtains pulled back and my beautiful son was shown to me with a purple cover over him. Within 10 seconds they closed the curtains. I banged and banged on the window while screaming to see my son. They opened the curtains again for another 10 seconds.'

Mary Corrigan, mother of Keith McGrath

'Six heads peered over the screen whilst we identified our loved one.'

Debbie Matthews, sister of Brian Matthews

'I [Edna] said I would like to see him, and they took me into the Medico Legal Centre. My friend was with me and a social worker. They were behind glass. I didn't question anything that happened. Why didn't I? I didn't understand. We were not allowed to touch them.'

Edna and Tony Murray, parents of Paul Murray

'The three of them [my husband, his nephew and friend] went to Northern General and the other hospital looking for Stephen and Dave. Back to the Boys' Club for hours and hours.

Paul Owens our nephew was eventually taken to makeshift mortuary (gym) to look through photographs for the two of them. My husband rang me at 1.45 am Sunday to tell me that they were both dead.

I rang on the Sunday to see if I could go and see Stephen and was told no come Monday at 11am. (I have since found out Stephen's post mortem wasn't carried out until 10.30am on the Monday morning only minutes before we had to view his body.) We were put in a room, no bigger than a small cupboard, my husband and I and our daughter who was 12 years old at the time.

We were escorted to another room the three of us and could only look at Stephen through a glass window at the Medico Legal Centre. He was covered with a dark coloured velvet like a table cloth we could see only his face. We were not allowed to touch Stephen and were told he was the property of the coroner.'

Pat O'Neill, mother of Stephen Francis O'Neill

1.11 Maria Eagle, who has been MP for the Merseyside constituency of Garston and Halewood since 1997, provided this powerful summary in her written submission to this report:

'They were already traumatised. Some had seen the scenes unfolding on the TV – after all, this disaster was broadcast live – and were immediately and understandably filled with foreboding and worry. Some heard by word of mouth and could not believe what they were hearing – deaths, and a mounting toll being intoned over the media.

They were all looking for children, brothers, sisters, fathers, mothers and close relatives. They had already driven over from Liverpool in fear in the days before mobile communication and by their own accounts endured a frightening and worryingly stressful time wondering what they would find.

These were ordinary law abiding citizens in the middle of a nightmare situation which led them to find that family members, often their children, had been killed. They should have been treated with dignity and respect, with sympathy and understanding, but they were not.

The stories that I have heard from many of those who went there about what was said and done by South Yorkshire Police, particularly in the gymnasium at the ground, which was a makeshift morgue, are scarcely believable, though they happened.'

The initial police investigation

1.12 A police investigation into Hillsborough was started by South Yorkshire Police on the day of the disaster and taken over by West Midlands Police, as an independent force, on the following day. The investigation was intended to consider any criminal and police disciplinary charges as well as provide evidence to Lord Justice Taylor's public inquiry and the coroner's inquest.

1.13 Many families expressed concern to me about the way in which they had been treated by the police investigations, both on the day of the disaster and subsequently. Several said that in interviews which took place immediately after they had formally identified their loved ones, and which ostensibly were part of the identification process, they were asked inappropriate questions by South Yorkshire Police. Many families reported being asked questions focused on alcohol: such as whether their loved one been drinking on the day and, if so, how much. Other relatives described further deeply disturbing questioning.

'[I] had just come out from identifying [my] husband when they started asking questions about alcohol consumption and travel arrangements.'

Wendy Hamilton, wife of Roy Hamilton

'Questions on when did you arrive? Did you have a ticket? Did you stop en-route? Did you have a drink?'

A family member

'Police were not interested in the families of the deceased. They were asking questions that were not relevant to issues of identification.'

Barry Devonside, father of Christopher Devonside

'...throughout [the interview] the police were more interested in what Gary had been drinking and whether he had a ticket.'

Phil Jones, father of Gary Philip Jones

'There were questions on drink. I said, "my son is 14, no he hadn't had any drink".'

Edna Murray, mother of Paul Murray

'On the night of the disaster we travelled across to Sheffield. We identified Richard as well as Richard's fiancée Tracey. We were then asked questions about how much they had had to drink on their way to the game as well as how much we had had to drink – even though we had just identified two dead bodies. We went back to Sheffield two days later and even though Richard had had his autopsy we were still not allowed to touch his body.'

Doreen Jones, mother of Richard Jones

'Our friend Steve had to go and identify the bodies [of Inger Shah and her friend Marian McCabe] and give a statement early on Sunday 16th April – just hours after the disaster. He told me South Yorkshire police officers asked if he was 'shagging my mum'.¹⁴

Becky Shah, daughter of Inger Shah

1.14 Bereaved family members spoke of similarly painful experiences with West Midlands Police. Relatives described police interviewing children with no adults present, disrespectful handling of property, family members feeling bullied into watching video footage of the disaster, and – again – a focus on alcohol.

'No adult was present when both my brother [13 years old] and I [17 years old] gave separate statements. We were both wards of court at the time. My brother told me they tried to get him to say my mum and Marian and all our friends had been drinking before the match. They asked him if my mum drank a lot at home, if she had several boyfriends, and if she went out drinking with these boyfriends... The smearing of my mum's good name was totally abhorrent, reprehensible and so deeply upsetting.'¹⁵

Becky Shah, daughter of Inger Shah

'West Midlands Police questioned a 15 year old boy in the back of a police car without an adult present.'

Wendy Hamilton, wife of Roy Hamilton

'...West Midlands Police phoned up to say that they had Brian's personal effects and that they would be available to collect from a police station in Liverpool.'

However, this was the same day as Brian's funeral, but we were told that if they did not come to collect them on this particular day then they would be disposed of. So we went to the police station and waited all day. Eventually Brian's possessions were brought out, but the police officer just emptied the contents onto a table. This included the polaroid photograph of Brian which had been taken hours after his death, and which we had never seen before. The police officer was from Merseyside police.'

Debbie Matthews, sister of Brian Matthews

'We had a phone call to say that [the police] were in Liverpool for a couple of days and they had Paul's clothing. I explained that it was Paul's funeral on the Thursday. I was told, "Well if you want them you will have to attend a police station near Liverpool city centre". I felt at that time, why are they not being more compassionate? We hadn't even buried Paul. Surely, they would bring them to your house.'

4 From an article for Amnesty, published at <https://www.amnesty.org.uk/blogs/campaigns/after-hillsborough-i-fought-justice-27-years>

5 From an article for Amnesty, published at <https://www.amnesty.org.uk/blogs/campaigns/after-hillsborough-i-fought-justice-27-years>

We had Paul's funeral, then I was taken by an uncle to the police station. I had to leave my family on one of the saddest days of my life. I needed to be with them. I was met by an officer and taken into a room. I could see Paul's clothes in a bag behind the officer. I just wanted them in my arms. To smell my brother, one last time. But before I could do this the officer then asked me about Paul. "Did Paul like a drink?"... That was my first experience of the police. No, "I'm sorry for your loss". No, "I know how difficult this must be". I just cried and said "'I've just buried my brother, I want his clothes".'

Donna Miller, sister of Paul Carlile

'West Midlands Police hired an old nursing home to show a video of the disaster to the families for no apparent reason. The whole experience was very distressing.'

'One police force should not investigate another police force.'

Wendy Hamilton, wife of Roy Hamilton

'One night my sister had just got in when the [West Midlands] police knocked on the door. They had a coat and a couple of shoes in a bag. They said they had a jacket for me to look at. We had a glass table and they threw the jacket on the table. I looked at it in horror. Whoever the jacket belonged to had been sick on the inside of it. I said, "Do me a favour and take it away". They took it away and, when they had left, I told my family to get rid of the table. I could not sit and eat at it ever again...'

West Midlands Police came to the house and said they wanted me to go down to the police station. I asked why. They said, "We want you to look at some videos about the disaster. We are doing a health and safety exercise and we want you to identify your brother". I asked what he meant. He said, "Just pick him out". I said no, I had just come home, I didn't want to go and watch my brother die. He said, "Ok, we will go and ask your sister". I said, no, my sister's not well. He said "Ok, we will go and ask your mother". I told him no, my mother has breast cancer. He said, "One of you will fucking go".'

Steve Kelly, brother of Michael Kelly

'Later in the week, Tuesday, I got a phone call from a police woman named Tyler saying she had my son's shoe and was on the way down to my home. She was very abrupt.'

I phoned my social worker who came right down and was there when the two Police came and passed me a plastic see-through bag which contained my son's shoe, money and ticket. The social worker, Tony, asked why she was abrupt to me on the phone. Her answer was, "Just doing my job".'

Mary Corrigan, mother of Keith McGrath

'Two plain clothed police officers, one female the other male, visited my home not long after the disaster. I was still raw, traumatised and alone. On entering my home one officer commented, "Oh you have a nice home", which I found to be very condescending. The other officer leered at me saying, "Don't worry you're not a suspect". Photographs of deceased were laid in front of me, which I had to identify my dad (Gerard Baron Snr). While the male officer questioned me the female officer strolled around the house browsing my books and VHS tapes.'

Gerard Baron Jnr, son of Gerard Baron

'The first two [police officers] came from West Midlands and within a few days after the disaster, they came to interview me. I felt I was under suspicion. It was about drinking.'

Many of the police who were put in charge with dealing with recently bereaved families were insensitive and displayed extremely poor behaviour in probing questions relating to whether the victims had been drinking, had tickets etc. Proper training/procedural changes are required to address this.'

Edna Murray, mother of Paul Murray

'At some stage police officers from West Midlands came to our home to take a statement from Barry but they came mob handed. There were about 10 of them, so many they couldn't all sit down. It was completely unnecessary for there to be that many of them. It felt intimidating and I think that was their intention... One of the officers was pleasant but he seemed to be very low in rank. Some of the others were just doing their jobs, some were rude and one of them was extremely rude. He plonked himself down in a chair and didn't move. The look on his face was very unpleasant. I attempted to talk to him but he just brushed me off. Afterwards I thought I should have told him to leave and in normal circumstances I would have done that but on this occasion I just didn't feel able to stand up for myself. The number of officers in my home was intimidating and it showed the way the police were thinking.'

Jac Devonside, mother of Christopher Devonside

The media

1.15 Chapter 12 of the Hillsborough Independent Panel's report, 'Behind the headlines: the origins, promotion and reproduction of unsubstantiated allegations', sets out in detail some of the speculative and false media reporting which followed the Hillsborough disaster, tracing it back to its apparent origins – which in many cases were either named or anonymous police officers and politicians.

1.16 It is not the purpose of this report to repeat the work of the Panel. But it is important to describe here some of the impact that media coverage which presented unsubstantiated allegations as fact (or, famously in The Sun's case, as 'THE TRUTH') had on the bereaved families and on the wider public understanding of Hillsborough.

1.17 Families told me that they felt degraded by the press coverage, and that it disparaged both them and their loved ones who had died in the disaster. One family member described their feelings succinctly in the following way:

'We felt we were treated like scum.'

Brenda Fox, mother of Steven Fox

1.18 Other family members said that the false media narrative of the culpability of Liverpool fans has had long lasting effects on their mental health, as well as their personal and professional lives. For example:

'I tried hard not to speak about Hillsborough but it was everywhere but I managed to develop what I would call a "guarded watchfulness". If I ever sensed that Hillsborough, Liverpool or football supporters were going to be discussed I would get myself out of the situation. For example, there were times I can remember when clients would start talking about Hillsborough, unaware that I was from Liverpool, and I would start to panic. I wanted to stand up for all the fans but felt vulnerable and weak, knowing I would break

down in tears. I wanted to be professional and good at my job, but felt constantly angry that judgements were being made by the media, press and the general public.'

Dorothy Griffiths, sister of Vincent Fitzsimmons

1.19 Although by no means all of the bereaved families are from the city of Liverpool, I was told that press coverage of Hillsborough, combined with negative stereotypes of Liverpool and Liverpoolians, acted itself as a barrier to truth and justice, in that it affected people's willingness to engage with the families' campaign. For example:

'The continuing struggle to find the truth about Hillsborough was dismissed by many people as Liverpoolians moaning and not accepting the truth about the real cause of the disaster – our own fans. I heard this said many times by people – a couple of people actually said to me that it was time to let go and grieve for our relatives rather than just going on about it. I know that they completely believed the versions of the "truth" given by the police because why would they lie, it was unthinkable.'

Dorothy Griffiths, sister of Vincent Fitzsimmons

1.20 David Conn, a Guardian journalist who has written extensively about Hillsborough, made a similar point in his written submission to this report. He wrote:

'The inaccurate media coverage, failure to check stories and perpetuation of prejudice against the victims did terrible damage to the families and survivors, and also contributed to the injustice and failure to hold it to account.'

1.21 The false narratives surrounding Hillsborough were also apparently at play in Lord Justice Stuart-Smith's remark about families arriving 'late' to meeting him, which as is discussed later in this report led to the families understandably losing confidence in the independence and veracity of his Scrutiny.

1.22 Separate to the pain caused to the bereaved families by false reports and negative stereotyping, the behaviour of individual journalists and the lack of respect shown for families' privacy was also a strong theme in the accounts given to me in producing this report. Families spoke of being harassed outside their homes, and of their children being stopped on the way to school. Several were suspicious as to how the press had found their home addresses.

'Three days after the disaster the press were outside my home. How had they got to my house? The only people that had my name and address were South Yorkshire Police. I've still not had an answer to how they got my address.'

Dave Golding, nephew of Arthur Horrocks

'My mother and I were hounded by the press. She would have to take me to school late and collect me early to avoid reporters from getting a photograph of me. It was frightening and a complete violation of our privacy. There was no respect for our loss, just greed and humiliation like we were criminals but my dad was a good, hardworking, decent and honest man and he would have been beyond horrified and the fact that his daughter was being treated in such a way.'

The disaster was so high profile and the media was so determined to dig dirt on those that died and their families, that it got too much for my mother, along with our contributing factors surrounding my father's death, and so she made the decision to move away.'

I lost my father, my family, the house I had grown up in, my friends and my whole life as I knew it within four months. My dad died in April and by September I was starting a new school, too young to understand what had happened. It wasn't long before the press ran yet another story about my father and I, and as a result of that the people who lived in our new area then knew who we were and the Hillsborough Disaster was controlling our lives again.'

Charlotte Hennessy, daughter of James Hennessy

'I had to run the gauntlet to go to school while I was doing my GCSEs. The press besieged my house. It should never have been allowed – it should have been a child protection issue. The press took photographs of children and something needs to be done to stop this.'

Becky Shah, daughter of Inger Shah

'The press. We had quite a bit of trouble with them... Opposite us was a friend's garage and the reporters were all stood around in front of this garage with cameras and, although I don't like net curtains, I was really pleased I had them on my bay window, because they couldn't take photos of inside the house. I was trying to keep them away from Tony. I was trying to protect us, but they then moved to the bottom of the street. A lady from Pebble Mill came to the door and I said no. She then went round knocking on all our neighbours' doors. She then went to the end of the street and stopped people coming into the street, asking if anyone knew Tony and Paul. A friend thought she was helping, because the woman told her that if she didn't talk to her, she would knock on our door and disturb us (although she obviously already had).

It was like that every day until the day of Paul's funeral on 26th April.'

Edna Murray, mother of Paul Murray

'Then we had a call from the headmistress, telling us that the reporters were stopping the kids as they went into school. We hadn't said anything to them – but stopping kids is not right. The kids wouldn't know anything... A lot of people had the same trouble... You are relying on them [the journalists] to see it's too traumatic.'

Tony Murray, father of Paul Murray

'We had asked for privacy for the funeral. The media paid the neighbours around the parish church where Christopher and Kevin were buried to film my family while we were grieving. They then proceeded to take a photograph which was published in the Sun newspaper.'

Theresa Arrowsmith, sister of Christopher and Kevin Traynor

'Quite literally the media is a law unto itself, we have had the "good" the "bad" and most definitely the "ugly" over the past 27 years. Certain tabloids have had a huge detrimental effect in our fight for justice and on me and my family personally. It is a corrupt society who have invaded our private lives, poured scorn over us, how can such be? It is just inhumane.'

Gerard Baron Jnr, son of Gerard Baron

'I realised for the first time that losing a loved one in any disaster is a very public affair and there is scant regard for the bereaved families. The press and media litter details of disasters to suit themselves without thinking of the consequences.'

Dorothy Griffiths, sister of Vincent Fitzsimmons

'I was practically a baby, it was just 7 weeks before my 7th birthday, I was left without the man that I adored. I saw my dad every single day and suddenly he was gone.

*My maternal family were not offered any support or any form of counselling. We were left to come to terms with my father's death alone and then subjected to the vicious lies printed within the S*n newspaper...*

*As I grew up it was the lies of the S*n that became responsible for a lot of my demons. It was extremely difficult to explain to others what had happened to my father without the lies of Liverpool fans being responsible coming into conversation. I used to become so deeply upset and angry.'*

Charlotte Hennessy, daughter of James Hennessy

1.23 Points of learning to be drawn from the families' experiences are set out later in this report, but as a general point I would support the following statement made by Alastair Machray, Editor of the Liverpool Echo, in his written submission to this report. He wrote:

'... in covering huge news events, all media should be aware that what they say and do will live as long as the memories of the event. They should realise too that they are dealing with damaged individuals who do not need or deserve further misery.'

1.24 As a separate point, I would like to place it on record that a number of families also raised the Leveson Inquiry with me, including the Inquiry's proposed Part 2. Part 2 of the inquiry was originally intended to consider:

'the extent of unlawful or improper conduct within News International, other media organisations or other organisations. It will also consider the extent to which any relevant police force investigated allegations relating to News International, and whether the police received corrupt payments or were otherwise complicit in misconduct.'

1.25 I note the recent Conservative Party manifesto commitment not to proceed with Part 2 of the inquiry. The manifesto states that this is because of 'the comprehensive nature of the first stage of the Leveson Inquiry and... the lengthy investigations by the police and Crown Prosecution Service into alleged wrongdoing'. Nevertheless, I register here the fact that families who raised the Leveson Inquiry with me expressed strong support for Part 2 proceeding.

Have the lessons been learned from the Hillsborough families' experience?

1.26 The events described in this chapter took place 28 years ago. In order to understand whether there remain lessons to be learned, I have held meetings with – among others – representatives of the College of Policing, the National Police Chiefs' Council, the Home Office and the Chief Coroner. I have also spoken to the charity INQUEST, and I have heard from a number of bereaved families with recent experience of treatment by the police and others following the death of a loved one. Finally, I have considered the work of the Leveson Inquiry into press ethics and practice, and the changes made to media practice following that inquiry.

1.27 This section of the report considers the issues raised across three categories: the aftermath of a major incident; police ethics, ethos and character; and the media's treatment of bereaved families.

The aftermath of a major incident

1.28 According to the evidence submitted to me in the production of this report, both police and coronial practice have moved on significantly since the Hillsborough disaster in terms of their response to major incidents and disasters. As the College of Policing put it in its written submission:

‘Policing has applied many of the lessons from the Hillsborough disaster and other incidents to make significant improvements in the planning, preparation and response of the police service to mass fatality incidents.’

1.29 In particular, the College drew attention to advances in the professionalism of what is termed Disaster Victim Identification (DVI), which is subject to internationally agreed processes and procedures adapted for UK use. Other key advances in the processes by which police respond to cases of death arising from emergencies and major incidents have come about as a result of another 1989 tragedy, the Marchioness disaster, in which 51 people drowned. In 2001, a public inquiry into ‘The Identification of Victims following Major Transport Accidents’ took place in response to concern about identification procedures followed in the aftermath of the Marchioness disaster, and in particular the removal of the hands of a number of those who had died. The public inquiry report, written by Lord Justice Clarke, made 36 recommendations and set out four principles which I am told have since brought about significant change in the way in which the police and others operate. The principles, each of which I support, were as follows:

1. Provision of honest and, as far as possible, accurate information at all times and at every stage;
2. respect for the deceased and the bereaved;
3. a sympathetic and caring approach throughout; and
4. the avoidance of mistaken identification.

1.30 In its submission to this report, the College of Policing described various aspects of the improvements which have been and are still being made. They wrote:

‘The significant improvements in DVI arrangements in the UK have taken many forms including updating legislation such as the Civil Contingencies Act 2004 and 2015, The Human Tissue Act 2004, The Coroner and Justice Act 2009, as well as national and international guidance...’

There are now clear national arrangements for the planning, implementation and leadership within DVI. These include:

- *coordination of the national multi-agency response from the Home Office and Cabinet Office*
- *establishment of Local Resilience Forums, which have arrangements in place for dealing with a mass fatality incident, including publication of a mass fatality plan*
- *responsibilities for the Local Authority for supporting any response by providing shelter and welfare support for survivors at a Survivors Reception Centre, Humanitarian Assistance Centre and emergency mortuary facilities*
- *coordination of DVI processes by established procedure in the operational setting including Strategic Coordination Groups and Mass Fatality Coordination Groups, Identification Boards/Commissions*

- formalised procedures and plans for locating and identifying those who are deceased or their remains by using Mortuary Management Teams...

Since establishment, the College has built on work of previous organisations in designing and developing the national DVI Curriculum. The College has also developed national occupational standards for DVI and role profiles for key functions...

The College have also developed a Continuing Professional Development programme for DVI. This includes mandatory refresher training facilitated by licensed trainers within regions. UK policing also undertake a series of multi-agency exercises in regions on a bi-monthly basis to ensure these improvements are embedded within forces. A national DVI conference is held each year and is attended by practitioners and interested parties from across policing. Events such as these help ensure this area of policing continues to improve.'

1.31 The office of the Chief Coroner also provided me with information about how the response to a 'mass fatality event' should differ now from the situation in 1989. They wrote:

'The local senior coroner would be responsible for establishing the identity of the deceased and then the cause of death, which would be explored in full at a subsequent inquest. He or she would be in touch with the Chief Coroner to provide him with updates. This work would begin immediately as part of a sophisticated and coordinated emergency response to the event, involving the police, local authority and other blue-light services. The senior coroner would be reliant on a number of specialists (such as pathologists and other medical professionals) as well as Disaster Victim Investigation (DVI) trained police to aid with identification and post-mortem work. There would be a designated mortuary which might be the local authority or hospital mortuary where space has been made or in more extreme circumstances a specially constructed temporary mortuary. All this would follow well-developed local plans and would be activated and would involve a large number of participants, not just the coroner.

This sort of response has been seen in recent tragic events like the Shoreham air crash and the terrorist attacks in Westminster, Manchester and London Bridge. There have also been similar approaches abroad, such as in Brussels following the airport and metro bombings.'

1.32 The information provided by the College of Policing and the Chief Coroner's office indicates that significant progress has been made in the management of the aftermath of major incidents and disasters. Based on the information provided to me, I am reassured that should a comparable incident take place today, arrangements would be significantly more organised and professional.

1.33 However, it is clear that some of the issues faced by the Hillsborough families persist.

1.34 Terry Munyard, a barrister who represented a number of Hillsborough families at the recent inquests, provided me with a detailed submission focusing on the way in which police officers and other officials deal with access to and handling of the body of those who have died. He wrote:

'...still some police officers will tell grieving families, insensitively, that the body of their loved one "belongs to the coroner". That is of course not accurate; the coroner merely has custody and control of the body; it does not belong to him or her.'

1.35 The office of the Chief Coroner was also asked about this issue. They responded that:

'...in law, bodies are under the "control" of the coroner because this gives them the ability

to carry out their independent statutory functions without hindrance. A coroner should not use the word “property” in 2017 and the Chief Coroner would expect coroners and coroners’ officers to explain the functions and responsibilities of the coroner, along with any legal language, carefully to families.’

1.36 The Chief Coroner’s office also stated:

‘What precise physical facilities for viewing there are would depend a great deal on what is locally available. Coroners, who are judicial office holders, do not own or run their mortuaries; they are run by local authorities or hospitals and coroners tap in to and rely on those facilities.’

1.37 And that:

‘Whilst the Chief Coroner cannot comment on individual cases, there are always issues that need to be balanced about continuity of ID and preserving evidence. The coroner would need to take a view depending on the unique circumstances of each case and it isn’t possible for the Chief Coroner to say that in every type case in the future a family member would be able to physically touch the body of their loved one in the mortuary. What is key is that the Chief Coroner would expect coroners to provide as much information to families within as quick a timescale as possible in the circumstances, and to keep families informed of issues throughout.’

Police ethics, ethos and character

1.38 The second area in which I have considered whether lessons have been learned is police ethics, ethos and character. The experience of the Hillsborough families reveals rudeness, thoughtlessness and a lack of empathy on the part of police officers dealing with people who had been recently bereaved in tragic circumstances. The separate question of whether individual officers or police forces corporately may have committed criminal or disciplinary offences in the aftermath of Hillsborough is outside the scope of this report.

1.39 The stories families tell are punctuated by frequent acts of rudeness and thoughtlessness on the part of public officials, principally the police. I was told, for example, that there had been ‘no care or compassion for those who died.’ It was also striking that in my conversations with family members, these painful interactions were recalled in great detail and in many cases with evident ongoing distress.

1.40 The approach of the police officers involved in these interactions with family members touches on a number of issues: it touches on police ethics and ethos, but also on the character of those people employed and retained by individual police forces.

1.41 The issue of police ethics, ethos and character, and the question of public confidence in policing has been the major theme of police reform in recent years. It is right to say that many of the reforms which have taken place – in particular those which have been introduced since the Hillsborough Independent Panel’s report was published in 2012 – have been expressly driven by the experience of Hillsborough and its aftermath, and the impact it has had on public confidence in the police. Theresa May, when Home Secretary, spoke about Hillsborough in this context on a number of occasions, including at the 2016 Police Federation Conference, where she said:

‘Remember Hillsborough. Let it be a touchstone for everything you do. Never forget that those who died in that disaster or the 27 years of hurt endured by their families and loved ones. Let the hostility, the obfuscation and the attempts to blame the fans serve as a reminder of the need for change. Make sure your institutions, whose job it is to protect the

public, never again fail to put the public first. And put professionalism and integrity at the heart of every decision, every interaction, and every dealing with the public you have.'

1.42 This short section describes particular elements of recent reforms to policing and discusses their impact. Changes to police complaints and disciplinary procedures are discussed in chapter 4.

Code of Ethics

1.43 The College of Policing was created in 2012. Its role is to set professional standards for policing, to seek out best practice and ensure that officers adopt it. These professional standards include the policing Code of Ethics, developed in the aftermath of the Hillsborough Independent Panel's report and published in 2014.

1.44 The Code sets out the core principles and standards of professional behaviour which apply to everybody working in policing. The nine policing principles it sets out are accountability, integrity, openness, fairness, leadership, respect, honesty, objectivity and selflessness. As the foreword to the Code says, these principles should not simply be given lip service, but should be core to policing:

'These principles underpin and strengthen the existing procedures and regulations for ensuing standards of professional behaviour for both police officers and police staff...'

These principles should also underpin every decision and action across policing. They should be used, for example, in day-to-day operations as interventions are planned and debriefed, in the selection of new staff, in educational and development programmes, in annual reviews and in promotion. The principles must be more than words on a page and must become embedded in the way police professionals think and behave.'

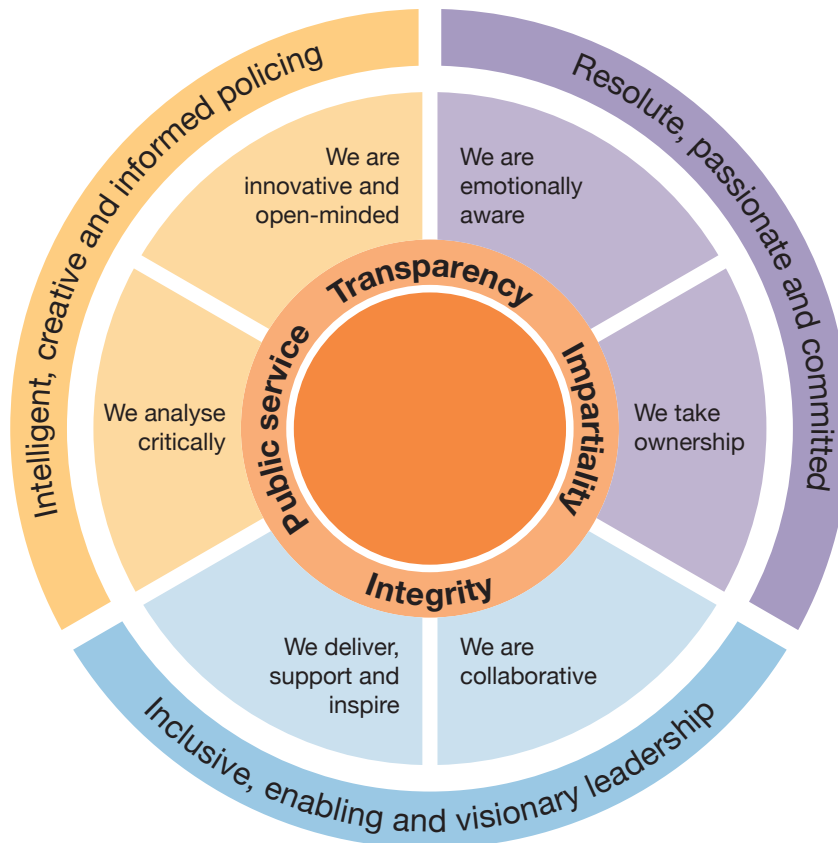
1.45 The Code of Ethics is a statutory code of practice to which every chief constable must have regard. The question of how well forces have adopted the Code is considered by Her Majesty's Inspectorate of Constabulary (HMIC). In HMIC's assessment of 2016, it found that:

'... while some disparities between force values and the Code remain, most forces have taken effective action to improve workforce understanding of the Code, including the importance of treating people with fairness and respect. Whilst there is further continuing work required to develop the Code and ensure it is central to every aspect of policing, these improvements demonstrate the important strides that have been taken to build public confidence through ethical policing and improved integrity.'

1.46 The College of Policing told me that it recognised that work remained to be done 'in embedding the Code and ensuring that it is consistently applied'. The College referred to a Leadership Review it had conducted, which recommended that the values articulated in the Code of Ethics should be embedded in all local and national selection and promotion processes. To support that, the College has developed what it calls the Competency and Values Framework. In its written submission, the College explained that:

'This framework will ensure that there are clear expectations of everyone working in policing which in turn will lead to standards being raised for the benefit and safety of the public... The framework has six competencies that are clustered into three groups... All of the competencies are underpinned by four values that should support everything we do as a police service.'

1.47 The framework is expressed in the following diagram:



1.48 Documentation published by the College of Policing summarises the ‘Resolute, compassionate and committed’ cluster of competencies as follows:

‘How we conduct ourselves in our service and the values that underpin our behaviour are a key part of our thought processes and relationships. Empathy means listening to the public, colleagues and partners, responding directly and quickly, and having a genuine interest in ourselves and others. We are always focused on doing our best for the public and our customers. By understanding our thoughts and the values behind our behaviour, we can maintain a professional and resolute stance, demonstrate accountability and stand by the police service’s established values to maintain the service’s professional legitimacy.’

Direct Entry

1.49 Direct recruitment at grades other than Constable (known as Direct Entry) also has the potential to contribute to public confidence in the ethics, ethos and character of the police. Direct Entry is now available nationally at Inspector and Superintendent levels, and the Metropolitan Police has announced its own plans to recruit a number of people directly as detectives. I welcome Direct Entry, which should bring new ideas and thinking into policing, impacting on culture and ethos as well as efficiency and effectiveness.

The media's treatment of bereaved families

1.50 The Hillsborough disaster occurred at a time of significant public anxiety about the behaviour of British newspapers. In April 1989, the same month in which the disaster occurred, the government established the Calcutt Committee on Privacy and Related Matters. As David Waddington, Home Secretary at the point at which the committee published its final report, put it, this was 'in response to widespread concern about invasions of privacy by the press'. The Calcutt Committee recommended the creation of a new non-statutory commission which would be responsible specifically for the adjudication of complaints. This new Press Complaints Commission replaced the old Press Council.

1.51 The Press Complaints Commission operated until 2014. It was closed down in the wake of the phone hacking scandal and the publication of Lord Justice Leveson's 'Inquiry into the Culture, Practices and Ethics of the Press'.

1.52 In the course of the Leveson Inquiry, evidence was given of a number of examples of intrusion into the lives of the bereaved, quite separate and more recent than the experience of Hillsborough families described in this chapter. As Lord Justice Leveson wrote in Volume 2 of his final report:

'Witnesses told the inquiry of occasions when journalists and press photographers intruded into moments of grief, shock and similar personal difficulty, in the face of clause 5 of the [then existing] Editors' Code and the wish of the witnesses to be left in peace.'

1.53 Following the publication of the Leveson report, two new voluntary regulatory bodies have been established to replace the Press Complaints Commission. They are the Independent Press Standards Organisation (IPSO) and the Independent Monitor for the Press (IMPRESS). Since October 2016, IMPRESS has been officially recognised under the Royal Charter on Self-Regulation of the Press, while IPSO has declined to apply for such recognition.

1.54 Both the IPSO Editor's Code of Practice and the draft IMPRESS Code include provisions which should on the face of it provide protection against the kind of experience faced by the Hillsborough families. An extract from the IPSO code, for example, reads as follows:

2. *Privacy

- i) Everyone is entitled to respect for his or her private and family life, home, health and correspondence, including digital communications.*
- ii) Editors will be expected to justify intrusions into any individual's private life without consent. Account will be taken of the complainant's own public disclosures of information.*
- iii) It is unacceptable to photograph individuals, without their consent, in public or private places where there is a reasonable expectation of privacy.*

3. *Harassment

- i) Journalists must not engage in intimidation, harassment or persistent pursuit.*
- ii) They must not persist in questioning, telephoning, pursuing or photographing individuals once asked to desist; nor remain on property when asked to leave and must not follow them. If requested, they must identify themselves and whom they represent.*
- iii) Editors must ensure these principles are observed by those working for them and take care not to use non-compliant material from other sources.*

4. *Intrusion into grief or shock*

In cases involving personal grief or shock, enquiries and approaches must be made with sympathy and discretion and publication handled sensitively. These provisions should not restrict the right to report legal proceedings.

[The provisions with an asterisk are subject to an exemption when breached in the public interest]

Points of learning

1.55 Points of learning that I believe can be drawn from the experiences described in this chapter are set out below. In addition, I set out here the detail of my proposed Charter for Families Bereaved through Public Tragedy – a charter inspired by the experience of the Hillsborough families and aimed at bringing about the cultural change needed to address what I describe earlier in this report as ‘the patronising disposition of unaccountable power’.

Point of learning 1 – Charter for Families Bereaved through Public Tragedy

The experience of the Hillsborough families of ‘the patronising disposition of unaccountable power’ calls for a substantial change in the culture of public bodies. To help bring about that cultural change, I propose a Charter for Families Bereaved through Public Tragedy – a charter inspired by the experience of the Hillsborough families and made up of a series of commitments to change – each related to transparency and acting in the public interest. I encourage leaders of all public bodies to make a commitment to cultural change by publicly signing up to the charter.

In signing up to the charter, leaders of public bodies should put in place a plan to deliver the particular changes needed within their organisation to make the behaviours described in charter a reality in practice. They should also make a commitment to review progress against that plan on a regular basis. When an organisation has signed up to the charter, it should declare this fact publicly.

I welcome the government’s commitment, made in the Conservative Party manifesto, to create an independent public advocate to act for bereaved families after a public disaster. Once a public advocate has been appointed, I offer the charter to them as a benchmark against which they may assess the way in which public bodies treat those bereaved by public tragedy. The text of the charter is as follows:

Charter for Families Bereaved through Public Tragedy

In adopting this charter I commit to ensuring that [this public body] learns the lessons of the Hillsborough disaster and its aftermath, so that the perspective of the bereaved families is not lost.

I commit to [this public body] becoming an organisation which strives to:

1. In the event of a public tragedy, activate its emergency plan and deploy its resources to rescue victims, to support the bereaved and to protect the vulnerable.
2. Place the public interest above our own reputation.
3. Approach forms of public scrutiny – including public inquiries and inquests – with candour, in an open, honest and transparent way, making full disclosure of relevant documents, material and facts. Our objective is to assist the search for the truth. We accept that we should learn from the findings of external scrutiny and from past mistakes.
4. Avoid seeking to defend the indefensible or to dismiss or disparage those who may have suffered where we have fallen short.
5. Ensure all members of staff treat members of the public and each other with mutual respect and with courtesy. Where we fall short, we should apologise straightforwardly and genuinely.
6. Recognise that we are accountable and open to challenge. We will ensure that processes are in place to allow the public to hold us to account for the work we do and for the way in which we do it. We do not knowingly mislead the public or the media.

1.56 In bringing together the other points of learning which flow from the Hillsborough families' experiences set out in this chapter I have used the same structure as within the chapter generally, addressing the issues raised in three categories: the aftermath of a major incident; police ethics, ethos and character; and the media's treatment of bereaved families.

The aftermath of a major incident

1.57 It is clear that practice in responding to disasters and major incidents has developed enormously since Hillsborough. The state of recruitment, training, planning and readiness in the police and other relevant agencies has progressed significantly, and the area has been greatly professionalised. Nevertheless, I have identified a number of points of learning to which I would draw attention.

Point of learning 2 – Reappraisal of the treatment of families following a major incident

The experience of the Hillsborough families as set out in chapter 1 identifies specific failures in the response to the disaster in 1989. The material in that chapter presents an opportunity for police forces, the College of Policing, coroners and the Chief Coroner to undertake an honest self-appraisal of their own policies, practice and state of readiness for responding to a major incident in the present day – in particular in respect of the treatment of families. The instinctive position of such organisations may be to say ‘It couldn’t happen now’, and it is true that practice has undoubtedly come a long way. But relevant organisations should use this report in order to engage in the critical self-reflection that can ensure that the perspective of the Hillsborough families is not lost. In particular, relevant organisations should ensure that the specific experience of families being asked to identify loved ones through the viewing of scores of unsorted photographs of those who have died is never repeated. In addition, the importance of treating families with respect cannot be overstated.

Point of learning 3 – Interviewing family members, especially minors, after public tragedy

The Hillsborough families’ experience demonstrates the need for the bereaved family and friends of those who have died to be questioned only as absolutely necessary in the immediate aftermath of a major incident. Minors should not be questioned in the absence of family or an appropriate adult. In presenting this point of learning, I accept that in some instances there may be an immediate need to conduct interviews with bereaved families – for example, to prevent further loss of life, or in cases where for other reasons it is operationally necessary.

In addition, regardless of the timing of such an interview, the experience of the Hillsborough families demonstrates that how family members are interviewed can make all the difference to that family’s experience. As this report shows, 28 years later, the way in which interviews of Hillsborough families were conducted has scarred many deeply.

The College of Policing should ensure that the training and guidance it provides to police officers properly reflects this point of learning and the experience of Hillsborough families expressed in this report.

Point of learning 4 – Support and counselling in the aftermath of a public tragedy

The families’ experience demonstrates the need for social work and other support to be made available at the earliest opportunity following a public disaster. That support should be capable of referring on bereaved families to relevant support in the area in which they live. I believe that this will be an important area of focus for the independent public advocate envisaged in the Conservative Party manifesto.

1.58 The next point of learning relates to the issue of families being told that their loved ones were the ‘Property of the coroner’. As the report sets out in depth, many families said that they were prevented from holding or touching the body of their loved one and described the pain that this had caused. Several were told that their relative was now the ‘Property of the coroner’. Jenni Hicks, mother of Sarah and Victoria Hicks, told me ‘Property of the coroner? No they’re not, they’re your children’.

1.59 It is clear from my research that these issues persist. Some bereaved families are still being told that their loved one is the ‘Property of the coroner’ and some families are being prevented from seeing, touching and holding their loved one’s body. I agree with the charity INQUEST, who wrote in their submission to this report that:

‘Many families have been told that they cannot view the body or can only view it from behind a screen... [T]he needs of the family should be the primary concern at this critical point. Being able to say farewell in dignity is crucial to the grieving process. For a bereaved person to face obstruction and a disregard for their emotional needs at a time when feelings will be very raw undermines dignity and respect and sets the tone for the way the family will feel within the coronial system. For many it can also raise suspicions about the circumstances of death.’

Point of learning 5 – ‘Property of the coroner’

It has been submitted to me that the issue of family members being told that their loved one is the ‘property of the coroner’ and being prevented from seeing, touching and holding their body in part arises from a lack of clarity in law as to the rights of bereaved families. The Ministry of Justice should consider whether the law in this area is sufficiently clear and, if not, bring forward proposals in order to clarify it. In addition, the College of Policing and Chief Coroner should work together to develop clear guidance setting out the rights of bereaved families in terms of access to their loved one’s body, along with best practice on how best to give effect to those rights. Organisations who assist the bereaved, such as INQUEST, police forces, social services departments and counselling organisations should be involved in the development of such guidance.

The guidance should make it is clear that the suggestion that the body of someone who has died is the ‘property of the coroner’ is wrong and that use of the term should be eliminated. The guidance should also emphasise the importance of families having physical access to the body of their loved one rather than being restricted to viewing through a glass window. The guidance should also include information on the arrangements which can be made to ensure that forensic evidence is not compromised and how best to properly and sensitively explain this to families.

Police ethics, ethos and character

1.60 The experience of the Hillsborough families reveals rudeness, thoughtlessness and a lack of compassion on the part of police officers and others dealing with people who had been recently bereaved in tragic circumstances. The separate question of whether individual officers, police forces corporately, or others may have committed criminal offences in the aftermath of Hillsborough is outside the scope of this report.

1.61 I recognise the focus placed in recent years on the subject of police ethics. I recognise too the role that Hillsborough, and in particular the report of the Hillsborough Independent Panel played in bringing that focus to bear. The College of Policing, Her Majesty's Inspectorate of Policing, the National Police Chiefs Council and police forces themselves all have important roles to play in making ethics, ethos and character key to the future of policing. Based on what I have seen in the course of producing this report, the signs are encouraging that those with key positions in policing want to bring about this change and are working in order to do so.

Point of learning 6 – Hillsborough, the 'touchstone'

On police ethics and ethos, I would echo the words of Theresa May, who as Home Secretary told the 2016 Police Federation Conference to:

'Remember Hillsborough. Let it be a touchstone for everything you do. Never forget that those who died in that disaster or the 27 years of hurt endured by their families and loved ones. Let the hostility, the obfuscation and the attempts to blame the fans serve as a reminder of the need for change. Make sure your institutions, whose job it is to protect the public, never again fail to put the public first. And put professionalism and integrity at the heart of every decision, every interaction, and every dealing with the public you have.'

I support the police Code of Ethics and its continuing development, as well as the ongoing work to embed it within all aspects of policing. The Code must not be treated as box that has been ticked – it instead requires an ongoing commitment to cultural change.

As a further point of learning, building on the then Home Secretary's 2016 speech and the work already undertaken by the College of Policing and others, I believe that the Hillsborough families' experiences demonstrate that empathy and integrity should be considered as central to both recruitment and professional development.

The media's treatment of bereaved families

Point of learning 7 – Media ethics and training

Bereaved families told me that they felt degraded by much of the press coverage of the Hillsborough disaster, as well as harassed by individual journalists and press photographers. Both of these aspects of the media's behaviour undoubtedly caused great distress.

One family member described their feelings succinctly in the following way:

'We felt we were treated like scum.'

Brenda Fox, mother of Steven Fox

Both the Independent Press Standards Organisation (IPSO) and the Independent Monitor for the Press (IMPRESS) have developed codes of practice which – if they were adhered to – should prevent other families from suffering the harassment and invasions of privacy faced by the bereaved Hillsborough families in 1989. However, more needs to be done to ensure that this happens.

I believe that there is an important role here for the independent public advocate envisaged in the Conservative Party manifesto, and that the advocate should engage with IPSO, IMPRESS, media organisations and bereaved families to determine what further steps should be taken to ensure that those bereaved by public tragedy are treated with dignity and respect by the media. In particular, I agree with Alastair Machray, editor of the Liverpool Echo, who made the following point in his written submission to this report. He wrote:

'...within my industry, as far as I am aware, no one trains journalists in specific techniques for interviewing trauma victims. This would appear to be an oversight. Both victims and journalists alike may be better served if journalists have training of this nature...'

Point of learning 8 – False public narratives

As a further point of learning, the experience described in chapter 1 of this report should also act as a reminder to those organisations and individuals called upon to make public comments in the immediate aftermath of serious incidents that the public narrative, once established, is difficult to change. A false public narrative is an injustice in itself, and organisations and individuals should take great care in making public comments before the facts are known.

Chapter 2 – Inquests

'[At the first inquest] they actually read out the names of everybody and the amount of alcohol. They read our 14 year old son's name out and then said "nil". I was horrified. They had his height and weight wrong... They hadn't taken much care. But surely you would take care to take measurements etcetera? It was very hurtful.'

Edna Murray, mother of Paul Murray

'The first inquest was dehumanising. The deceased were numbers not names. That dehumanisation impacted on my mental and physical health.'

Becky Shah, daughter of Inger Shah

'Police interests were well represented but the families – 43 of them – were represented by only one barrister, which we had to fund ourselves.'

A family member

'For the first inquests, some families paid for one member of Counsel. We could not be included in this, so my brother was not represented. I, along with my partner, attended the inquest independently on a few occasions but felt really excluded as when the families went into a private room with the barrister, we were not privy to these conversations as we were not a paying client. We had no input into the first inquests whatsoever.'

Debbie Matthews, sister of Brian Matthews

'We have always been led to believe that Paul was being helped in the pen by [a witness] which gave me and my family great comfort knowing there was somebody with my son and he wasn't alone and scared.'

[At the recent inquests this was shown to be not the case.] 'That destroyed me.'

Sandra Stringer, mother of Paul Carlile. Sandra Stringer died shortly after writing the letter from which this quote is drawn

'Mortuary photographs were included as part of my witness bundle at the recent inquests. I couldn't understand why they were there. We raised it with the solicitor to the inquests and I was told that they should not have been there. Seeing those photographs affected me deeply.'

Dave Golding, nephew of Arthur Horrocks

'After the [fresh] inquests I was at an all-time low. It made me look at things I thought I had dealt with.'

'If people thought that families would be coming home celebrating that was not the case.'

Jenni Hicks, mother of Sarah and Victoria Hicks

'I would love to be able to take the pathology section away. It took me back to that awful place. The anger and the hatred. It was just like losing James again.'

'Grief is just beginning as we have been fighting to get to the truth.'

Margaret Aspinall, mother of James Aspinall

'I found all of my own witnesses who tried to save Andy. I did the majority of the work for Op Resolve and the IPCC.'

'Because the Inquests were being held in Warrington, I lived out of a hotel for 25 months which caused greater anxiety and stress to me as I was away from home five days per week. I would like people to start considering us families who don't live in Liverpool, when they choose locations and take into consideration the miles we have to travel to attend meetings and court. To put police witnesses in the same hotel as us bereaved families who were staying at the Penta hotel during the inquests was absolutely disgraceful!'

Louise Brookes, sister of Andrew Mark Brookes

'Two police officers... both stated that they handled Graham. Their statements conflict with each other and neither accurately described Graham or the clothing he was wearing. [One of the officers] stated that when he left Graham he was still breathing and when he came back moments later he was dead. If Graham was breathing then surely, with the right care he could have been saved? I'll never know if this was Graham but it was one of the deceased. I truly believe this person could have been saved.'

[Following evidence given at the fresh inquests] The information about Graham is now even more confusing than it was 26 years ago.... The initial statements we received tortured my parents and I, and I can get no comfort from the further statements and answers given during cross-examinations that went on last year.'

Sue Roberts, sister of Graham Roberts

'Instead of learning my dad's truth I have been left with the devastation that my father died needlessly. Simple, basic first aid and hospital treatment would have saved his life and now my three sons and I will forever live with that torment. That is unforgivable and no amount of justice will ever make that better.'

I only hope my father can rest in peace knowing that I did everything that I possibly could to be his voice and make sure his truth was heard.'

Charlotte Hennessy, daughter of James Hennessy

'My engagement with the justice system, especially the initial inquest, was disgraceful. I had no legal representation whatsoever, other than a Mr King (barrister) who I had never met or spoken with until I was literally in the dock to submit my evidence. Through this process I felt as I had committed a crime and I began to question myself. The coroner, Mr Popper, was very condescending, unsympathetic and disrespectful of my evidence.'

Looking back, the Criminal Justice System and all it was held up to be, was denied to the Hillsborough families and survivors. It took 24-25 years to gain access to proper legal representation, while the advantaged completely wallowed in it during such time, absolutely disgraceful and very dejecting.'

Gerard Baron Jnr, son of Gerard Baron

'I think the second inquest was wholly different from the initial one because the odds were stacked against us at the first inquest. The police officers had a whole team of solicitors, whereas we only had one.'

Paul Joynes, brother of Nicholas Joynes

'Funding and equality of arms is the single most important consideration expressed by families in ensuring a just and fair outcome after decades of a gross inequality as between them as families and victims of state and institutional failings. [At the first inquests] the police, ambulance service, other bodies were at liberty to deploy resources, representation and advice. The recent inquests demonstrated this in stark contrast to what had gone before, and confirmed a direct link between meaningful access to justice, and outcome.'

Written submission by Marcia Willis Stewart of Birnberg Pierce, solicitors to families who are members of the Hillsborough Family Support Group

'The [new] inquests started with the family background statements which became known as pen portraits. It was an incredibly difficult process for us but was so important and an excellent idea. Instead of our son being Number 17 we were able to tell the jury about his life. For the first time our son was dealt with as a person rather than just a number.'

Barry and Jac Devonside, parents of Christopher Devonside

I feel it is of the utmost importance to highlight that even in 1998 – when White v Chief Constable of South Yorkshire was brought to court – it was noted that we, the bereaved, were denied redress where police officers received it, although it was noted that we were more deserving of it, yet we actually received nothing, and we have still received nothing nearly three decades on. This imparity has occurred from 15 April 1989 right through to today and it is only right that it should not be forgotten, that nine years after the event which took our loved ones the courts could see that we were at a disadvantage to police officers, and we were being denied justice, yet it took a further 18 years for us to receive “a full and proper inquest”, but even now our fight is not over.'

Deanna Matthews, niece of Brian Matthews

The original inquests: 1990/1991

2.1 There have been two sets of coroner's inquests into the deaths caused by the disaster at Hillsborough. The original inquests took place between April 1990 and March 1991, reaching a verdict of 'accidental death'. In December 2012, following publication of the Hillsborough Independent Panel's report, the then Attorney General Dominic Grieve QC successfully applied for the original inquests to be quashed and fresh inquests to take place. Those new inquests – the longest inquest as well as the longest jury proceedings in British legal history – took place between March 2014 and April 2016. They reached a conclusion of 'Unlawful Killing'.

2.2 Bereaved families spoke movingly about both sets of inquests and drew comparisons between the two. In respect of the original inquests, the following strong themes emerged:

Pathology

2.3 The decision by the High Court in December 2012 to quash the original inquests and order new proceedings rested heavily on the Hillsborough Independent Panel's findings in respect of pathology evidence. It had been a critical aspect of the original inquests – based on the evidence of pathologists – that those who died had all suffered the injuries which caused their deaths before 3.15 pm. In other words, by that time their deaths were inevitable. On the basis of the pathology evidence, the coroner ruled that no evidence relating to events beyond 3.15 pm on the day of the disaster would be heard. That was the time when the first ambulance arrived on the pitch. This meant there was no investigation into whether any of those who died might have survived if the rescue effort had been better, and no investigation into whether any actions or omissions of the rescue process might have contributed to the death of those who might have survived.

2.4 The Hillsborough Independent Panel's scrutiny of the relevant documentation led it to conclude that the pathology evidence presented at the original inquests was flawed, and that for some people it was 'highly likely that what happened... after 3.15 pm was significant' in determining whether they survived. 'On the basis of this disclosed evidence,' wrote the Panel, 'it cannot be concluded that life or death was inevitably determined by events prior to 3.15 pm, or that no new fatal event could have occurred after that time'. The High Court accepted the Panel's findings in respect of the pathology evidence, recognised the subsequent failures of the original inquests, and ordered new proceedings.

2.5 In the course of producing this report, family members told me that at the first inquests they felt they lacked basic information about pathology, and felt unable to challenge the system. This arose in various different ways, with serious consequences – in some cases families believe it has prevented them from ever being able to find out the truth about whether their loved one could be saved. For example, I was told:

'At no stage was there any mention of the fact that families had the right to be present at the post mortem – either personally or to have their own doctor attend on their behalf. That right should have been communicated to the families when they had to identify their loved one... Had we had our own doctor present they might have queried why the blood sample needed to be taken. They might also have suggested that a sample be taken from the brain. Chris' brain weight suggested there might have been prolonged survival. Had a sample been taken it could have either confirmed or refuted that suggestion. Brain weight and its potential significance (prolonged survival) was never discussed at the original inquest. Now we are simply left wondering whether Chris was alive for far longer than we were previously told and whether there was an opportunity to save him.'

Barry Devonside, father of Christopher Devonside

'My father's initial "autopsy" report was scant, no explanation whatsoever, just two pieces of paper, mailed, stating "Traumatic Asphyxia" along with two other contributory factors to his death. This I refused to accept – a butcher would have been more sympathetic and precise.'

Gerard Baron Jnr, son of Gerard Baron

2.6 In a group discussion, families described the impact of these pathology failures. For example, I was told:

'23 years believing that this was the way it was [i.e. that the original pathology report was correct] has left me with severe depression and severe psychological issues. It was a lie on that original pathology report – he could have lived.'

Charlotte Hennessy, daughter of James Hennessy

2.7 Professor Jack Crane, the Acting State Pathologist for Northern Ireland, who advised the Attorney General in 2012 in respect of his application to have the original inquest verdicts quashed and subsequently was the senior pathologist instructed by the coroner to review the autopsy reports in respect of the 96 fatalities, provided me with his personal view of the pathology at the original inquests. He wrote that:

'It is not difficult to be critical when conducting a retrospective review on an incident which occurred over 25 years ago. That is not to say however that things could not have been done differently and perhaps better even in 1989. This in no way implies criticism of any of the individual pathologists involved in conducting the autopsies and giving evidence at the original inquests. Those of us who conducted the review on behalf of the coroner are satisfied that the original pathologists acted with absolute integrity and with a desire to complete the autopsies as quickly as possible to facilitate the early release of bodies back to the families. Also it is not clear from the available evidence as to what instructions were received from the coroner in respect to the conduct of the post-mortem examinations and it may be that these instructions were either inadequate or incomplete. There is also incontrovertible evidence to show that all the pathologists at the time of the original inquests were prepared to meet and discuss the post-mortem findings with the next of kin. It is perhaps unfortunate however that in the 1980s medical practitioners, pathologists included, tended to adopt a more "paternalistic" attitude with patients and relatives if only to spare them anguish and grief. There was often a desire to spare relatives any distress by stating that death occurred rapidly or instantaneously when other evidence might have indicated the contrary. I think it is fair to say that all of us were guilty of this in the past although it was done without any malice and usually with the best of intentions.'

2.8 He also told me that:

'Whilst it is obviously desirable to conduct the autopsies in a mass disaster incident as expeditiously as possible, there is clearly a requirement for such examinations to be conducted thoroughly and appropriately and by pathologists experienced in dealing with unnatural deaths and in presenting evidence in court. It is our view that the decision to use several non-forensic pathologists to conduct some of the post-mortem examinations was flawed. It became apparent to us that the reports from the non-forensic pathologists were not as detailed as those from their forensic colleagues and this posed some difficulties in determining the precise cause of death in some cases. Also, we found that in some cases the brain descriptions indicated apparent survival of victims for periods of up to several hours when, from the other evidence available, this was clearly not the case.'

2.9 He added that:

‘It is my personal view that the senior forensic pathologist was trying to demonstrate the efficiency of the post-mortem facilities at the new Medico Legal Centre and his focus was primarily to get the post-mortem examinations conducted as quickly as possible. This was, in my opinion, inappropriate and unnecessary. As one relative at the new inquest put it to me – “we want the right answer, not the quick answer”.’

2.10 In her contribution to this report Maria Eagle MP drew attention to the impact that failures of pathology at the first inquests had on many of the families. She wrote:

‘Anne Williams (and many other family members) had to simply go out and find out herself what had happened to her son, what his movements had been, how and when he had died, who had been with him. She did so. Many families were unable to make the progress that she did in this quest and that left them in pain. However, it always struck me at these times – that is what the inquest should have told them.’

Lack of public funding and ‘inequality of arms’

2.11 Families received no public funding for representation at the first inquests. Publicly funded representation was however provided jointly to South Yorkshire Metropolitan Ambulance Service and Trent Regional Health Authority, as well as to Sheffield City Council. Senior South Yorkshire Police officers were represented by five separate legal teams.

2.12 Representation for the families stood in stark contrast. No public money was provided for the families’ legal expenses, and so what representation they had was self-funded. At the ‘mini-inquests’, a single solicitor represented the interests of over 90 families. At the ‘generic inquest’, one barrister represented 43 families, one family was represented by the mother of the person who had died and the remaining families had no representation at all.

2.13 As a result, families told me that they felt underrepresented and lacked access to necessary advice. Public bodies, however, appeared to spare no expense on their own legal advice and representation. Many families shared the view that ‘You can’t have families footing the cost of their legal representation while the taxpayer funds the police’. Margaret Aspinall, mother of James Aspinall, told me:

‘When James died I had no idea that we had to pay for an inquest. The biggest insult was that I was offered around £1200 compensation for the death of my son. Unfortunately I had no choice but to accept it, to put towards the costs of the generic inquests. To me that was the biggest and most painful insult, I felt very guilty having to accept it to represent my son and I don’t want any other families to have to go through that again.’

2.14 It was suggested to me that had proper, publicly-funded representation been made available to the families at the first inquests then the fresh inquests – and the intervening 25 years of distress – may have been avoided. As Barry Devonside, father of Christopher Devonside, put it:

‘The lack of legal representation led to a mini disaster.’

2.15 Similarly, Marcia Willis-Stewart of Birnberg Peirce, who at the inquest represented families who were members of the Hillsborough Family Support Group (HFSG), argued that ‘none of the flaws in the original pathology evidence were exposed in the first inquests’, and that ‘because of a lack of resources, the original pathology evidence was never properly questioned let alone probed at the time and the families’ justified suspicions about the pathology evidence were never allayed at the first inquests.’ Given the weight later placed on the flawed pathology evidence by the High Court, this is an important point.

2.16 The issue of public funding of legal representation for the bereaved is discussed further below.

Alcohol testing

2.17 Many families told me that at the original inquests South Yorkshire Police sought to blame fan behaviour, including drunkenness, for the disaster at Hillsborough. At the fresh inquests, this narrative was emphatically rejected by the jury who, when asked ‘Was there any behaviour on the part of football supporters which caused or contributed to the dangerous situation at the Leppings Lane turnstiles?’ answered unanimously ‘No’. Allegations on this point formed part of the recent criminal investigations, and this report is careful to include nothing which could prejudice the outcome of those investigations. But I do consider it important to place on record the distress that the testing of the deceased for blood alcohol – including those who were children – and the subsequent publication of the test results had on the families I listened to.

2.18 For example, Anne Burkett, mother of Peter Burkett, told me that there was:

‘...no care or compassion for those who died. The dead were degraded by the police and media. Testing for blood alcohol was one example of this including for children. They were treated as though they didn’t matter’.

2.19 Edna Murray, mother of Paul Murray, described her experience as follows:

‘They actually read out the names of everybody and the amount of alcohol. They read our 14 year old son’s name out and then said “nil”. I was horrified.’

2.20 Dorothy Griffiths, sister of Vincent Fitzsimmons, told me that:

‘I had opened the newspaper only to find that they had printed the blood results from all the victims showing the alcohol levels. I was having a lunch break at the time and just sat with tears streaming down my face seeing Vincent’s name and nil alcohol next to it. They had even included the details of the children who died. I was incensed and felt so angry that these details were published – it was almost as if we were sub-human in some way.’

Other aspects of the first inquest

2.21 In my discussions with bereaved families, I have also heard of criticism other particular aspects of the original inquests, including the following.

2.22 Families said that the structure and pace of the inquests failed them. The inquests were split into two sections. ‘Mini-inquests’ took place first. These focused on what were considered by the coroner to be the uncontroversial aspects of each death, such as who the deceased were, where they had died and the individual pathology evidence. The ‘generic inquest’, which followed, focused on the causes of the disaster.

2.23 ‘Mini-inquests’ were short, with several taking place on each day. Instead of the inquests hearing directly from witnesses, summaries of evidence were instead presented by officers from West Midlands Police, with no advance disclosure to the family. Families said that they felt proceedings were too curtailed, with no opportunity to ask questions of witnesses and too little focus on the individuals who had died. For example, I was told:

‘It’s as though they thought to get it out of the way quickly and then be forgotten. We were not given a chance to sit back and think logically about it. The mini inquests were just unbearable. All the coroner said was that it was about who, where, how and when they died and there are to be no controversial issues brought up, and if there are, I will close them down so that you can get on with mourning your loved one. At the end of the day it was used against us because we did not challenge anything at the inquests.’

Edna Murray, mother of Paul Murray

‘We went in not knowing much about Chris’ movements. I don’t recall seeing any statements beforehand. We didn’t have any advance disclosure so our legal team had their hands cuffed behind their back and that makes the whole thing a farce. We didn’t know which witnesses would be called to give evidence.’

Barry Devonside, father of Christopher Devonside

‘I felt the families were conned. We were told that our questions would be answered at the “generic” inquest, but they weren’t.’

Trevor Hicks, father of Sarah and Victoria Hicks

‘The first inquest was dehumanising. The deceased were numbers not names. That dehumanisation impacted on my mental and physical health.’

Becky Shah, daughter of Inger Shah

‘Dr Popper said to my nephew’s step-father, “I don’t know why you are upset he wasn’t even your son”.’

Danny Gordon, uncle of Kevin Williams

‘The first inquests rubbished and dismissed the families.’

Margie Matthews, wife of Brian Matthews

‘What is the coroner’s point in not involving the families? You can’t touch them, you can’t kiss them. There’s no excuse.’

Brenda Fox, mother of Steven Fox

‘The coroner had his own agenda. A law unto himself.’

Doreen Jones, mother of Richard Jones

2.24 Maria Eagle MP also commented on this aspect of the first inquests in her submission to this report. She wrote:

'Many years thereafter, I can recall at family meetings and meetings with my constituents affected by Hillsborough much informal discussion about a new piece of evidence, fact or witness that someone had found that might give a further clue to what had been the movements of one of the 96. I was struck by how catastrophically the supposed purpose of inquests had not been fulfilled in this case.'

'Families were still trying to find out what had happened to their lost loved ones. Some families only found out what really happened to their loved ones at the second inquests which established that they were unlawfully killed and which provided as much information as possible about the movements of each of the 96 on that day.'

2.25 Several families raised concerns about a lack of accountability in the inquest system. There is no right of appeal, with routes of redress limited to judicial review or an application to the High Court for an inquest to be quashed. Paul Robinson, brother of Steven Robinson, said 'The coroner was not accountable to anyone. He was able to pick the witnesses and was able to omit vital video evidence without any effective challenge – the families had no say'. Other families expressed concern that the coroner and the police were too close. For example:

'A coroner who is in a close relationship with the police shows that there is no independence and a bias in favour of the police. I don't think any coroner should be staffed by police. It completely undermines the appearance of independence and any confidence the families may have in the process. This is particularly the case where the police (even if from another force) are a party to the proceedings. I also think that a coroner from outside the area who has no links with the force being investigated should be used.'

'At the end of Dr Popper's Inquest I witnessed something that proved my opinion that Dr Popper was too close to the police. After the verdicts were delivered everyone left the courtroom but I stayed behind for a little while. As I left the Council Chamber I saw Dr Popper's office. The door was open and I could see police officers inside laughing. I then saw two further police officers emerge either from a lift or stairs. They were carrying crates of wine and beer and they took it into the office. They were having a celebration. Dr Popper was in there with the police. An officer saw me and slammed the door in my face.'

Barry Devonside, father of Christopher Devonside

'Coroner's officers are too close to the police.'

A family member

Challenges to the first inquests

2.26 A number of legal challenges to the first inquests were made between 1992 and 2005. Each failed. They included a judicial review on behalf of six families, as well as three applications to the Attorney General for a new inquest made by Anne Williams for her son Kevin. Having campaigned tirelessly over many years, Anne Williams sadly died in 2013 – after the High Court decision to hold new inquests, but before the new proceedings had begun.

2.27 Each of the challenges to the original inquests contested the pathology evidence at the original proceedings and the coroner's decision to impose the '3.15 cut off'. Although the Hillsborough Independent Panel's 2012 report, the 35,000 documents disclosed by the Panel, and in particular the Panel report's analysis of each of the original post-mortem records undeniably added to the evidence available to the Attorney General and High Court, it was a matter of concern to some of those who contributed to this report that the legal system did not recognise and correct the failings of the first inquests sooner. Doreen Jones, mother of Richard Jones, spoke about the judicial review of the first inquests in particular:

'I felt that the process was a complete whitewash. They hadn't really looked at anything, it was just a case of rubber stamping the lower court decision.'

2.28 Dr Nathaniel Cary, lead pathologist instructed on behalf of the Hillsborough families at the fresh inquests, also provided me with his perspective. He wrote:

'From my own personal point of view it is very sad that Anne Williams, the mother of Kevin Williams, died before the fresh Inquests. My association with her goes back as far as 2002. Indeed my report on her behalf back in 2002 was one of the documents considered by the Hillsborough Independent Panel. Prior to then she had been assisted by two eminent pathologists, Dr Jim Burns and Dr Iain West, my predecessor. Given the concerns raised by all three of us it is deeply disappointing that it took so long for there to be any prospect of fresh Inquests... It is apparent from the unlawful killing verdicts of the fresh inquests that the previous views of attorney generals and others in rejecting grounds for fresh Inquests were wrong and against natural justice.'

2.29 Maria Eagle MP also commented on the families' legal challenges in her written submission:

'Most of the legal actions undertaken by the families made things worse and sent the families backwards in their search for truth, accountability for those responsible and justice for their loved ones. This happened so completely that the families' experience was that the system was not in fact about justice but about protecting the state actors – the police who were responsible for what happened – from facing that responsibility. Families understandably became pretty cynical and distrustful of the justice system and the political system.'

The fresh inquests: March 2014 to April 2016

2.30 Following a series of pre-inquest hearings, the fresh Hillsborough inquests ran from March 2014 to April 2016 – becoming the longest in British legal history. As a result of a decision made by the then Home Secretary Theresa May MP, legal representation for the families was funded by the government, along with funding for travel and subsistence. Funding was not subject to means testing and was provided for the full period from before the quashing of the original inquests by the High Court in December 2012 through to the months following the conclusion of the fresh inquests in April 2016.

2.31 In discussions held in support of this report, families universally welcomed the granting of the fresh inquests, the funding of legal representation, as well as specific aspects of the way in which the inquests themselves were run – in particular the use of ‘pen portraits’ which enabled families to speak about their loved ones. Families also described elements of the inquests that they found distressing, and spoke movingly about the impact of the new inquests on their personal grieving process. There were a range of views and experiences on this point, including:

‘The second inquest gave me my children back.’

Jenni Hicks, mother of Sarah and Victoria Hicks

‘Grief is just beginning as we have been fighting to get to the truth.’

Margaret Aspinall, mother of James Aspinall

2.32 Positive and negative aspects of the families’ experience of the fresh inquests are discussed in more depth below.

Funding for legal representation / equality of arms

2.33 The provision of funding was widely welcomed by the families, who described the difference it had made to their experience of the fresh inquests – and their outcome. For example, Barry Devonside, father of Christopher Devonside, expressed the view that:

‘If the families’ current legal teams had not been funded the families would not be where they are now.’

2.34 Similarly, Marcia Willis-Stewart of Birnberg Peirce Ltd, who at the fresh inquests represented families who were members of the Hillsborough Family Support Group (HFSG), wrote that:

‘Funding and equality of arms is the single most important consideration expressed by families in ensuring a just and fair outcome after decades of a gross inequality as between them as families and victims of state and institutional failings. The police, ambulance service and other bodies were at liberty to deploy resources, representation and advice. The recent inquests demonstrated this in stark contrast to what had gone before, and confirmed a direct link between meaningful access to justice, and outcome.’

2.35 The government funding scheme for representation at the fresh inquests included provision for medical expertise to allow the families to fully explore the available pathology evidence. A document produced for this report by Marcia Willis-Stewart, along with Nicholas Brown and Paula Sparks, barristers instructed by Birnberg Pierce Ltd, analysed the impact of this aspect of the funding scheme, arguing that:

‘...it is only because the families did have proper funding and were therefore able to obtain their own expert medical evidence that a satisfactory resolution of the medical issues was achieved at the new inquests.’

2.36 Pete Weatherby QC and Elkan Abahamson, who also represented a number of families at the fresh inquests, gave a similarly strong account of the impact of publicly funded legal representation. They wrote:

'Had the families been properly supported from the outset this massive miscarriage of justice may well have been avoided.'

2.37 David Conn, a Guardian journalist who has written extensively about Hillsborough over a number of years, argued similarly that:

'[I] would observe from my own reporting of the inquests, that without the lawyers the families were able to instruct due to the Home Office funding, their case could have been lost again. Such was the aggression with which the police case was fought; the families' lawyers had to be, and were, forensic in every detail. It was a highly adversarial battle.'

2.38 Margaret Aspinall, mother of James Aspinall, linked her support for funding for families' legal representation to her support for the 'Hillsborough Law', discussed later in this report, which proposes funding for families at inquests along with other measures. She told us that she was a:

'...great believer in what Andy Burnham was saying and there needs to be a level playing field. That's why I fully back the proposals for the Hillsborough Law.'

Pen portraits

2.39 Many families raised with me the use of 'pen portraits' at the fresh inquests. At the suggestion of family legal representatives, the coroner gave every family the opportunity to submit a statement to the inquest about their loved one. These 'pen portraits' were deeply personal and moving. Families told me that the pen portraits humanised the inquests:

'I believe these introductions of our loved ones to the court were invaluable to all. They are... a brilliant way of engaging with the jury and others when shows of any emotion are apparently not tolerated.'

Veronica Rogers, mother of Henry Rogers

'The "pen portraits" was the birth of something extraordinary in public inquests. The 96 had just been a number. They were human beings that had lives and families. To be able to portray my father to the jury and court as the beautiful human being he was, is something that I will never forget, the jury were able to build a picture.'

Gerard Baron Jnr, son of Gerard Baron

'The only positive from the whole process was that the 96 became more than a number and we learnt about these wonderful individuals, who were loved by their families so deeply.'

Charlotte Hennessy, daughter of James Hennessy

'The inquests started with the family background statements which became known as pen portraits. It was an incredibly difficult process for us but was so important and an excellent idea. Instead of our son being Number 17 we were able to tell the jury about his life. For the first time our son was dealt with as a person rather than just a number.'

Barry and Jac Devonside, parents of Christopher Devonside

“Pen portraits”. The use of proper evidence to show who the deceased was, is essential in humanising the proceedings. The deceased should not become a number or a mere name.’

Submission by Pete Weatherby QC and Elkan Abrahamson, who represented 22 families at the fresh inquests

2.40 The pen portraits were published as part of the full inquest record held at hillsboroughinquests.independent.gov.uk as well as on the BBC News website.

Human Rights Act and disclosure

2.41 The remit of a coroner’s inquest is to determine the factual answers to who, when, where and how a person died. As a consequence of the Human Rights Act 1998, in inquests relating to cases where the state may have played a part in the death of a person the question of ‘how’ is interpreted as meaning not only by what means did that person meet their death, but also in what circumstances did they die. This broadens the scope of an inquest in these cases – a significant departure from the prevailing situation in 1989.

2.42 Rules and practice on the disclosure of material to families in advance of inquests also changed significantly between the first and second set of Hillsborough inquests. At the first inquests, there was no advance disclosure, with families instead being provided with summaries of relevant evidence on the day of the ‘mini-inquest’ relating to their loved one. At the fresh inquests, rules of disclosure entitled the families’ legal representatives to any document held by the coroner, save in particular circumstances. In addition, the 35,000 documents published online by the Hillsborough Independent Panel in 2012 aided the families and their legal representatives in their preparation. I was told:

‘[The new inquests] were so different to the previous inquests mostly because of the Human Rights Act and the fact that we had advance disclosure. That meant that everyone was on an even playing field. The families hadn’t experienced that before.’

Barry and Jac Devonside, parents of Christopher Devonside

Criticism of the fresh inquests

2.43 Families described the new inquest proceedings, which lasted a total of 25 months, as both gruelling and painful:

‘If people thought that families would be coming home celebrating that was not the case.’

Jenni Hicks, mother of Sarah and Victoria Hicks

‘The original estimate for the length of the inquest was 6-9 months. This was always going to be unrealistic and should have been addressed far earlier. Giving the families and the jury such a short estimate was unfair.’

Barry and Jac Devonside, parents of Christopher Devonside

‘The pathology carried out on James was not to the same standard as in other cases. This was such an important part of the inquest that we had the right for this to be carried out properly. I think there needs to be some guidance or rules to ensure that the same standards for pathology are applied in all cases.’

'When I was asked by media how I felt after the verdict I told them I was angry and at the same time it was sweet. They asked why I was angry, and my response was how could it take 27 years to get the correct verdict when all the evidence was there from day one? To put us through all those years of torture.'

Margaret Aspinall, mother of James Aspinall

'...[the inquest process caused an] extraordinary amount of distress and extended pressure...'

Julie Fallon, sister of Colin Sefton

'After the [fresh] inquests I was at an all-time low. It made me look at things I thought I had dealt with.'

Jenni Hicks, mother of Sarah and Victoria Hicks

'A process that was going to be difficult enough for family members was made even more difficult by the "rules" set by the coroner. For two years we were constantly told that we were not allowed to show emotion. That was one of the most difficult parts. For years we had been ignored, the only way I can describe the feeling of knowing your dad was neglected and denied the right to medical help is like standing in a room full of people and screaming at the top of your lungs, yet not one person acknowledges your cries.'

Now we were here in a court room, finally allowed to speak about our loved ones as individuals and amazing human beings that they were and then within weeks and months were being told that we had to leave the court room if we felt anger and if we couldn't control our crying.'

Charlotte Hennessy, daughter of James Hennessy

'... some individuals remain significantly traumatized and haunted by grief, anger and guilt following the 27 years since the disaster. Without exception they found the inquest process gruelling and a sense that it opened up old wounds which had never been allowed to heal. Having to visit the events of the past in such close detail was deeply painful, while at the same time a chance to rectify the lies of the past, and finally achieve justice, helped to lay to rest some agonies.'

Marcia Willis-Stewart of Birnberg Peirce, who at the inquest represented families who were members of the Hillsborough Family Support Group

2.44 Beyond the duration of proceedings and the inherently painful nature of an inquest, the main criticism from families about the new inquests related to the conduct of some of the inquests' 'Interested Persons', and in particular South Yorkshire Police. Following publication of the Hillsborough Independent Panel report in 2012, the then Chief Constable, David Crompton, said that in 1989 'disgraceful lies were told which blamed the Liverpool fans for the disaster' and that 'these actions have caused untold pain and distress for over 23 years'. On behalf of the force he was, he said, 'profoundly sorry'.

2.45 Yet at the new inquests families and their legal representatives told me South Yorkshire Police lawyers sought to 'repeatedly revisit points about which there had already been concessions, such as alcohol, and fan behaviour'. In my judgement, this assertion is borne out by the contents of the inquest transcripts.

2.46 No acknowledgement of responsibility was made by South Yorkshire Police lawyers before the inquest jury, but the force's legal representatives did seek to raise the contributory responsibility of others such as Sheffield Wednesday Football Club and Eastwood & Partners civil engineers. As lawyers for the families put it in a written submission to the Coroner provided during the inquest proceedings:

'Having made an unequivocal and unconditional public apology... involving recognition that SYP was responsible for the deaths and that senior officers falsified claims concerning the supporters to minimise their own position, it is quite outrageous that the current Chief Constable has adopted tactics which failed to make clear his erstwhile public stance, attempted to shift responsibility to supporters and any other convenient individual or body, and remained silent and thereby tacitly supported the assertions of SYP's own ex-senior officers [who had signalled in pre-inquest written submissions that they would be making the allegation that 'drunkenness among spectators contributed significantly to the disaster].'⁶

2.47 Individual family members also raised this issue with me. For example, Julie Fallon, sister of Colin Sefton, wrote in her contribution that:

'... the families were well aware of the games that were being played by the SYP and others... we were helpless against them.'

2.48 Making a related point, Ian Burke, son of Henry Burke, shared the view that:

'I felt that police witnesses were given more favourable treatment than the survivors.'

2.49 This defensive and adversarial approach was not limited to police legal representatives. Other interested persons also sought through their questioning of witnesses to emphasise the culpability of others. Marcia Willis-Stewart told me that this approach 'lengthen[ed] the process and significantly increase[ed] the distress to families.' It was also in conflict with the comments made by the then Lord Chief Justice Igor Judge, who in his judgement quashing the original inquest wrote that 'We should deprecate this new inquest degenerating into the kind of adversarial battle which... scarred the original inquest'.

2.50 Following the conclusion of the fresh inquests, a complaint was made to the Independent Police Complaints Commission about the conduct of South Yorkshire Police at the hearings. It alleged 'that David Crompton instructed counsel acting on behalf of SYP to pour blame on the Liverpool fans in an attempt to deflect blame and that this was in conflict with earlier apologies he publically made.' After consideration of the allegation, the IPCC determined that a full investigation would not be in the public interest. This was in part because South Yorkshire Police refused to waive legal privilege to allow the IPCC access to the instructions they had given to their lawyers but also because in the IPCC's view the transcripts of the inquest provided 'insufficient evidence to suggest [that] questions [asked by SYP lawyers] were part of a deliberate and concerted attempt by SYP to blame Liverpool fans for the disaster'.⁷

6 Submission regarding 'Reports to Prevent Future Deaths', by Pete Weatherby QC, Mark George QC, Henrietta Hill QC, Kate Stone, Andrew Fitzpatrick, 19 February 2015

7 IPCC decision on the Mode of Investigation following a complaint against South Yorkshire Police Chief Constable Mr David Crompton https://www.ipcc.gov.uk/sites/default/files/Documents/investigation_commissioner_reports/David%20Crompton%20MOI%20Decision%20Rationale%20Document.pdf

2.51 A separate issue emerged from statements made by South Yorkshire Police after the inquest concluded. On the day the inquest reached its conclusions, South Yorkshire Police issued a statement in the name of Chief Constable Crompton. The first three paragraphs read:

'I want to make it absolutely clear that we unequivocally accept the verdict of unlawful killing and the wider findings reached by the jury in the Hillsborough Inquests.

On 15th April 1989, South Yorkshire Police got the policing of the FA cup semi-final at Hillsborough catastrophically wrong. It was and still is the biggest disaster in British sporting history. That day 96 people died and the lives of many others were changed forever. The force failed the victims and failed their families.

Today, as I have said before, I want to apologise unreservedly to the families and all those affected.'

2.52 On the following day, shortly before a House of Commons statement on the inquests, the force issued a second statement. This second statement included the following paragraph:

'The intention throughout these proceedings has been to assist the jury understand the facts. We have never sought, at any stage, to defend the failures of SYP or its officers. Nevertheless, these failures had to be put into the context of other contributory factors. In other words, where do the failings of SYP stand in the overall picture?'

2.53 Following this statement, Chief Constable Crompton was suspended by the Police and Crime Commissioner for South Yorkshire, Dr Alan Billings. Dr Billings subsequently required David Crompton to resign – a decision which Mr Crompton has successfully challenged through judicial review.

2.54 In his written contribution to this report – provided prior to the conclusion of judicial review proceedings – Dr Billings discussed his decision in respect of Mr Crompton, but also his thoughts on the cultural change required in South Yorkshire Police. He wrote:

'In April 2016 I suspended the Chief Constable because I believed a statement he made after the inquests' verdicts revealed that particular lessons had not been learnt by South Yorkshire Police. The force had made a full apology for its part in the disaster and aspects of its conduct subsequently (as it had following the conclusions of the HIP [Hillsborough Independent Panel]). I think everyone who heard the apology in April thought it included addressing some of the lines of questioning at the inquests by the legal team where they touched on the behaviour of supporters. The families needed to hear that SYP was apologising for that as well as the more distant past. The attempt to justify the line of questioning in a statement the day after the apology had been made was seen as undermining the apology of the day before, and suggested that the force's first knee jerk response was still one of defensiveness and self-justification.

This was a disastrous message for SYP to send out – for the Hillsborough families, for other victims of crime in SY, not least for the victims of abuse who need to be able to have complete trust in the police if they are to come forward, for the public in SY and for the local representatives of the public, the councillors and MPs.

For me, this was an indication that the force still had a way to go in moving to a place where it was not defensive and was open and transparent; a place which could not be labelled 'the patronising disposition of unaccountable power'. It is one of the challenges facing the new Chief Constable to ensure this cultural shift happens and is maintained.

I would not underestimate this challenge. It is partly about the way many if not most organisations are tempted to react when criticised or found wanting. It is partly about the roles of Parliament, the media and the legal profession in creating an environment in which organisations feel able to admit, and apologise for, mistakes, and then to explore resolution together before positions become polarised and hardened. It is partly about the way each new generation of recruits is unconsciously socialised into an existing culture. In my view, insufficient attention is paid to the mechanism of inculcation by policing as a whole. If anything comes from your review as far as the police service is concerned, I would like to see some acknowledgement of this issue: how do you change a culture?’

2.55 Dr Billings’ letter concluded:

‘...the force needs to see itself as others it has harmed see the force, and understand that embedding ethical conduct is not about implementing an action plan, but is about nurturing a culture of living by shared values and “doing the right thing”.’

2.56 This report discusses police ethics and ethos in depth in Chapter 1.

2.57 Another key issue raised by the families in respect of the new inquests was that of pathology. In its report, the Hillsborough Independent Panel conducted an analysis of the post mortem records relating to those who died as a direct result of the Hillsborough disaster. The documentary evidence showed that the first 94 post mortem examinations were undertaken very rapidly, and that there was a preconceived expectation that traumatic asphyxia was the cause of death in all. This was subsequently confirmed as the post mortem findings by the examining pathologists to the original inquests, with responses to questioning from the coroner that claimed that those who died became unconscious within seconds and died within minutes. The unvarying nature of the supposed pattern of death was striking.

2.58 The Panel’s analysis showed that the post mortem records did not support a single, unvarying, rapid pattern of death. Some post mortems suggested severe compression of the chest, with others suggested lesser – or perhaps intermittent – compression. Well-developed cerebral oedema in some of those who died suggested circulation in the blood vessels around the brain for more than the few minutes suggested in the original inquests. Details of the Panel’s findings, which were independently reviewed prior to publication by a forensic pathologist, are set out in Chapter 5 of the Panel’s report.

2.59 As set out elsewhere in this report, the Panel’s analysis of post mortem records formed a major part of the Attorney General’s successful application to the High Court for the quashing of the original inquests.

2.60 When the fresh inquests were announced, the coroner required a fresh approach to the evidence, and appointed a team of forensic pathologists and other medical experts to advise. Lawyers representing the different families also took on forensic pathologists and other medical experts. There commenced a prolonged phase of around two years duration while preparatory work was undertaken for the inquests.

2.61 In writing this report I had heard differing opinions as to the efficacy of the processes used to develop the pathology evidence at the fresh inquests. Professor Jack Crane, who advised the Attorney General in 2012 in respect of his application to have the original inquest verdicts quashed and subsequently was the senior pathologist instructed by the coroner to review the autopsy reports in respect of the 96 fatalities, provided me with the following positive assessment:

‘At the new inquests there were obvious advantages in the presentation of the pathology findings jointly by the coroner’s pathologist and the pathologist acting on behalf of the

family. There had also been a number of meetings between the medical experts to agree their evidence and if necessary to discuss areas of disagreement. The pathology evidence was presented in a non-adversarial and non-confrontational manner which it was hoped did not unduly distress the relatives of the deceased. This approach should be adopted in other so-called “controversial” inquests.’

2.62 But I also heard concerns. Dr Bill Kirkup, former Associate Chief Medical Officer in the Department of Health, member of the Hillsborough Independent Panel and Chairman of the 2015 investigation into maternity and neonatal services in Morecambe Bay NHS Foundation Trust, provided me with his analysis. He wrote:

‘Expert advisors to the families’ lawyers initially disagreed with several elements of the analysis put forward by the coroner’s pathologists... When the coroner was made aware of the disagreement between the expert witness he had appointed and those advising the families, he let it be known that he expected agreement at the inquest and that they should resolve their differences beforehand. The resulting compromise diminished the medical evidence to the point that it effectively became non-contributory to consideration of the time of death...’

Having considered all of the evidence, including the essentially non-contributory pathology evidence as well as the evidence on the likely timing of cardiac arrest from eye-witnesses, statements and video recordings, the jury concluded that a wide range of possible time of death should be recorded for all but one of the deceased. Although this vindicated the view that the original 1990/91 inquests had been based on a false premise, both the outcome and the process by which it had been reached left several questions unresolved.’

2.63 Some families also mentioned this lack of resolution. As one family member put it to me:

‘Every expert seems to have a conflicting opinion. We’re left with more questions regarding the pathology due to receiving so many inconsistent opinions from the conclusion of the HIP report right through to the day of Brian’s individual inquest.’

Debbie Matthews, sister of Brian Matthews

2.64 A number of contributors to this report also made reference to the way in which organisations represented at the inquest sought to make use of the medical evidence in order to argue that an earlier emergency response could have made no difference. This was despite these organisations previously accepting the findings of the Hillsborough Independent Panel and apologising for their failings. Dr Bill Kirkup wrote in his submission to this report that:

‘It is clear that defensiveness, or institutional self-protection, was a widespread feature of the [fresh] inquests. This was most obvious in the line taken by lawyers representing South Yorkshire Police, but also by those representing Yorkshire Ambulance Service, who sought to establish at every opportunity that an earlier emergency response could have made no difference.’

2.65 On the same theme, Pete Weatherby QC and Elkan Abrahamson wrote in their submission to me that:

‘...the families have been appalled at the approach of a range of public authorities even during the recent inquests: two police forces, the ambulance service, the local council – all pointing the finger at each other in order to escape censure.’

2.66 As to the impact of the various challenges to the pathology evidence, Dr Bill Kirkup submitted to me that:

'In the end, the only result of these challenges was a great deal of unnecessary distress for the families of those who died. Families were distressed by hearing new suggestions about the timing and mechanism of their loved one's death, and by hearing argumentative questioning concerning the futility of resuscitation, just as they were by the re-emergence of suggestions of hooliganism and drunkenness.'

2.67 In their submission to this report, the Yorkshire Ambulance Service NHS Trust, the successor body to South Yorkshire Metropolitan Ambulance Service, sought to explain its approach to the inquest. The document reads:

'The Trust's approach to the inquests was... to ensure that all evidence relating to the ambulance service response was before the jury and that individuals were given the opportunity to provide their own account. Questions were asked of witnesses when it was felt that following other questioning there remained gaps in the evidence and points which the witnesses wished to make which had not been elicited by the earlier questioning. There was also a need on occasions to ask questions to give witnesses the opportunity to set out an alternative view to the one put to them in earlier questioning or to provide balance and context. Such an approach was seen as appropriate to ensure that in reaching its conclusions the jury had heard all the relevant evidence...'

The Trust was not the organisation providing the ambulance service on 15 April 1989 and as such, had no interest in strategy, deflection of blame, or taking a defensive stance and did not at any time identify a preferred outcome or findings in relation to any organisation or individual. The Trust simply wanted the jury to come to decisions following a full and fair examination of the evidence through the inquest process. It is of course accepted that this is what was the jury delivered on 26 April 2016.'

2.68 A number of families also raised with me their disappointment at the way in which death certificates were issued following the fresh inquests. They told me that when death certificates were delivered to them they were done so without any explanation, in particular with no covering letter or warning that the certificate was being sent out. They described the significant distress that this caused.

2.69 I put this criticism to the Home Office, which – through the Registrar General for England and Wales – has responsibility for this area. The Home Office responded by saying that:

'It is the norm for a registrar to act sensitively in their registration duties, particularly when registering deaths. Given the high profile and emotive nature of the Hillsborough inquests, Sheffield registration service was particularly sensitive to the needs of the families by ensuring the deaths were registered as quickly and smoothly as possible. As the deaths occurred over 12 months before the registrations it is a legal requirement in England and Wales for the registrations to be authorised by the Registrar General. The superintendent registrar liaised very closely with both the coroner's office and the General Register Office to ensure the paperwork was received and authorised quickly so the deaths could be registered and certificates issued. The deaths were registered on a Saturday outside of normal office hours to ensure they could all be completed at the same time. As soon as the deaths were registered the superintendent registrar informed the coroner's office so they could in turn advise the families, or their representatives, that certificates were available for issue...'

Regarding the issue of the certificates, the superintendent registrar did not have any contact details for the families so could only issue certificates once an application was received. All applications were made by email or telephone from family members or their solicitors. The address of the recipient would have been provided by the applicant so it was not unreasonable for the registrar to have assumed the recipient was aware of the application and expected to receive the certificate. It is regrettable that the receipt of the certificates caused distress for some families. The Registrar General for England and Wales would, of course, be happy to consider any points of learning that you may wish to make.'

Have the lessons been learned from the Hillsborough families' experience?

2.70 I have considered whether the experience of the bereaved Hillsborough families in respect of inquests is unique. In some senses, the experience clearly is exceptional. The 1990/91 inquests represented at the time the longest set of inquest proceedings ever held in England and Wales. The new inquests now have that status. The experience of living through two sets of inquest proceedings, 23 years apart and held under different rules and with completely different levels of legal representation is also unique.

2.71 As with the other issues raised in this report, I have considered whether there are points of learning relevant to today's circumstances. In respect of inquests I asked the charity INQUEST to hold a 'Family Listening Day' to which, as INQUEST describe it, invitations were extended to families 'on the basis of their lived experience of the inquest system relating to state related inquests'. This included family members whose relatives had died following contact with the police, in prisons and in mental health and learning disability settings.

2.72 Families at the listening day said that although they recognised that giving evidence at an inquest would be difficult, they were not prepared for what they described as the intensity and ferocity of the approaches taken by lawyers representing public authorities.

2.73 From the listening day and from conversations with other families I have gathered accounts of their recent experience of inquests. I have considered publishing their accounts in this report but have decided that their experience calls for further investigation beyond my terms of reference. I have therefore ensured personally that this material is available to the Secretary of State for Justice and to the Prime Minister and Home Secretary. The experiences which have been described to me are persuasive that the points of learning identified in my report reflect current practice and should not be seen as limited to the historic circumstances of Hillsborough.

2.74 On the separate issue of disclosure, although the experience of the Hillsborough families at the new inquests was positive, in the production of this report I have heard that bereaved families' experiences of public sector disclosure vary significantly. My attention was drawn, for example to the coroner's comments following a recent inquest into a death at HMP Woodhill in Milton Keynes. The coroner, Crispin Giles Butler, the Senior Coroner for Buckinghamshire, wrote:

'...there were significant concerns surrounding the co-ordination of disclosure by HMP Woodhill, initially by volume disclosure direct to the coroner, and subsequently in a piecemeal, partial fashion via Government Legal Department... these concerns, together with late identification of relevant witnesses and provision of witness statements caused delays to the coronial investigation which may also have delayed the overall learning process and compromised the ability of HMP Woodhill to implement change in a manner specific to the issues and concerns identified...'¹⁸

2.75 The charity INQUEST also raised problems with disclosure, writing that:

'A recurrent problem is the failure of state bodies to provide full disclosure to the coroner in advance of the inquest. It remains common for disclosure to occur just before a long awaited hearing or for new relevant documents to come to light during the course of the hearing.'

The smallest pieces of evidence have the potential to significantly change the picture surrounding a death. Late and erratic disclosure is distressing to families and undermines the legal process. For example, a previously unseen document cannot be explored with earlier witnesses and can result in gaps in the issues before the jury. It also fosters the perception that state bodies are not being transparent and fully open, and feeds family concerns that matters are being deliberately concealed or that other relevant evidence may not to have emerged. In some cases, further material comes to light after the inquest is over.'

Reform of the inquest system

2.76 In 2003, the Fundamental Review of Death Certification and Investigation in England, Wales and Northern Ireland (Fundamental Review) was published. Chaired by Tom Luce, the Fundamental Review made a series of recommendations for reform of the inquest system. They included the creation of a national coroners jurisdiction headed by a Chief Coroner; greater disclosure of information to families; greater access to legal aid in cases where a public authority was represented; a process of appeals against coroners' decisions without necessitating judicial review; and that exceptionally complex or contentious inquests should be handled by suitably prepared senior judges.

2.77 Six years after the publication of the Fundamental Review, the Coroners and Justice Act 2009 (the Act) received Royal Assent. Although the Act did not implement the Fundamental Review in full, it did include provision for a Chief Coroner, public funding for legal representation in certain cases and a system of appeals.

2.78 Under the Act, the Chief Coroner has a range of roles, including providing support, leadership and guidance for coroners, setting national standards for coroners, developing training for coroners and their staff and approving all future coroner appointments.

2.79 Regulations underpinning the Act have improved the system of disclosure to families and a practice has developed of senior judges presiding over complex inquests – as was the case at the new Hillsborough inquests. In addition, a 'Guide to Coroner Services', explaining the inquest process and setting out the standards of service that coroners should meet, has been published by the Ministry of Justice with the status of a Code of Practice under the Act.

2.80 Not all of the Coroners and Justice Act 2009 has been implemented, however. The Act's provisions on appeals and public funding were never brought into force and have now been repealed. In addition, a Chief Coroner was not appointed until 2012 – three years after the Act received Royal Assent.

2.81 As Steve Rogers, father of Henry Rogers, put it to me:

'It's hard to change the coronial process because the system has been in place for so long, but there is now a Chief Coroner who could supervise large inquests like Hillsborough.'

Steve Rogers, father of Henry Rogers

2.82 The impact of the Act is currently the subject of a review by the Ministry of Justice.

Points of learning

2.83 The bravery and tenacity of the Hillsborough families has been exceptional; it is clear that without their determination and endurance there would never have been any redress for their 96 loved ones. But the fact that this level of resolve and persistence was necessary demonstrates a systemic failure of the processes that should work to bring about accountability and justice.

2.84 The first inquests had an obligation to establish who the deceased were, where and when they died, and how they came about their deaths. They failed to do so accurately. Flawed pathology evidence as to the medical causes of death was followed by – and contributed to – an inquest process wrongly conducted on an artificially narrow basis and therefore unable to properly answer the wider question of how the deaths occurred. Legal representation available to the families was unfunded and inadequate, and unable to challenge successfully the flawed basis on which the inquests took place. The tools available to contest the inquests after they had concluded – judicial review or an application to the Attorney General – also failed to make amends. This situation persisted until the publication of the Hillsborough Independent Panel’s report in 2012.

2.85 Bereaved families told me that throughout the first inquests and during the period until those proceedings were quashed in 2012, they felt that the power of the state was not on their side, but was instead exclusively supporting the public institutions from whom they were trying to extract the truth. In practical ways – such as the provision of public funding for the police, ambulance service and local authority at the original inquests, but not for the families – this was unarguably true. The other examples quoted in this chapter demonstrate that this was not an experience unique to Hillsborough. The points of learning I believe can be drawn are set out over the following pages.

Point of learning 9 – Proper participation of bereaved families at inquests

A fundamental point of learning from the Hillsborough families' experiences is that the state must ensure 'proper participation' of bereaved families at inquests at which a public body is to be represented. This includes inquests following a disaster such as Hillsborough, but also – for example – following deaths in custody or in some cases deaths following NHS care.

There are four strands to 'proper participation', each of which are vital:

- I. Publicly funded legal representation for bereaved families at inquests at which public bodies are represented.
- II. An end to public bodies spending limitless sums providing themselves with representation which surpasses that available to families.
- III. A change to the way in which public bodies approach inquests, so that they treat them not as a reputational threat, but as an opportunity to learn and as part of their obligations to those who have died and to their family.
- IV. Changes to inquest procedures and to the training of coroners, so that bereaved families are truly placed at the centre of the process.

2.86 The government has previously argued that an inquest is simply an inquisitorial process, within which a coroner is able to ensure that families' questions are asked and answered. Legal aid is therefore only available in exceptional circumstances, and even then families are subjected to a detailed means test while at their most vulnerable.

2.87 In a simple, non-contentious inquest – 79% of inquests, according to the 2003 Fundamental Review of Death Certification and Investigation – 'proper participation' may not require legal representation on the part of either the family or any other interested person. Instead, the Coroner should ensure that the family is placed at the heart of proceedings and that their questions meet with proper responses.

Point of learning 9 (i) – 'Proper participation': legal representation for families

Publicly funded legal representation should be made available to bereaved families at inquests at which a public authority is to be legally represented. This could be achieved through amendments to the Ministry of Justice's Lord Chancellor's Exceptional Funding Guidance (Inquests) and should not need primary legislation. The requirement for a means test and financial contribution from the family should also be waived in these cases. Where necessary, funding for pathology or other expert evidence should also be made available.

The cost of this change should be borne by those government departments whose agencies are frequently represented at inquests – including the Home Office, Department for Health, Ministry of Justice and Ministry of Defence – based on the number of inquests which in an average year relate to each department's areas of responsibility.

Point of learning 9 (ii) – ‘Proper participation’: legal representation for public bodies

At the fresh Hillsborough inquests, the Home Office provided money to South Yorkshire Police to fund their legal expenditure. Importantly, however, Theresa May when Home Secretary placed conditions on the funding she provided to the police in order that it could not be used to fund legal representation more advantageous than that which was available to the families under the scheme established for them. The government should learn the lesson of this approach and identify a means by which public bodies can be reasonably and proportionately represented, but are not free to treat public money as if it were limitless in providing themselves with representation which surpasses that available to families.

2.88 However, at inquests in cases in which a public authority has been granted interested person status, ‘proper participation’ of the bereaved family requires that they too are represented. The experiences of the Hillsborough families at the original and fresh inquests, described in detail in this report, provide in my view an unanswerable case for this important change.

2.89 Tom Luce’s Fundamental Review of inquests and death certification made a very similar recommendation to the first part of this point of learning in 2003. In particular, the Fundamental Review recommended that publicly funded legal representation should be provided at all inquests involving a public authority. This was costed at an additional £3 million per year (£4.4 million in real terms). This figure provides a starting point for the detailed costing work which will be required in order to deliver this aspect of the report.

2.90 The next issue relates to cultural change. An inquest is intended to be an inquisitorial process: a process of investigation, quite unlike a traditional adversarial trial. There are no parties, no prosecution and no defence. It cannot apportion guilt or blame. Instead, it is intended simply to attempt to establish the facts.

2.91 In what might be termed a ‘normal’ inquest, this description may hold. But in a contested case such as Hillsborough, as in other inquests in which the failings of an individual or organisation may have led to or contributed to a death, the evidence I have seen while producing this report reveals it to be a fiction.

2.92 The then Lord Chief Justice, Lord Judge, in his judgement of 19 December 2012 which quashed the original inquests, described the original proceedings as having been ‘scarred’ by having degenerated ‘into [a] kind of adversarial battle’. He counselled against the same thing occurring at the new inquest. Nevertheless, as is described earlier in this chapter, this is precisely what happened.

2.93 The Hillsborough families’ experience demonstrates what happens when an inquest becomes overly adversarial in nature. First, it is likely to take longer – far longer, in the case of Hillsborough – and cost the public purse more. Second, it makes it harder for the inquest to deliver on its purpose of finding out how a person has died – increasing the risk of the truth being suppressed. Finally, and as this report sets out in detail, it also greatly increases the stress faced by bereaved families.

2.94 As is set out in this chapter, this experience is not unique to the Hillsborough families. I have met a number of other families who have lost loved ones in circumstances in which public bodies have been involved, ranging from deaths in police custody to deaths in NHS care. Those families also reported their experiences of institutional defensiveness and of the impact of public bodies taking an unduly adversarial approaches to their loved one’s inquest.

2.95 That is why I believe that ‘proper participation’ of bereaved families at an inquest is not just a question of funding, but also of cultural change.

Point of learning 9 (iii) – ‘Proper participation’: cultural change

The concept of an inquest as an inquisitorial process has much to recommend it, but it was not the reality of the Hillsborough inquests, and it is not the reality of other inquests in which the narrative of events is contested. I accept that a complex or contentious inquest will inevitably become adversarial to some degree, but the experiences of the Hillsborough families – and many of the other families to whom I have spoken – suggest that this has gone too far. I believe that the point of learning to be drawn from this is that a cultural change is needed in order to tackle the increasingly adversarial nature of many inquests – and to instead imbed a culture of openness and lesson learning.

To bring about this change, and in addition to my proposed Charter, I recommend that relevant Secretaries of State should make clear to the public bodies for which they are responsible:

- That they expect public bodies to approach inquests in an open, honest and transparent way – and that defensive and adversarial strategies, or the vilification of the deceased or their families, are not appropriate.
- That public bodies should approach the disclosure of relevant material in an open and timely manner prior to inquest proceedings, and should not unreasonably seek to limit an inquest’s scope or prevent the summoning of a jury.
- That public bodies should approach inquests as an opportunity to learn. As a matter of principle, public bodies should not argue against coroners producing Prevention of Future Deaths reports, as frequently happens at present.
- That relevant public sector inspectorates should make use of reports on the Prevention of Future Deaths in their inspection regimes.
- That they will hold public bodies’ senior personnel – NHS Chief Executives, Chief Constables, Prison Governors and so on – accountable for the way in which their organisation acts at inquests.

In addition, the highly adversarial behaviour of some lawyers employed by public bodies suggests that additional training may be required for solicitors and barristers working in the inquest system. The Chief Coroner and Ministry of Justice should work with the relevant professional bodies for the legal profession to review whether the current level of training as to the proper way for legal representatives to approach inquisitorial – as opposed to adversarial – proceedings is adequate. If it is not, it should be improved.

2.96 The experience of the bereaved Hillsborough families also suggests a number of points of learning in respect of the inquest process and in relation to the training of coroners, so that bereaved families are truly placed at the centre of the process. As set out above, this is the third element of the changes needed to ensure ‘proper participation’.

Point of learning 9 (iv) – ‘Proper participation’: inquest processes and training for coroners

The use of pen portraits at the fresh Hillsborough inquests helped to put the families at the heart of proceedings. The process was vital in humanising the inquests and was both important and therapeutic for the bereaved families. In my view, the use of pen portraits is an important point of learning and the Chief Coroner should ensure that families are offered the opportunity to read a pen portrait of their loved one into proceedings at all inquests. In addition, at the recent inquests, a photograph of the family’s loved one was shown while the pen portrait was being read. Allowing a photograph to be displayed is an important part of putting the family at the centre of an inquest and I can see no proper reason why a coroner should seek to prevent it. The Chief Coroner should ensure that the practice of allowing a photograph to be shown is widely adopted.

At the fresh Hillsborough inquests, lawyers acting on behalf of the families proposed the use of position statements – suggesting that the coroner require a statement to be made by each interested person as to the stance they intended to take during proceedings. The coroner at the fresh inquests, Sir John Goldring, declined to require the production of position statements in this instance. Nonetheless, I believe that the Chief Coroner and Ministry of Justice should consider whether the use of position statements – particularly in contested or complex inquests – has the potential to make the inquest process more efficient, for example in determining which witnesses need to be called, as well as more transparent. In drawing attention to this point of learning, I caution however against the use of position statements to unduly restrict the numbers of witnesses called, since hearing the explanations and where appropriate the apologies of witnesses is crucial to those who have suffered the loss of a loved one.

The Chief Coroner should also consider the creation of an Inquest Rule Committee, or advisory committee, to provide him with ongoing advice to ensure that Inquest Rules remain up to date and fit for purpose. The committee should draw on the experience of the rule committees in place for civil and criminal procedure, and bring together a range of experience – including legal representatives with experience of working for bereaved families. More generally, I believe there is scope for the Chief Coroner to make arrangements to hear from a wider range of stakeholders – including bereaved families – in the normal course of his work.

One issue which became highly contentious at the recent inquests was the question of whether previous admissions and apologies made by public bodies should have been put before the jury. There are clearly complex legal issues engaged by this debate, and I therefore recommend that the Chief Coroner considers this issue in detail and issues guidance on the matter in due course.

The Chief Coroner and Ministry of Justice have already done a great deal to improve the recruitment and training of coroners, but more needs to be done. In addition to the ongoing programme of training already planned or in place, I suggest:

- The Chief Coroner should make it clear that it is part of a coroner’s role to place the bereaved family at the centre of proceedings. As a practical example, coroners should not describe an inquiry into the death of a family’s loved one as ‘my inquest’.

- Training should also make it clear that coroners have a responsibility to ensure that family members are treated at all times with respect and dignity. Coroners should be trained to intervene to protect family members from unfair and hostile questioning. A similar robust line should be adopted by coroners in response to attempts by legal representatives to disparage the deceased.
- Bereaved families with experience of inquests, including Hillsborough families, should be invited to contribute to the training given to coroners. They have a vital perspective to share. Lawyers with experience of representing families should also be invited to contribute.
- Finally, the Chief Coroner is due to publish guidance on the issue of disclosure. I believe that he should develop this guidance in consultation with legal practitioners, relevant charities and other stakeholders. The guidance should emphasise the importance of full disclosure by interested persons in good time prior to inquest proceedings, as well as recommending that coroners take a comprehensive approach to onward disclosure to bereaved families. In addition to the publication of effective guidance, I would support amendment of the current Coroner's Rules to extend a coroner's duty to disclose to families all documents 'potentially relevant to the inquest'. Currently, a higher bar of 'relevant to the inquest' is set, meaning that families and their lawyers are prevented from seeing documents to make their own assessment and submissions about possible relevance. The Hillsborough inquests demonstrate the importance of maximum possible disclosure.

Point of learning 10 – Evaluating coroners' performance

The absence of a coroners' service inspectorate creates the risk that a lack of clarity about current performance acts as a barrier to improvement. Since there are, I understand, no plans to create a relevant inspectorate, I suggest that the Chief Coroner explores alternative mechanisms for allowing coroners' performance to be evaluated and for the relevant performance data to be made public.

At a basic level, this should include the use of standardised feedback forms for interested persons and juries at inquests, the results of which could be simply and inexpensively collated and the headline data published on the Chief Coroner's website. The Chief Coroner should then draw on this data in developing training and guidance, as well as in identifying local performance issues and national strengths and weaknesses.

Learning lessons from inquests

2.97 Bereaved Hillsborough families told me that they wanted to ensure that lessons were learned from their experiences, and of course that is a key part of the purpose of this report. For example, I was told:

'It felt at times that the 96 were worth nothing. Very often you had to look where you were going not where you had been – and try to change things for the future. The 96 can be a legacy of change for the future for everybody.'

Margaret Aspinall, mother of James Aspinall

2.98 The desire for lessons to be learned was also a strong theme in my conversations with other bereaved families, and in the contributions I received from lawyers with experience of representing families at inquests. I was told that an inquest should be an opportunity to learn the lessons of a death in order to help the living, and that a key tool for achieving this should be through the coroner's power to issue Prevention of Future Deaths (PFD) reports.

2.99 The Chief Coroner has shown considerable leadership in working to ensure that all PFD reports are published on the judiciary website, along with the responses to them by those bodies whose work they concern. But the Chief Coroner does not have sufficient resource to confirm that responses to PFD reports are adequate, or to identify and share themes which may emerge across coroner areas.

Point of learning 11 – Learning the lessons from an inquest

An inquest should be an opportunity to learn the lessons of a death in order to help the living. A key tool for achieving this should be through the coroner's power to issue Prevention of Future Deaths (PFD) reports.

I have been told by the legal representatives of families that PFD reports are currently under-utilised and that practice among coroners as to the circumstances in which they make PFD reports varies considerably. Distribution of PFD reports is too limited. There is no follow up to ensure that an organisation's response to the issues identified in a PFD report is adequate. The Chief Coroner publishes the reports but does not have the resources to spot widespread or thematic issues and to draw attention to them.

2.100 I have also considered the mechanisms by which inquests and coroners may be challenged. My suggested point of learning is as follows.

Point of learning 12 – Applications to the Attorney General

Utilising the legal routes available in the absence of an appeal process, Anne Williams, mother of Kevin Williams, made three Section 13 applications to the Attorney General asking him to apply to the High Court for the original inquests to be quashed. Each application failed. Anne Williams' applications to the Attorney General were based on medical analysis of a similar nature to that undertaken by the Hillsborough Independent Panel. As is set out elsewhere in this report, the Panel's analysis ultimately did lead to the Attorney General making an application to the High Court for new inquests. In order that the Hillsborough families' perspective is not lost, and to understand whether changes are needed, I believe that the Attorney General's Office should review its processes for consideration of Section 13 applications to ensure that they are fit for purpose.

Duty of candour

2.101 Following the conclusion of the new inquests, a number of lawyers who had been involved in the representation of bereaved families produced a piece of draft legislation entitled The Public Authority Accountability Bill – known informally as 'The Hillsborough Law'. A number of families have told us of their strong support for the Bill, a copy of which is provided at appendix 3.

2.102 The Bill aims to set out in statute the existing public law duty of public authorities and public servants to tell the truth and act with candour (this is sometimes described as a 'duty

of candour’), both generally and specifically with respect to court proceedings, inquiries and investigations. The proposed law draws on the experience of the establishment of a duty of candour in the NHS, following Sir Robert Francis’ inquiry into Mid-Staffordshire NHS Foundation Trust. The Bill also addresses the issue of public funding for family legal representation at inquests, discussed above.

2.103 In respect of the duty of candour, the Bill would create a mechanism through which a person who believed that an individual or public body had breached that duty could apply to the relevant court or inquiry to request that the duty was enforced. It would also establish an offence of intentionally or recklessly misleading the public, media or court proceedings.

2.104 In addition, the Bill would require that public bodies establish a Code of Ethics and whistleblowing process. Finally, it would require a person who has previously been a public servant but has since resigned or retired to comply with a subsequent request to give evidence relating to their conduct or knowledge in that public service role.

2.105 The proponents of the Bill give the following explanation of why they consider it to be necessary:

‘Public authorities and servants should tell the truth and act with candour – the sad fact is that they generally don’t. Institutional defensiveness and a culture of denial are endemic amongst public institutions as has been demonstrated not only by the Hillsborough cover up but countless other examples. Scandal after scandal, such as Plebgate and the child sex abuse investigation failures, have increased public distrust in the police. But the police are by no means the only public institution where such a culture prevails.

Incidents such as those explored in the Mid Staffs NHS Foundation Trust Public Inquiry led to the introduction of a “duty of candour” across the NHS in 2014. This was a step in the right direction, and the proposed “Hillsborough Law” will further strengthen transparency and public accountability, this time across all public institutions. The ‘Hillsborough Law’ will also create a level playing field, where all public institutions openly accept their fair share of responsibility rather than seeking to blame each other and other parties, as seen during the recent Hillsborough Inquests.

Legislation isn’t the answer to creating a culture of honesty and candour – but it is part of the answer. The “Hillsborough Law” will encourage public authorities to tell the truth and will empower individuals employed by these authorities to come forward and do the right thing.⁹

2.106 A number of the family members who contributed to this report expressed their support for the Bill. For example, Stuart Hamilton, son of Roy Hamilton, wrote that:

‘Much of the Hillsborough discourse by current and former public servants has seen individuals and groups defending their actions and behaviour and introducing uncertainty on the actions of others as opposed to seeking a truthful account of events. Police, officials, and civil servants should have a duty of revealing the full facts and not merely selecting some truths to reveal but not others. Not lying or not misleading is simply not good enough. Without this future disasters cannot be averted and appropriate policies and procedures cannot be developed to protect society. Such selective revealing of information also results in the delay of justice to the point of which it cannot be served...

I believe that without a change not only in the law but also in the mindset of the public authorities (which a law can encourage) then very little exists to stop the post-event actions happening again. The goal should not only be to prevent tragedies such as

Hillsborough but to prevent the actions and behaviours that have led to an almost 30-year wait for a resolution. Indeed, in many ways, the second of these points is at least as important as this is what I feel the Public Accountability Law will go some way to addressing.'

Point of learning 13 – The 'Hillsborough Law'

A great deal of excellent work has gone into producing the draft Public Authority Accountability Bill, or 'Hillsborough law'. I agree with the Bill's aims and with the diagnosis of a culture of institutional defensiveness which underpins it. I have drawn heavily on the Bill's principles in the drafting of the charter and in my proposals for 'proper participation' for bereaved families at inquests. I agree with the view that while legislation isn't the answer to creating a culture of honesty and candour, it is part of the answer. My proposal for a duty of candour for police officers, set out in Point of learning 14 is made on the basis that it represents the clearest and best next step in putting the statutory duty of candour into place.

The Bill proposes amendments to a complex and changing area of law. In particular, the Law Commission's detailed work aimed at reforming the offence of Misconduct in Public Office is ongoing. Once the Law Commission's work is complete, and government has agreed the detail of the reform the Commission sets out, full consideration should be given by government to the Public Authority Accountability Bill.

2.107 The Bill was introduced into the 2016-2017 Parliamentary session by Andy Burnham. I recognise that the Bill seeks to amend complex areas of law, and that there are other proposed amendments to the current legal position also currently under consideration. In particular, I have discussed with the Law Commission the extent to which an overlap exists between the offences outlined in the Bill and in their work on reforming the offence of Misconduct in Public Office. The Law Commission told me that:

'A number of consultees raised in their responses to our consultation paper concerns that a culture of denial and unaccountability exists within public bodies. Our current review is limited to consideration of the misconduct in public office offence. In our final report, we hope to discuss the concerns raised and to what extent, if at all, a breach of a duty of candour by a public office holder could create criminal liability under our proposed reforms.'

2.108 The Law Commission's report on Misconduct in Public Office is due to be published later this year.

2.109 In addition to proposals set out in the Public Authority Accountability Bill, I have considered the particular need for openness within the police.

Point of learning 14 – A duty of candour for police officers

One specific element of the Public Authority Accountability Bill is a proposed ‘duty of candour’ for all public officials. Such a duty has already been introduced in the National Health Service, following Sir Robert Francis’ inquiry into Mid-Staffordshire NHS Foundation Trust. In my view, the Hillsborough families’ experiences make the case that the next extension of the duty of candour should be in respect of police officers. Just as the NHS duty of candour is tailored to healthcare, so the police duty of candour should recognise the particular issues facing policing.

As a minimum, the duty of candour should require police officers – serving or retired – to cooperate fully with investigations undertaken by the Independent Police Complaints Commission or its successor body, the Independent Office for Police Conduct. But there is also scope for a wider duty of candour in respect of policing.

In a Guardian article published in May 2016 (‘Accept blame, then learn from it: this should be a police credo’) Sara Thornton, Chair of the National Police Chiefs’ Council, wrote that:

‘The Hillsborough inquest verdict raises the gravest concerns about the leadership culture in policing. While many officers will argue that 1989 was long before they joined the service and some will argue that everything is different now, I do not think we can ignore the central issue of a culture that can be defensive and closed – a culture that struggles to learn from failure.

Hillsborough was not unique. Despite all our efforts to run a service in which our officers and staff behave honestly and ethically, the tendency to avoid straight answers at best, and to hide the truth at worst, can still be a problem for us.’

Having made this powerful admission, Sara Thornton suggested that a duty of candour for police officers might form part of the remedy. She wrote:

‘We will learn from other professions and consider a police service duty of candour. We will listen to our staff to ensure they feel able to challenge their leaders and colleagues when they are behaving unethically. No one wants to protect bad cops, but we cannot have officers fearful that if they do tell the truth, they will become that single point of blame.’

I commend this commitment to explore how a wide ranging police duty of candour would operate, and encourage the Home Office, National Police Chiefs’ Council and the College of Policing to work together to publish detailed proposals.

Pathology

2.110 The following points of learning address the important issue of pathology.

Point of learning 15 – Pathology failures at the first inquests

It is difficult to overstate the impact of the failures of pathology at the first inquest. The impact is deeply personal for those families who feel they will now never know how their loved one died, but it also has a wider resonance – leading as it did to the necessity for new inquest proceedings 25 years after the disaster occurred.

Given that impact, there should be proper consideration of the potential for learning from the failings of the pathology evidence to the original inquests. A review should be commissioned by the Pathology Delivery Board, which oversees the provision of forensic pathology services in England and Wales, and delivered independently. As well as reviewing how the evidence at the first inquests came to be misleading and why, the review should also consider whether there are adequate safeguards to prevent it happening again, including clinical governance and revalidation processes that are made more difficult by the small size of the subspecialty of forensic pathology and its distinctive employment mechanism. This review should also consider whether a process of accountability is appropriate in respect of the misleading evidence presented at the original inquests. Finally, the review should consider how to embed the lessons from the Hillsborough experience in the continuous professional development training of pathologists.

Point of learning 16 – Using the medical evidence from the fresh inquests

It has been submitted to me that the medical evidence presented at the fresh inquests may make a useful contribution to the content of additional training for police officers, prison staff and others whose job can involve the restraint of others – in particular in order to reduce the incidence of deaths and significant hypoxic injuries from restraint asphyxia. The Ministerial Board on Deaths in Custody should consider how best to ensure that the medical evidence from the recent inquests contributes to training in the prevention of restraint asphyxia, and I have written to the Council to invite it to do so.

2.111 In the course of producing this report, I have also been made aware of wider concerns about the current and future state of pathology services available to coroners. Since the failings of pathology are an important theme in the experience of the bereaved Hillsborough families, I consider these wider issues to be within the scope of this report.

2.112 In early 2014, the Home Office commissioned Professor Peter Hutton to conduct a review of forensic pathology provision in England and Wales. Professor Hutton reported in March 2015. Although Professor Hutton found that the standard of professional practice in forensic pathology was high, he drew attention to a number of issues. ‘The future of the forensic pathology service’, he wrote, ‘is fragile’, with ‘the provision of sub-specialty opinions... at crisis point’ and ‘the coronial autopsy system... in considerable difficulty’.

2.113 In his 2015-2016 annual report, the then Chief Coroner Peter Thornton raised similar issues. He wrote, ‘There is considerable concern amongst coroners about the dwindling availability of pathologists to carry out post-mortem examinations’. In addition, he warned that:

'As a result of the shortage of coroners' pathologists many coroners are facing delays in releasing bodies and in taking cases to inquests. Although pathologists' reports should sensibly be provided to the coroner within three to four weeks, the dwindling number of pathologists prevents that happening. Delays are now built into the system. There needs to be change.'

Point of learning 17 – Pathology services in England and Wales

The government has not responded publicly to warnings about the state of pathology provision in England and Wales made in a 2015 Home Office-commissioned review conducted by Professor Peter Hutton, or to warnings made by the Chief Coroner in his 2015-2016 annual report. Both raise important concerns which government should now address.

2.114 The coroner's decision at the first inquests to test all of the deceased, including children, for blood alcohol was a significant theme in my conversations with families – as was his later decision to make the results of the tests public. Both decisions caused great distress. As part of this report, the office of the Chief Coroner was asked whether guidance existed to coroners on blood testing and on whether sensitive medical information should be made public. They said:

'The Chief Coroner is not able to comment on decisions made in individual cases, whether historical or current. The fresh Hillsborough inquests which concluded in 2016 speak for themselves and the Chief Coroner is not able to add to them. Asking for toxicology tests (of all kinds) to be performed is a very common part of the toolkit that coroners have to fulfil their statutory duty to investigate and discover the cause of death. What the Chief Coroner would expect is that coroners would discharge their duties sensitively and carefully and independently in each case.'

What evidence is to be disclosed at inquest is subject to the discretion of the coroner and those decisions are often taken following submissions and complex legal arguments by the Interested Persons. The coroner must exercise his or her discretion within the bounds of statute and case law. The inquest is an open and transparent judicial process which means there is a presumption of relevant material forming part of the public evidence. But... disclosure is legally complex.'

Point of learning 18 – Toxicology and alcohol testing

I would encourage the Chief Coroner to ensure that all coroners are made aware of the experience of the Hillsborough families as set out in this report. Coroners should ensure that the decisions they make on toxicology – especially in respect of children – are made in a sensitive way, driven by necessity. Special care should be given to the way in which toxicology results are made public.

2.115 The position in respect of toxicology as explained by the Chief Coroner's office also underlines this report's support for 'proper participation' for families at inquests through funded legal representation. The point here is that even on an issue as relatively narrow as toxicology, a coroner's decision is made 'following submissions and complex legal arguments by the Interested Persons' and 'within the bounds of statute and case law'. At a complex or contentious inquest, families will face a series of issues of similar and greater complexity and importance. For the bereaved to be denied what I have described as 'proper participation' through publicly funded legal representation is a clear injustice.

2.116 The next point of learning relates to the information and support provided to bereaved families in the immediate aftermath of a death – before the processes of an inquest have begun – and throughout the process.

Point of learning 19 – Right to information

Families bereaved through public tragedy too often face a vacuum in respect of information about their rights and the process of an inquest. The Ministry of Justice's Guide to Coroner Services seeks to address this vacuum, but the evidence I have seen in producing this report demonstrates that more needs to be done. In particular, I suggest that:

- Clear information concerning the role and remit of coroner's officers should be provided to families to make clear areas of responsibility and decision making.
- The Chief Coroner should prepare standard national guidance for all coroners' officers to distinguish complex cases, including those which involve a public body, from more routine inquests. Families should be informed of their rights to legal advice and representation and the availability of public funding.
- Written information about sources of specialist support and advice including information about organisations such as INQUEST should be passed immediately to every family by the coroner's office following a death involving a public body.
- All bereaved families should be given clear information immediately following death concerning the post-mortem procedure and a family's full rights under the Human Tissues Act, including the right to a second post mortem.
- The government should review the level of funding support it provides to charities such as the Coroners' Courts Support Service, whose volunteers give emotional and practical support to families and other witnesses attending inquests. It has been submitted to me that the funding granted to such support services is inadequate, meaning that the support they are able to give falls seriously short of that provided to victims and witnesses in criminal cases.

In addition, I warmly welcome the government's commitment – expressed in the recent Conservative Party manifesto – to the creation of 'an independent public advocate, who will act for bereaved families after a public disaster and support them at public inquests.' I would anticipate that a key part of the advocate's role will be ensuring that bereaved families are kept properly and fully informed at all times.

2.117 The final point of learning I draw from chapter 2 relates to the issuing of death certificates.

Point of Learning 20 – Issuing death certificates

Families told me that they felt that the way in which death certificates were issued following the fresh inquests – with no covering letter and in some cases unexpectedly – caused great pain and distress. I accept the assurance provided to me by the Home Office’s that death certificates are in normal circumstances only issued on request, and that they should not therefore arrive unexpectedly. However, it is my view that for death certificates to be issued without the courtesy even of a short covering letter is inherently disrespectful to the deceased and to the bereaved, and that this practice should be stopped.

Chapter 3 – Public inquiries

‘It is a matter of regret that at the hearing, and in their submissions, the South Yorkshire Police were not prepared to concede they were in any respect at fault in what occurred... Such an unrealistic approach gives cause for anxiety as to whether lessons have been learned. It would have been more seemly and encouraging for the future if responsibility had been faced.’

The Hillsborough Stadium Disaster, Interim Report of Inquiry, by Lord Justice Taylor

‘Have you got more people coming or are they all here? It’s not like Liverpool fans to turn up at the last minute.’

Lord Justice Stuart-Smith: Speaking at his first meeting with bereaved families in October 1997

‘I had a telephone call from the then South Yorkshire Chief Constable Med Hughes in the stages before the HIP was set up in 2009. During the call he said “I am under no obligation to disclose anything and the papers belong to me. If I wanted to I could take them into the yard and have a bonfire with them”. I replied if he did we would turn him into a guy and chuck him on the top of the fire.’

Trevor Hicks, father of Sarah and Victoria Hicks

Introduction

3.1 Over the 28 years since the Hillsborough disaster, three independent examinations have been conducted which are considered here under the description of ‘public inquiries’. Strictly speaking, only Lord Justice Taylor’s inquiry formally meets this description, but this chapter of the report considers that inquiry alongside Lord Justice Stuart-Smith’s ‘Scrutiny’ as well as the Hillsborough Independent Panel.

The Taylor Inquiry

3.2 On 17 April 1989, Lord Justice Peter Taylor, a Lord Justice of Appeal, was appointed by the Home Secretary to conduct a judicial inquiry into the Hillsborough disaster. His terms of reference were: ‘to inquire into the events at Sheffield Wednesday football ground on 15 April 1989 and to make recommendations about the needs of crowd control and safety at sports events’.

3.3 Lord Justice Taylor published his Interim Report on 1 August 1989. The ‘real cause’ of the disaster, he concluded, was ‘overcrowding’ and the ‘main reason’ was ‘the failure of police control’. Police failure to close the tunnel to terrace pens 3 and 4 after the opening of exit Gate C was ‘a blunder of the first magnitude’. Lord Justice Taylor was critical of Sheffield City Council, South Yorkshire Ambulance Service and Sheffield Wednesday FC, but reserved his strongest comments for South Yorkshire Police. He directed severe criticism towards senior officers, finding that the quality of officers’ evidence to his inquiry ‘was in inverse proportion to their rank’.

3.4 The Chief Constable of South Yorkshire Police, Peter Wright, offered his resignation to South Yorkshire Police Authority but it was refused. He subsequently retired in May 1990.

3.5 Lord Justice Taylor’s final report, which focused on the future of sports stadium safety, was published in January 1990. In total, he made over 70 recommendations, including recommending the introduction of all-seater stadia for the top two tiers of English football.

Views from bereaved families

3.6 Many families said that they thought Lord Justice Taylor ‘got it right’, but that his criticism of the police and others was not properly acted on: there were no criminal prosecutions or disciplinary proceedings, Chief Constable Peter Wright’s resignation was refused by South Yorkshire Police Authority, and the original inquest into Hillsborough was to reach a verdict of accidental death. There was frustration that it had taken over 25 years for the Hillsborough Independent Panel and the new inquests to start to bring about justice, when Lord Justice Taylor had shone a light on the disaster in 1989. Other families said that they felt Lord Justice Taylor changed his tone between his interim and final reports, and that they were concerned he had been influenced improperly following the publication of his first report:

‘After Lord Justice Taylor’s report I truly believed truth and justice would prevail, however what happened subsequently was a complete systematic degradation and humiliation of the 96, families, survivors and all the good I was raised to believe in.’

Gerard Baron Jnr, son of Gerard Baron

‘Lord Justice Taylor had been right to a certain extent, but I was concerned about the role of the Home Office.’

Christine Burke, daughter of Henry Burke

‘Lord Justice Taylor conducted it properly. He painted a clear picture of who was responsible – he identified where the blame lay but it was not acted upon.’

‘His terms of reference were limited and so there were limited outcomes and recommendations – only all-seater stadia. High level civil servants did not want to go any further.’

‘The government did not support the families.’

Barry Devonside, father of Christopher Devonside

‘Lord Justice Taylor’s interim report was highly critical of South Yorkshire Police, but in the final report he had reined back. I believe Taylor was leant on but who by? Why was the final report markedly different?’

Becky Shah, daughter of Inger Shah

‘Families felt strongly that the evidence and matters revealed by the recent Inquests were largely based on knowledge of the truth of what happened which they had for many years, and much of which had been established in the Taylor enquiry. Justice was far too long in coming, and had devastating consequences for the families on many levels, including psychological, financial, impact on working life, and family life etc.’

Written submission by Marcia Willis Stewart of Birnberg Pierce, solicitors to families who are members of the Hillsborough Family Support Group

3.7 Maria Eagle, MP for the Merseyside constituency of Garston and Halewood, provided the following reflection:

‘Despite the public inquiry being quite clear, every subsequent time that media and public talked about Hillsborough as being caused by Liverpool fans, or bad behaviour or drunkenness or hooliganism, (and this has happened a lot) they felt they had to defend the reputations of the dead and the traumatised, their relatives and the survivors, Liverpool FC fans in particular. It kept the disaster at the front and centre of all their lives – a living nightmare that had potentially to be dealt with every day. Families had to be ready at the drop of a hat, at any time to defend the 96 dead and the Liverpool fans – and to relive the horror they had experienced. They were kept on tenterhooks for years, a great psychological strain that certainly took its toll on the health of some.

It is a gross failure of public administration by government, central and local, and in the administration of justice that this was allowed to happen given that the reality of what occurred was clearly set out by the public inquiry within four months of the disaster.’

3.8 David Conn, who has written extensively for the Guardian on the subject of Hillsborough, made a similar argument in his written submission to this report. He wrote:

‘I believe that your report should consider how, after the Taylor report was so conclusive, and the Prime Minister of the day given so severe a warning about the police’s inability to “perceive and admit faults,” the police were not held to account at all by the government...[A]t no point does the government appear to have made any intervention at all, after the Taylor report. I have not seen that the government expressed any concern about the conduct and findings of the first inquest, which became the major injustice against which the families had to campaign.

Nor does the government appear to have supported the bereaved families in any way then; in fact they believed for 20 years that successive governments, as well as the police, legal establishment and sections of the media, opposed them. As is well recognised now but inadequately recognised for 20 years, they had no legal funding for the legal processes or to sustain their groups and appeals, while the police and other authorities had public funding for lawyers.'

The Stuart-Smith Scrutiny

3.9 In June 1997, Lord Justice Stuart-Smith was commissioned by the then Home Secretary, Jack Straw, to conduct a scrutiny into whether there was 'any fresh evidence which might have a bearing on the various legal procedures and decisions that have been taken'. These procedures and decisions included the Taylor Inquiry, decisions by the Director of Public Prosecutions and Attorney General, police disciplinary decisions, and decisions by the Home Secretary as to whether to hold a further public inquiry.

3.10 The establishment of the Stuart-Smith Scrutiny followed the broadcast of the powerful drama-documentary 'Hillsborough' in December 1996 and the publication in 1995 of 'No Last Rights: The Denial of Justice and the Promotion of Myth in the Aftermath of the Hillsborough Disaster', by Professor Phil Scraton, Sheila Coleman and Ann Jemphrey.

3.11 As the Hillsborough Independent Panel was to reveal publicly in 2012, the government had concluded before the Scrutiny was established that there was 'no new evidence', but considered that this would not be accepted publicly without independent examination. As Home Secretary Jack Straw wrote to colleagues in June 1997:

'My officials have thoroughly examined the alleged new evidence and the allegations made in the Granada television programme and have concluded that there are no grounds for establishing a new public enquiry. The material has also been considered by the Attorney General's Office and the DPP's Office. None of those who have examined the material consider that there is evidence to justify a new public enquiry, a re-opening of the inquest, or the prosecution of individuals. But I am certain that continuing public concern will not be allayed with a reassurance from the Home Office that there is no new evidence. I therefore propose that there should be an independent examination of the alleged new evidence by a senior legal figure – a respected judge (serving or recently retired), or perhaps a senior Counsel.'

Letter from Home Secretary Jack Straw to John Morris QC MP, Attorney General, 5 June 1997 – as published by the Hillsborough Independent Panel

3.12 In his report, which was published in February 1998, Lord Justice Stuart-Smith summarised his findings as follows:

'... for the reasons I have set out, I have come to the clear conclusion that there is no basis upon which there should be a further judicial inquiry or a reopening of Lord Taylor's inquiry. There is no basis for a renewed application to the Divisional Court or for the Attorney General to exercise his powers under the Coroners Act 1988 [to order a new inquest]. I do not consider that there is any material which should be put before the Director of Public Prosecutions or the Police Complaints Authority which might cause them to reconsider the decisions they have already taken. Nor do I consider that there is any justification for setting up any further inquiry into the performance of the emergency and hospital services. I have carefully considered the circumstances in which alterations were made to some of the self-written statements of South Yorkshire Police officers, but I do not consider that there is any occasion for any further investigation.'

None of the evidence I was asked to consider added anything significant to the evidence which was available to Lord Taylor's inquiry or to the inquests.'

Scrutiny of evidence relating to the Hillsborough Stadium Disaster, by Lord Justice Stuart-Smith

3.13 Families I listened to were critical of Lord Justice Stuart-Smith's conclusions and the way in which his Scrutiny was established and conducted. This included criticism of a comment made by Lord Justice Stuart-Smith to a bereaved father at a meeting in October 1997, when he said 'Have you got more people coming or are they all here? It's not like Liverpool fans to turn up at the last minute.' For many families, this comment led to any confidence they had in the Scrutiny being lost, and the pain the remark caused is still evident.

3.14 Families made the following points:

'The Stuart-Smith Scrutiny... was set up to fail and Jack Straw (a trained barrister) was party to this as he was made aware that there were a significant amount of altered police statements and evidence that was withheld. Scrutinies of this nature should only be undertaken if they are done fairly and act upon what facts emerge. Jack Straw should have been sacked for his role in this. To offer false hope to the families knowing it would fail is unforgiveable.'

Paul Robinson, brother of Steven Robinson

'A public inquiry has to be totally impartial. How could a high court judge act in this way?'

Barry Devonside, father of Christopher Devonside

'His mind-set was that the families were late, like the Liverpool fans.'

Charlotte Hennessy, daughter of James Hennessy

'The families did not have a voice.'

Karen Hankin, wife of Eric Hankin

'The families felt intimidated such that they were not able to get their points across.'

Paul Robinson, brother of Steven Robinson

'When we went to meet Jack Straw on the day of publication of the Stuart-Smith Scrutiny he told us that no one would have seen the report before publication, but we were told later that the police had received the report and had seen it four weeks earlier.'

Margaret Aspinall, mother of James Aspinall

'In 1997 I gave up my job, moved away from Bromsgrove in Worcestershire and away from my parents to live in Liverpool to be closer to the Hillsborough Campaign as we never knew what was going on. If it wasn't on the national news or in the national papers, we never knew what was going on. It was like living on a different planet.'

Louise Brookes, Sister of Andrew Mark Brookes

The Hillsborough Independent Panel

3.15 On 15 April 2009, over 30,000 people attended a memorial service held at Anfield to mark the 20th anniversary of the Hillsborough disaster. As Andy Burnham, the then Secretary of State for Culture, Media and Sport, spoke he was interrupted with a shout of ‘Justice’. Then the whole crowd got to their feet and joined the chant, ‘Justice for the 96!’. On his return to Westminster, Andy Burnham began discussions within government with the aim of bringing about a fresh examination into the issues surrounding the Hillsborough disaster. Those discussions eventually led to the decision by the then Home Secretary, Alan Johnson, to announce the setting up of the Hillsborough Independent Panel.

3.16 The Panel was established in December 2009. Its remit was to oversee maximum possible disclosure of documents relating to Hillsborough held by government and relevant public authorities – including South Yorkshire Police – and to write a report setting out what the disclosed documents added to public understanding of the disaster and its aftermath. The Panel was made up of nine members with expertise in a wide range of relevant areas, including the police, media, medicine, freedom of information, archives, research and Hillsborough itself. I was appointed as the Panel’s Chairman.

3.17 The Panel’s terms of reference required us to consult the Hillsborough families as we conducted our work and to ensure that disclosure was to the families ahead of the wider public. In practice, the Panel made ‘families first’ a defining feature of how we operated – for example, meeting the family groups on the very first day that we met as a Panel, and regularly throughout our work.

3.18 Following the general election in May 2010, the new coalition government gave the Panel its full support, with the then Home Secretary Theresa May taking on the role of lead minister for Hillsborough. The Panel reported in September 2012.

3.19 Publication of the Panel’s final report had a profound impact on public understanding of what happened at Hillsborough and in the disaster’s aftermath. On the day of publication, the then Prime Minister David Cameron apologised on behalf of government for the injustices the bereaved families had suffered. In a statement to Parliament, he said:

‘It is right for me today as Prime Minister to make a proper apology to the families of the 96 for all they have suffered over the past 23 years. Indeed the new evidence that we’re presented with today makes clear, in my view, that these families have suffered a double injustice. The injustice of the appalling events, the failure of the state to protect their loved ones and the indefensible wait to get to the truth, and then the injustice of the denigration of the deceased – that they were somehow at fault for their own deaths. So on behalf of the government, and indeed our country, I am profoundly sorry for this double injustice that has been left uncorrected for so long.’

3.20 Others, including South Yorkshire Police, Yorkshire Ambulance Service and Sheffield Wednesday FC also offered their apologies to the bereaved families.

3.21 Families I listened to in the preparation of this report were generally very positive in their reflections about the way the Panel had operated and the impact of its work. I was told:

‘We were not entirely happy with the terms of reference but being engaged helped. It was important for the Panel to be truly independent.’

Trevor Hicks, father of Sarah and Victoria Hicks

'The organisation and planning of the Panel's disclosure on 12 September 2012 made all the families feel an integral part for the first time.'

Deanna Matthews, niece of Brian Matthews

'The Panel came to Anfield and listened to us. We didn't know them. The families then knew who they were and trusted the Panel a lot more.'

Brenda Fox, mother of Steven Fox

'The Panel provided total relief – the fans were exonerated.'

Becky Shah, daughter of Inger Shah

'The Panel had a wide cross-section of experience. Collectively it did well. For the first time, people were going to listen – they did a fantastic job.'

'The families were only taken seriously after the Hillsborough Independent Panel.'

Barry Devonside, father of Christopher Devonside

'I never thought that the police would still have the paperwork and hand it over – the police thought themselves invincible.'

Anne Burkett, mother of Peter Burkett

'I didn't expect [the Panel] to uncover as much as it did. We went on hope more than anything. We were just all stunned.'

Tony Murray, father of Paul Murray

'It was the first time there was an attempt to build trust. It was reassuring knowing that the families were being listened to.'

Margaret Aspinall, mother of James Aspinall

'With reference to the HIP report. If it wasn't for this report we families would still be knocking on the doors of the establishment. The evidence was always there... we families and survivors have been put through 28 years of hell and we still continue to go through hell. Until we get accountability, we will never have justice and we will only get justice when those people are held accountable in a criminal court for their actions or in some cases their lack of actions.'

'No parent should be deprived the right and sent to their graves never knowing how or why their child died... and then be protected by the establishment for almost 30 years.'

Louise Brookes, Sister of Andrew Mark Brookes

'After the Panel report, I took the report to the cemetery and said, "Look, Mum, he was not a hooligan." The Panel found out the truth.'

Steve Kelly, brother of Michael Kelly

3.22 Liverpool City Council provided me with information about the support it provided to bereaved families and survivors on publication of the Panel's report and in its aftermath. They explained that:

'In November 2011, the council's adult social care division was involved in providing crisis support and counselling to Hillsborough families involved in the disclosure relating to the tissue retention. A dedicated phone line was set up and a small team of social workers supported the families involved.'

In the months leading up to the release of the HIP report in September 2012, senior managers from adult services were involved with colleagues from the Home Office in the planning of this release and were in attendance at the Anglican Cathedral on the day of the disclosure to provide support for families and survivors. The city council provided a team of 10 social workers to be available to give advice and support on the day. Again a dedicated telephone number was set up for families before, during and after the publication of the report to enable them to directly access counselling services.'

In May 2013 and again in December 2013 social work support was again provided to support meetings between families their solicitors and the team from the IPCC. On these occasions the city council helped to facilitate the process, including liaison with colleagues in the IPCC during both periods which lasted for a number of weeks.'

Despite significant budget reductions, at all times social work support has been available when required and this is still the case today.'

3.23 Judith Moritz, North of England Correspondent for BBC News since 2006, provided me with a written submission which included helpful comments on the approach taken by the Panel to the families and the media. She wrote:

'The Panel's terms of reference specified that public disclosure must be made to the families and other interested parties before being made more widely available. This meant that no leaks appeared in the media during the two years that the Panel was in session. It established a principle which has largely been followed since. The media understands that no family wishes to hear information second-hand.'

In fact I would highlight the Panel experience as a positive point of learning, from the perspectives of both the families and media. The choreography of publication day in particular should be emulated as best-practice by other such inquiries in future... By keeping their work water-tight for two years, and then coordinating publication... the Panel managed to put the families' first but accommodated the media so that the story could be told...

Public bodies and inquiries should understand that it is possible to prioritise victims whilst also adequately accommodating the media. The two don't need to be at odds. And I would suggest that the victims' experience of a public inquiry or investigation can be improved when media arrangements are made sensibly.'

3.24 Separately, families I listened to in the course of producing this report described the trauma of receiving information from the Panel, in the form both of its public report and the medical evidence relating to some of those who died, which was provided privately. This was illustrated on the day of the report's publication, when three people were overcome and required medical attention during Dr Bill Kirkup's presentation of those aspects of the report on which he had led.

3.25 For example, I was told that:

'The Hillsborough Disaster is unique because of the length of time taken for the actual facts to be revealed to the grieving families. The publication of the Hillsborough Independent Panel (HIP) report and subsequent enquiry has enabled the families to find out exactly what happened to their loved ones on that awful day. However, I feel that it is very important not to lose sight of the fact that it is a double edged sword because the trauma of the HIP report and enquiry has, for me personally, opened up a distressingly deep wound which will impact on the rest of my life.'

Dorothy Griffiths, sister of Vincent Fitzsimmons

'The Hillsborough Independent Panel confirmed what all family members and survivors already knew, but the biggest blow was how many of the 96 could have survived had they been given the correct medical treatment.'

Charlotte Hennessy, daughter of James Hennessy

3.26 Some families also expressed their disappointment that the Panel had not, in their view, scrutinised particular issues in sufficient depth. There was frustration too that documentary disclosure had not come sooner.

'The Panel didn't look at the role of the West Midlands Police and the political establishment'.

'Why is there a 30 year rule? The families should have instant access to the material.'

Becky Shah, daughter of Inger Shah

3.27 I was also told of conversations held between families and South Yorkshire Police prior to the establishment of the Hillsborough Independent Panel. I was told:

'I had a telephone call from the then South Yorkshire Chief Constable Med Hughes in the stages before the HIP was set up in 2009. During the call he said "I am under no obligation to disclose anything and the papers belong to me. If I wanted to I could take them into the yard and have a bonfire with them". I replied if he did we would turn him into a guy and chuck him on the top of the fire.'

Trevor Hicks, father of Sarah and Victoria Hicks

3.28 Other members of the Hillsborough Independent Panel have confirmed to me that Chief Constable Med Hughes made a similar comment to them during the Panel process.

South Yorkshire Police emails

3.29 Emails released in 2013 under Freedom of Information provide an insight into internal discussions within South Yorkshire Police in the week preceding the publication of the Hillsborough Independent Panel's report. On 8 September 2012, in advance of the release of the report, David Crompton, the then Chief Constable of South Yorkshire Police, sent an email to senior colleagues in which he wrote:

'Can we talk on Mon/Tues about how we use our own website next week. I think we may be missing a trick.

I'm thinking that on Thursday morning at 8am we launch on our own public-facing website a page called something like... 'Hillsborough... did you know? (I'm trying to think of a non-threatening title).

We then publish links to CC apologies in the past, the conclusions about Deborah Martin, the Peter Wright memo saying we would not criticise the fans etc... etc... We keep it purely factual and always refer to the original source document. We then publicise it on Twitter. In effect, it amounts to the case for the defence. One thing is certain – the Hillsborough Campaign for Justice will be doing their version... in fact their version of certain events has become “the truth” even though it isn’t!!

I just have the feeling that the media “machine” favours the families and not us, so we need to be a bit more innovative in our response to have a fighting chance otherwise we will just be road kill.’¹⁰

3.30 Mr Crompton’s proposed ‘Hillsborough... did you know?’ webpage was not described in his email as an opportunity to offer a considered response to the Panel’s report, once it had been read. Instead, it was to be a ‘case for the defence’ to avoid the force becoming ‘road kill’ in the press.

Points of learning

3.31 Points of learning drawn from this chapter are set out below.

Point of learning 21 – Police approach to public inquiries

The response of South Yorkshire Police to criticism over Hillsborough has, over the years, included several examples of what might be described as ‘institutional defensiveness’. The force’s repeated failure to fully and unequivocally accept the findings of independent inquiries and reviews has undoubtedly caused pain to the bereaved families.

I consider that there is a point of learning here to be developed by the College of Policing. The College should consider what training and guidance is provided to senior police officers to assist them in ensuring an open and transparent approach to public inquiries and other independent investigations. This should include training and guidance on how forces can encourage its officers to accept and learn from adverse inquiry findings. There may, for example, be a role for a ‘restorative justice’ style approach, in the sense of police officers and those affected by the issue in question having an opportunity to meet to discuss how they have been affected by events and what should be done to repair the harm. In considering what training and guidance is necessary, the College should have regard to the other points of learning identified by this report – in particular those relating to the proposed Charter for Families Bereaved through Public Tragedy.

10 IPCC decision on the Mode of Investigation following a complaint against South Yorkshire Police Chief Constable Mr David Crompton

Point of learning 22 – Setting up public inquiries

The bereaved families' experience of the various public inquiries which have taken place into Hillsborough points to a number of points of learning. In particular:

- The Hillsborough Independent Panel demonstrates that formal inquiries under the Inquiries Act 2005 are not the only option available to government when it is considering external public scrutiny. A number of investigative panels have since been set up by government and the panel model is likely to be suitable for the scrutiny of other issues of public concern in the future. In order that the panel model is applied appropriately and successfully, we believe that the time has come to evaluate the various panels created to date in order to establish criteria for the model's future use.
- Chairs and secretaries to public inquiries and other forms of independent scrutiny should give careful consideration to the pain, stress and emotional damage that such processes can cause bereaved families – even in cases where they ultimately consider the result of the inquiry to be positive – and should ensure that adequate support for family members is put in place.

3.32 On the subject of Hillsborough and public inquiries into police misconduct more generally, David Conn, the Guardian journalist, wrote in his written submission that:

'Theresa May as Home Secretary supported the HIP process, the criminal investigations and inquests, and funded the families' legal costs... These have been positive government interventions, which have finally facilitated the overturning of injustice and the false narrative about the disaster, but it was a gross failure that it took 27 years to establish that truth from when the 96 people were unlawfully killed...'

It is very encouraging to have seen the wholesale change in the government's approach to the Hillsborough injustice and the bereaved families, but a review of their experience must face the inaction for so many years, understand it and seek to learn lessons so that other people do not similarly suffer. Successive governments ignored the families' appeals, suffering, campaign and failed to recognise the injustice they had endured and the validity of their case...'

On the specific issue of Orgreave and the lessons it has for how 96 people came to die at Hillsborough, this government has... done nothing at all... The government needs to clarify and set out what its policy is on historic inquiries into police malpractice and other injustice, and consider a principled policy of intervention to help people who might find themselves in a similar terrible situation as that of the Hillsborough families.'

Point of learning 23 – Home Office approach to historic inquiries

It is not within my terms of reference to comment on calls for a public inquiry into Orgreave or other historic issues involving the police.

Elsewhere in this report I suggest that the Attorney General's Office should review its processes for consideration of 'Section 13' applications for inquests to be quashed, to ensure those processes are fit for purpose. In my view, the Home Office should also consider whether it has appropriate systems in place to ensure that it is able to make informed and transparent decisions in respect of requests for public inquiries or other forms of independent scrutiny of matters of public concern.

I also agree with David Conn, who wrote in his submission to this report that the Home Office should also set out publicly 'what its policy is on historic inquiries into police malpractice and other injustice, and consider a principled policy of intervention to help people who might find themselves in a similar terrible situation as that of the Hillsborough families.' In doing so, the Home Office should have regard to one of the lessons of the Stuart-Smith Scrutiny: that if it is to commission independent examination of an issue it should not seek to internally pre-judge the findings of that examination.

3.33 Finally, I consider that there is an important point of learning from the Hillsborough Independent Panel's work in respect of police records which has not been acted upon. The Panel was concerned that police forces in England and Wales are not subject to the Public Records Acts. Neither are police force documents part of the record of local government. The effect of this is that in many cases the documentary evidence they hold is poor, and forces are under no legal obligation to retain records of national importance. Put simply, South Yorkshire Police were not required by law to retain the papers they held relating to Hillsborough. Had they destroyed those papers, the work of the Hillsborough Independent Panel would have been impossible, with the likely outcome that no new inquests would have been ordered and no police or IPCC investigation would have followed.

Point of learning 24 – Police records

In 2012, the Hillsborough Independent Panel made the following recommendation:

‘The Panel recommends that police force records are brought under legislative control and that police forces are added to Part II of the First Schedule to the Public Records Act 1958, thereby making them subject to the supervision of the Keeper of Public Records.’

This recommendation was intended to address the current legal framework, which – among other things – has the effect that police forces are under no obligation to keep records of historical interest. The recommendation has not been taken up by government.

It is a fundamental principle of accountability that public records are subject to proper rules relating to retention and inspection. Where this is missing, a key element of accountability is removed. The issue identified by the Hillsborough Independent Panel in 2012 and repeated here should now be addressed as a matter of urgency.

Since the Panel’s report was published it has been suggested to me that even if police forces were to be brought under the Public Records Act, this may not be sufficient to address the issues the Panel identified. I therefore suggest that the Home Office and the Department for Culture, Media and Sport, as the department responsible for the National Archives, work together to determine and deliver an appropriate solution to the issue. Given the changes to policing since the Panel’s report, I recognise that an approach involving police and crime commissioners may now be appropriate and desirable.

Chapter 4 – Criminal and disciplinary investigations

'The IPCC and Operation Resolve investigations might have good intentions but it's still "the police investigating the police" and this makes me suspicious and not confident.'

Gordon Baron, son of Gerard Baron

"I want you to trust me." After 23 years of lies why would I trust you? You start prosecuting police officers and I'll trust you.'

Danny Gordon, uncle of Kevin Williams

'I think the biggest frustration and the best example is with Operation Resolve and the IPCC. Their hands are tied. You come away from the meetings feeling bad sometimes because you are berating people who are trying to do their job. You get frustrated by the fact there are no laws in place to challenge the organisations... If you were a police officer in 1989, in 2014 you would still be receiving a pension. So you are still attached by duty. You should still uphold the law.'

Steve Kelly, brother of Michael Kelly

'I trust them 90%... I felt they were doing their job and getting on with the investigation... I have faith in them doing the right dutiful thing.'

A family member speaking about Operation Resolve and the IPCC

'...ordinary people, the bereaved and their supporters, forced the reinvestigations and new inquests and another group of ordinary people, the jury, righted the historic wrong. It is hardly surprising that the families should approach the other ongoing official investigations, Operation Resolve and the IPCC, with scepticism and look for substantial safeguards. Why wouldn't they?'

Submission by Pete Weatherby QC and Elkan Abrahamson, who represented 22 families at the fresh inquests

'We could express our views at the family forums. We found that helpful. As you can imagine, it is very frustrating sitting in the coroner's court and not being able to say anything – so it was helpful.'

Pat Joynes, mother of Nicholas Joynes

'The two ambulance officers... who walked past Pen 4 saw Nicholas was having problems in the crush. The young one mentioned that he had seen people dying in the crush. The older one said "Leave it and wait – I will only involve myself if a senior person tells me to do so"... I want to see the two people who could have helped Nicholas brought to justice – not the young one but the senior one. He should be brought to trial.'

Peter Joynes, father of Nicholas Joynes

'You cannot have 96 unlawfully killed and no one held accountable for it.'

Jenni Hicks, mother of Sarah and Victoria Hicks

The initial criminal and disciplinary investigations into the Hillsborough disaster

4.1 Chapter 1 of this report discusses the experience of bereaved families in the aftermath of the Hillsborough disaster. It includes discussion of families' early experiences of the criminal investigation into Hillsborough, which began on the day of the disaster and which concluded with a decision made in August 1990 by the Director of Public Prosecutions not to prosecute. As is set out in chapter 1, this first criminal investigation was initiated by South Yorkshire Police before being taken over by West Midlands Police as an independent force.

4.2 A police disciplinary investigation also took place at the time of the disaster. In July 1991, the Police Complaints Authority (the forerunner of the Independent Police Complaints Commission, or IPCC) directed that South Yorkshire Police bring disciplinary charges against Chief Superintendent David Duckenfield and Superintendent Bernard Murray. However, following David Duckenfield's retirement from South Yorkshire Police in October 1991 on medical grounds, no such charges were brought.

Operation Resolve and the Independent Police Complaints Commission

4.3 Two criminal inquiries were initiated following the publication of the Hillsborough Independent Panel's report in 2012, one by the Independent Police Complaints Commission (IPCC) and the other by a police investigation called Operation Resolve.

4.4 Operation Resolve's main role has been to investigate the deaths caused by the Hillsborough disaster, while the IPCC's principal work has been to investigate the disaster's aftermath. Neither the IPCC nor Operation Resolve have employed officers or former officers with any prior connection to the Hillsborough disaster, or who have worked in West Midlands, South Yorkshire, West Yorkshire or Merseyside police forces.

4.5 The themes which came through most strongly in my conversations with families about the IPCC and Operation Resolve were trust and the need for accountability. For example:

'The campaign was "Justice For The 96". We have had the truth. We now need accountability – only then will we have true justice.'

Deanna Matthews, niece of Brian Matthews

'Without accountability the families can't be set free.'

Christine Burke, daughter of Henry Burke

'Now that they have been found unlawfully killed I owe it to my daughters to get accountability, otherwise it would have been better never to have had the unlawful killing outcome. You can't have an unlawfully killed verdict without accountability.'

Jenni Hicks, mother of Sarah and Victoria Hicks

'How can we have any faith or trust in the IPCC when a significant number of staff are ex-police?'

Becky Shah, daughter of Inger Shah

'You can only have reconciliation once you've had truth and accountability.'

Trevor Hicks, father of Sarah and Victoria Hicks

'The IPCC and Operation Resolve investigations might have good intentions but it's still "the police investigating the police" and this makes me suspicious and not confident.'

Gordon Baron, son of Gerard Baron

'The hard part was done for Operation Resolve and the IPCC by others – the investigation teams had it handed to them.'

Deanna Matthews, niece of Brian Matthews

'I wouldn't trust the IPCC as far as I could throw them.'

Barry Devonside, father of Christopher Devonside

'We have no confidence in the IPCC.'

A family member

4.6 Families told me that part of their scepticism or lack of trust came from what they saw as the history of having been let down by the police and other public authorities, but particular personal interactions with the investigations also contributed. Families spoke of staff from Operation Resolve visiting family homes unannounced and uninvited, of inappropriate and insensitive comments being made by investigation staff while briefing families on video evidence from the day of the disaster and of mistakes made in the identification of those who died from that video material. Each of these incidents caused great distress to the families involved. For example:

'I went to Operation Resolve to view video material from the pens. [The member of staff from Operation Resolve] said "Well, what do you see?" You are already on edge. I was looking for Pete. And I said, "I am looking". He said "There he is, on the stretcher. Look – going, going, gone. They have dropped him". He said, "I will show you again", and they showed it again and he said exactly the same thing again. There were two or three other officers and they took us to one side and asked us if we wanted to make a complaint about his conduct. A complete lack of sympathy. I was devastated.'

Anne Burkett, mother of Peter Burkett

'There was a lot of photos and footage of Andy on the day. During the inquests my solicitor had to fight to get a photo timed at 15:09 put into his compilation as the coroner's team said they didn't have time to put it in. My solicitor was so outraged by this, she worked late and she did the work for them. In the photo timed at 15:09 you can clearly see Andy at the front of Pen 3 and alive. However, the Coroners Pathologist stated he couldn't be certain and said the photo timed at 15:03 was the last time he could be certain Andy was alive. I disputed this. A few months after the inquests had finished I was contacted by my solicitor to say Op Resolve had found another 16 photos of Andy. One was timed at 15:10. Again, you can clearly see Andy is alive. These photos were more horrific than the ones shown during Andy's inquest. I believe these 16 new photos found after the inquests were available during the inquests. If Op Resolve were doing their jobs properly then how did they miss these 16 photos? These new photos of Andy stood in exactly the same place as in all the other photos and timed within seconds and minutes of the ones shown at Andy's inquest.'

Louise Brookes, sister of Andrew Mark Brookes

4.7 The particular limitations on the legal powers of the investigations – especially those of the IPCC – also played a part in the families' concerns. Families were concerned that serving police officers might retire in order to avoid misconduct charges, and there was frustration

that serving and retired police officers could refuse to answer questions put to them. For example, I was told:

‘Something should be put in place to stop police officers using the same lies all over and over again.’

Deanna Matthews, niece of Brian Matthews

4.8 Some families also praised aspects of the investigations, with many commenting positively on the efforts of the video investigation and family liaison teams to establish the movements of their loved ones. A submission to this report from Marcia Willis-Stewart of Birnberg Peirce, who at the inquest represented families who were members of the Hillsborough Family Support Group, for example, described the investigations as maintaining ‘a respectful and in general helpful relationship with the families’.

The Hillsborough Article 2 Reference Group

4.9 The Hillsborough Article 2 Reference Group was first announced in a written statement to Parliament made by the then Home Secretary Theresa May on 19 December 2012. It was described originally as an ‘independent challenge panel’ whose role was to inform and advise Operation Resolve, the IPCC and CPS. Following the decision by the Sir John Goldring to use Operation Resolve and the IPCC as investigators for the fresh inquests, the work of the reference group was held in abeyance in order that it did not impinge on the independence of that judicial process.

4.10 Under updated terms of reference, the reference group’s work began in earnest following the conclusion of the inquest in April 2016. Its members are criminologist Dr Silvia Casale and barrister Tim Owen QC, and the group is advised by former Lord Justice of Appeal Sir Stephen Sedley. As the group’s terms of reference put it, its purpose is ‘to give practical effect to the obligation arising under Article 2 of the European Convention of Human Rights [the right to life] to involve the Hillsborough families and survivors in the investigative procedure to the extent necessary to safeguard their legitimate interests’. The reference group achieves this by monitoring and advising on aspects of the investigatory processes, by its ability to access any material held by the investigations other than that precluded by law or confidentiality, and by raising issues with the investigations that have been raised with the reference group by bereaved families in writing. The work of the reference group does not affect the independence of the investigations or the role of the CPS.

4.11 Fewer families spoke to us about the Article 2 Reference Group than the Family Forums, perhaps reflecting the fact that the reference group conducts itself principally through correspondence with the families’ lawyers rather than family facing meetings. Family lawyers were generally positive, while noting frustration about the lack of direct communication between the reference group and the families. For example:

‘The Hillsborough Article 2 Reference Group (HA2RG) was proposed by the families and is now operational. It allows for scrutiny of the investigations without compromising their independence. Crucially it provides a means by which the families can get their concerns regarding the criminal investigations properly raised. The HA2RG provides an extra layer through which the families can have appropriate involvement in those ongoing investigations and ultimately the Group will be able to report on the efficacy and integrity of the investigations which should serve as a salutary reminder to the investigators that they must do their duties effectively.’

Submission by Pete Weatherby QC and Elkan Abrahamson, who represented 22 families at the fresh inquests

'The families welcome the appointment of the oversight body HA2RG, but were frustrated by the lack of direct communication...'

Marcia Willis-Stewart of Birnberg Peirce Ltd, who at the inquest represented families who were members of the Hillsborough Family Support Group

4.12 Those families who did raise the reference group were generally positive about its role in maintaining trust in the investigations. For example, I was told:

'Although I receive regular updates, understandably I remain very very sceptical and cautious regarding the current investigations being carried out by Operation Resolve and the IPCC, although I am comfortable in the knowledge that this is being monitored by the Article 2 Reference Group, through which we can voice our concerns.'

Gerard Baron Jnr, son of Gerard Baron

The Family Forums

4.13 In 2013, recognising there was a need for families to be able to probe and ask questions of Operation Resolve, the IPCC and CPS, I suggested the idea of Family Forums – building upon the family meetings that had previously been held on an ad hoc basis during the lifetime of the Hillsborough Independent Panel and following the publication of its Report. The intention was to provide an opportunity for an exchange between families and the investigation teams regarding the progress of investigations, as well as to facilitate understanding of the processes and to aid public confidence. As the Family Forums' terms of reference state, 'The aim of the Hillsborough Family Forums is to provide clarification for the families on progress of further investigations by the IPCC and Operation Resolve while ensuring that the integrity of the ongoing criminal investigations is not in any way prejudiced'.

4.14 The first Family Forum discussions took place on 14 November 2013 with 15 further meetings having taken place at the time of writing. Members of both the Hillsborough Family Support Group and the Hillsborough Justice Campaign have attended separate Family Forum meetings and around 40 to 50 family members have attended on a regular basis. Senior representatives of Operation Resolve, the IPCC and CPS have attended all forum meetings.

4.15 Families expressed to me a range of views about the Family Forums, including disappointment about some of the answers which have been given by the IPCC and Operation Resolve to questions they had asked. A number of families praised the value of having somewhere they could express themselves and be listened to, especially when they were under instruction not to show emotion publicly at the fresh inquests. I was told:

'Another good idea and the principle is spot on.'

Trevor Hicks, father of Sarah and Victoria Hicks

'The Family Forums meant that the investigators knew that it wasn't going away.'

Danny Gordon, uncle of Kevin Williams

'They were a waste of time. We went but didn't get anything out of them – there was no point going. They didn't tell the families anything.'

Lynsey Barker, daughter of Eric Hankin

4.16 Families also spoke about the way in which representatives of the IPCC and Operation Resolve conducted themselves in the Forums. Charlotte Hennessy, daughter of James

Hennessy, said that she thought that representatives had been ‘defensive’, ‘patronising’ and ‘rude’. Danny Gordon, uncle of Kevin Williams, told me that:

‘I felt intimidated by all the police in the room. They knew and referred to the families by their first names – it was very creepy.’

4.17 In learning the lessons from this report, the IPCC and Operation Resolve should understand that it is easy to express things in a way which, for people with personal experience of tragedy, is patronising. This could be addressed in the training given to those employees whose roles involve engaging with family members.

4.18 In producing this report I received a joint written contribution from Operation Resolve, the IPCC, and the CPS. In respect of the Family Forums, the contribution reads:

‘[The Forums]... are very much in the spirit of Article 2 of the European Convention of Human Rights.

Each forum operates to a formal agenda which is drawn up in consultation with the families. Families can identify any issues that they would like to discuss in addition to the formal updates given by the IPCC, Operation Resolve and the CPS. They have provided an opportunity for the organisations to update the families on the investigations, explain the process and impart information about what they doing and they have provided the families with the chance to ask questions, express concerns and challenge the IPCC, Operation Resolve and the CPS.

From the outset, all parties were agreed that there should be no discussion which might potentially prejudice any criminal proceedings should there be any and they have operated in such a way that they did not impinge on the inquest. This has been paramount and has been strictly adhered to...

We cannot and would not purport to speak for the families who will no doubt provide their own views about the values of the Forums, however from a CPS, IPCC and Operation Resolve perspective, they have been invaluable. They have provided an effective way of not only giving effect to the spirit of Article 2 and complying with the obligations of the Victims Code, but to engage with a large number of families in an open and transparent way. The independent chair has provided space for the discussion as well as challenge to the organisations which is welcomed.

The meetings have been challenging and emotional at times and undoubtedly there have been times when the families have been frustrated by the information that they have been given or the lack of it. The seemingly slow progress due to the immense task that was being undertaken and to need to do so comprehensively and properly has no doubt taken its toll particularly given the history. It has not always been easy particularly when issues have been raised to which we have not had the answer or when we have been unable to share the information requested.’

Have the lessons been learned from the Hillsborough families’ experience?

4.19 There are significant differences between the families’ experiences of the original criminal and disciplinary investigations and those currently ongoing. This in part reflects the fact that the processes, structures and institutions in place in respect of police complaints and discipline have changed considerably since 1989, and continue to change.

4.20 The Police Reform Act 2002 abolished the Police Complaints Authority (PCA) and established the Independent Police Complaints Commission (IPCC). Unlike the PCA, the IPCC has the power to conduct its own independent investigations, in addition to supervising investigations undertaken by the police. Following a decision taken in the aftermath of the Hillsborough Independent Panel report to enhance the IPCC, the number of cases it investigates independently has increased fivefold, from 109 cases initiated in 2013/14 to 519 in 2015/16. That number is intended to continue to grow to over 1,000 per year.

4.21 Earlier this year the Policing and Crime Act 2017 was given Royal Assent. The Act aims to further strengthen the independence and powers of the IPCC, which is to be renamed 'The Independent Office for Police Conduct' (IOPC). Among the new powers granted to the IOPC by the Act is the ability to investigate complaints made by whistle-blowers independently. The IOPC will also have a duty to protect the identity of the whistle-blower.

4.22 Since the report of the Hillsborough Independent Panel was published, the police disciplinary system has also been reformed. Since May 2015 police misconduct hearings have been held in public, and they are now chaired by independent, legally-qualified people. In terms of the impact of these changes, the Home Office submitted to me that:

'Not only has this brought policing into line with other professions but it has also addressed long-standing concerns about the ability of the police to effectively police themselves. We are already seeing the effect of this independent decision-making in the decisions that are made and through the increased qualified scrutiny on policing investigations and the handling of allegations by professional standards departments.'

4.23 The Policing and Crime Act 2017 will also, for the first time, allow disciplinary proceedings into gross misconduct to continue to a conclusion even if the officer in question leaves the police force while proceedings are ongoing. This issue has long been a concern of the bereaved Hillsborough families as well as a matter of public concern more widely.

4.24 The reform will also mean that where an allegation comes to the attention of a force soon after an officer has resigned or retired that could have led to dismissal, this will be investigated and, where there is a case to answer, a disciplinary hearing can take place. In exceptional circumstances relating to the most serious acts of wrongdoing, the Act will also allow disciplinary proceedings to be brought regardless of how long after a person's resignation or retirement the matters in question come to light. According to the Home Office's submission to me, these changes, coupled with the introduction of a new 'Police Barred List' analogous to being struck off from medicine, 'have dramatically increased the level of accountability and the confidence the public can have that police officers who have committed serious wrongdoing can be held to account'.

Points of learning

4.25 The particular point of learning I have drawn from this chapter is set out below. This is in addition my proposal for a duty of candour for the police, as discussed in chapter 2.

Point of learning 25 – Police complaints and discipline

Policy and practice in respect of police complaints and disciplinary proceedings have been reformed substantially – largely in response to public concern following the publication of the Hillsborough Independent Panel’s report in 2012. I welcome those changes but recognise that is too early to assess their effectiveness.

The fresh criminal and disciplinary investigations have been very significant in scale. They represent the largest homicide investigation in British history, as well as the largest investigation ever conducted by the IPCC. Once the investigations and any prosecutions which flow from them are concluded, they should be the subject of a lessons learned exercise. This exercise could be led by the College of Policing, working with Operation Resolve and the IPCC, and with the involvement of the bereaved Hillsborough families. This exercise should consider the effectiveness of the Family Forums and the Article 2 Reference Group as well as the administration and performance of the investigations themselves. In doing so, it should consider whether similar mechanisms would be of use as part of the investigation into future major incidents.

Chapter 5 – Points of learning

This section provides a consolidated list of every point of learning identified by this report.

Point of learning 1 – Charter for Families Bereaved through Public Tragedy

The experience of the Hillsborough families of ‘the patronising disposition of unaccountable power’ calls for a substantial change in the culture of public bodies. To help bring about that cultural change, I propose a Charter for Families Bereaved through Public Tragedy – a charter inspired by the experience of the Hillsborough families and made up of a series of commitments to change – each related to transparency and acting in the public interest. I encourage leaders of all public bodies to make a commitment to cultural change by publicly signing up to the charter.

In signing up to the charter, leaders of public bodies should put in place a plan to deliver the particular changes needed within their organisation to make the behaviours described in the charter a reality in practice. They should also make a commitment to review progress against that plan on a regular basis. When an organisation has signed up to the charter, it should declare this fact publicly.

I welcome the government’s commitment, made in the Conservative Party manifesto, to create an independent public advocate to act for bereaved families after a public disaster. Once a public advocate has been appointed, I offer the charter to them as a benchmark against which they may assess the way in which public bodies treat those bereaved by public tragedy. The text of the charter is as follows:

Charter for Families Bereaved through Public Tragedy

In adopting this charter I commit to ensuring that [this public body] learns the lessons of the Hillsborough disaster and its aftermath, so that the perspective of the bereaved families is not lost.

I commit to [this public body] becoming an organisation which strives to:

1. In the event of a public tragedy, activate its emergency plan and deploy its resources to rescue victims, to support the bereaved and to protect the vulnerable.
2. Place the public interest above our own reputation.
3. Approach forms of public scrutiny – including public inquiries and inquests – with candour, in an open, honest and transparent way, making full disclosure of relevant documents, material and facts. Our objective is to assist the search for the truth. We accept that we should learn from the findings of external scrutiny and from past mistakes.
4. Avoid seeking to defend the indefensible or to dismiss or disparage those who may have suffered where we have fallen short.
5. Ensure all members of staff treat members of the public and each other with mutual respect and with courtesy. Where we fall short, we should apologise straightforwardly and genuinely.
6. Recognise that we are accountable and open to challenge. We will ensure that processes are in place to allow the public to hold us to account for the work we do and for the way in which we do it. We do not knowingly mislead the public or the media.

Point of learning 2 – Reappraisal of the treatment of families following a major incident

The experience of the Hillsborough families as set out in chapter 1 identifies specific failures in the response to the disaster in 1989. The material in that chapter presents an opportunity for police forces, the College of Policing, coroners and the Chief Coroner to undertake an honest self-appraisal of their own policies, practice and state of readiness for responding to a major incident in the present day – in particular in respect of the treatment of families. The instinctive position of such organisations may be to say ‘It couldn’t happen now’, and it is true that practice has undoubtedly come a long way. But relevant organisations should use this report in order to engage in the critical self-reflection that can ensure that the perspective of the Hillsborough families is not lost. In particular, relevant organisations should ensure that the specific experience of families being asked to identify loved ones through the viewing of scores of unsorted photographs of those who have died is never repeated. In addition, the importance of treating families with respect cannot be overstated.

Point of learning 3 – Interviewing family members, especially minors, after public tragedy

The Hillsborough families' experience demonstrates the need for the bereaved family and friends of those who have died to be questioned only as absolutely necessary in the immediate aftermath of a major incident. Minors should not be questioned in the absence of family or an appropriate adult. In presenting this point of learning, I accept that in some instances there may be an immediate need to conduct interviews with bereaved families – for example, to prevent further loss of life, or in cases where for other reasons it is operationally necessary.

In addition, regardless of the timing of such an interview, the experience of the Hillsborough families demonstrates that how family members are interviewed can make all the difference to that family's experience. As this report shows, 28 years later, the way in which interviews of Hillsborough families were conducted has scarred many deeply.

The College of Policing should ensure that the training and guidance it provides to police officers properly reflects this point of learning and the experience of Hillsborough families expressed in this report.

Point of learning 4 – Support and counselling in the aftermath of a public tragedy

The families' experience demonstrates the need for social work and other support to be made available at the earliest opportunity following a public disaster. That support should be capable of referring on bereaved families to relevant support in the area in which they live. I believe that this will be an important area of focus for the independent public advocate envisaged in the Conservative Party manifesto.

Point of learning 5 – 'Property of the coroner'

It has been submitted to me that the issue of family members being told that their loved one is the 'property of the coroner' and being prevented from seeing, touching and holding their body in part arises from a lack of clarity in law as to the rights of bereaved families. The Ministry of Justice should consider whether the law in this area is sufficiently clear and, if not, bring forward proposals in order to clarify it. In addition, the College of Policing and Chief Coroner should work together to develop clear guidance setting out the rights of bereaved families in terms of access to their loved one's body, along with best practice on how best to give effect to those rights. Organisations who assist the bereaved, such as INQUEST, police forces, social services departments and counselling organisations should be involved in the development of such guidance.

The guidance should make it clear that the suggestion that the body of someone who has died is the 'property of the coroner' is wrong and that use of the term should be eliminated. The guidance should also emphasise the importance of families having physical access to the body of their loved one rather than being restricted to viewing through a glass window. The guidance should also include information on the arrangements which can be made to ensure that forensic evidence is not compromised and how best to properly and sensitively explain this to families.

Point of learning 6 – Hillsborough, the ‘touchstone’

On police ethics and ethos, I would echo the words of Theresa May, who as Home Secretary told the 2016 Police Federation Conference to:

‘Remember Hillsborough. Let it be a touchstone for everything you do. Never forget that those who died in that disaster or the 27 years of hurt endured by their families and loved ones. Let the hostility, the obfuscation and the attempts to blame the fans serve as a reminder of the need for change. Make sure your institutions, whose job it is to protect the public, never again fail to put the public first. And put professionalism and integrity at the heart of every decision, every interaction, and every dealing with the public you have.’

I support the police Code of Ethics and its continuing development, as well as the ongoing work to embed it within all aspects of policing. The Code must not be treated as a box that has been ticked – it instead requires an ongoing commitment to cultural change.

As a further point of learning, building on the then Home Secretary’s 2016 speech and the work already undertaken by the College of Policing and others, I believe that the Hillsborough families’ experiences demonstrate that empathy and integrity should be considered as central to both recruitment and professional development.

Point of learning 7 – Media ethics and training

Bereaved families told me that they felt degraded by much of the press coverage of the Hillsborough disaster, as well as harassed by individual journalists and press photographers. Both of these aspects of the media’s behaviour undoubtedly caused great distress.

One family member described their feelings succinctly in the following way:

‘We felt we were treated like scum.’

Brenda Fox, mother of Steven Fox

Both the Independent Press Standards Organisation (IPSO) and the Independent Monitor for the Press (IMPRESS) have developed codes of practice which – if they were adhered to – should prevent other families from suffering the harassment and invasions of privacy faced by the bereaved Hillsborough families in 1989. However, more needs to be done to ensure that this happens.

I believe that there is an important role here for the independent public advocate envisaged in the Conservative Party manifesto, and that the advocate should engage with IPSO, IMPRESS, media organisations and bereaved families to determine what further steps should be taken to ensure that those bereaved by public tragedy are treated with dignity and respect by the media. In particular, I agree with Alastair Machray, Editor of the Liverpool Echo, who made the following point in his written submission to this report. He wrote:

‘...within my industry, as far as I am aware, no one trains journalists in specific techniques for interviewing trauma victims. This would appear to be an oversight. Both victims and journalists alike may be better served if journalists have training of this nature...’

Point of learning 8 – False public narratives

As a further point of learning, the experience described in chapter 1 of this report should also act as a reminder to those organisations and individuals which are called upon to make public comments in the immediate aftermath of serious incidents that the public narrative, once established, is difficult to change. A false public narrative is an injustice in itself, and organisations and individuals should take great care in making public comments before the facts are known.

Point of learning 9 – ‘Proper participation’ of bereaved families at inquests

A fundamental point of learning from the Hillsborough families’ experiences is that the state must ensure ‘proper participation’ of bereaved families at inquests at which a public body is to be represented. This includes inquests following a disaster such as Hillsborough, but also – for example – following deaths in custody or in some cases deaths following NHS care.

There are four strands to ‘proper participation’, each of which are vital:

- I. Publicly-funded legal representation for bereaved families at inquests at which public bodies are represented.
- II. An end to public bodies spending limitless sums providing themselves with representation which surpasses that available to families.
- III. A change to the way in which public bodies approach inquests, so that they treat them not as a reputational threat, but as an opportunity to learn and as part of their obligations to those who have died and to their family.
- IV. Changes to inquest procedures and to the training of coroners, so that bereaved families are truly placed at the centre of the process.

Each strand is discussed in more depth below.

Point of learning 9 (i) – ‘Proper participation’: legal representation for bereaved families at inquests

Publicly-funded legal representation should be made available to bereaved families at inquests at which a public authority is to be legally represented. This could be achieved through amendments to the Ministry of Justice’s Lord Chancellor’s Exceptional Funding Guidance (Inquests) and should not need primary legislation. The requirement for a means test and financial contribution from the family should also be waived in these cases. Where necessary, funding for pathology or other expert evidence should also be made available.

The cost of this change should be borne by those government departments whose agencies are frequently represented at inquests – including the Home Office, Department for Health, Ministry of Justice and Ministry of Defence – based on the number of inquests which in an average year relate to each department’s areas of responsibility.

Point of learning 9 (ii) – ‘Proper participation’: legal representation for public bodies

At the fresh Hillsborough inquests, the Home Office provided money to South Yorkshire Police to fund their legal expenditure. Importantly, however, Theresa May when Home Secretary placed conditions on the funding she provided to the police in order that it could not be used to fund legal representation more advantageous than that which was available to the families under the scheme established for them. The government should learn the lesson of this approach and should identify a means by which public bodies can be reasonably and proportionately represented, but are not free to treat public money as if it were limitless in providing themselves with representation which surpasses that available to families.

Point of learning 9 (iii) – ‘Proper participation’: cultural change

The concept of an inquest as an inquisitorial process has much to recommend it, but it was not the reality of the Hillsborough inquests, and it is not the reality of other inquests in which the narrative of events is contested. I accept that a complex or contentious inquest will inevitably become adversarial to some degree, but the experiences of the Hillsborough families – and many of the other families to whom I have spoken – suggest that this has gone too far. I believe that the point of learning to be drawn from this is that a cultural change is needed in order to tackle the increasingly adversarial nature of many inquests – and to instead imbed a culture of openness and lesson learning.

To bring about this change, and in addition to my proposed charter, I recommend that relevant Secretaries of State should make clear to the public bodies for which they are responsible:

- That they expect public bodies to approach inquests in an open, honest and transparent way – and that defensive and adversarial strategies, or the vilification of the deceased or their families, are not appropriate.
- That public bodies should approach the disclosure of relevant material in an open and timely manner prior to inquest proceedings, and should not unreasonably seek to limit an inquest’s scope or prevent the summoning of a jury.
- That public bodies should approach inquests as an opportunity to learn. As a matter of principle, public bodies should not argue against coroners producing Prevention of Future Deaths reports, as frequently happens at present.
- That relevant public sector inspectorates should make use of reports on the Prevention of Future Deaths in their inspection regimes.
- That they will hold public bodies’ senior personnel – NHS Chief Executives, Chief Constables, Prison Governors and so on – accountable for the way in which their organisation acts at inquests.

In addition, the highly adversarial behaviour of some lawyers employed by public bodies suggests that additional training may be required for solicitors and barristers working in the inquest system. The Chief Coroner and Ministry of Justice should work with the relevant professional bodies for the legal profession to review whether the current level of training as to the proper way for legal representatives to approach inquisitorial – as opposed to adversarial – proceedings is adequate. If it is not, it should be improved.

Point of learning 9 (iv) – ‘Proper participation’: inquest processes and training for coroners

The use of pen portraits at the fresh Hillsborough inquests helped to put the families at the heart of proceedings. The process was vital in humanising the inquests and was both important and therapeutic for the bereaved families. In my view, the use of pen portraits is an important point of learning and the Chief Coroner should ensure that families are offered the opportunity to read a pen portrait of their loved one into proceedings at all inquests. In addition, at the recent inquests, a photograph of the family’s loved one was shown while the pen portrait was being read... Allowing a photograph to be displayed is an important part of putting the family at the centre of an inquest and I can see no proper reason why a coroner should seek to prevent it. The Chief Coroner should ensure that the practice of allowing a photograph to be shown is widely adopted.

At the fresh Hillsborough inquests, lawyers acting on behalf of the families proposed the use of position statements – suggesting that the Coroner require a statement to be made by each interested person as to the stance they intended to take during proceedings. The Coroner at the fresh inquests, Sir John Goldring, declined to require the production of position statements in this instance. Nonetheless, I believe that the Chief Coroner and Ministry of Justice should consider whether the use of position statements – particularly in contested or complex inquests – has the potential to make the inquest process more efficient, for example in determining which witnesses need to be called, as well as more transparent. In drawing attention to this point of learning, I caution however against the use of position statements to unduly restrict the numbers of witnesses called, since hearing the explanations and where appropriate the apologies of witnesses is crucial to those who have suffered the loss of a loved one.

The Chief Coroner should also consider the creation of an Inquest Rule Committee, or advisory committee, to provide him with ongoing advice to ensure that inquest rules remain up to date and fit for purpose. The committee should draw on the experience of the rule committees in place for civil and criminal procedure, and bring together a range of experience – including legal representatives with experience of working for bereaved families. More generally, I believe there is scope for the Chief Coroner to make arrangements to hear from a wider range of stakeholders – including bereaved families – in the normal course of his work.

One issue which became highly contentious at the recent inquests was the question of whether previous admissions and apologies made by public bodies should have been put before the jury. There are clearly complex legal issues engaged by this debate, and I therefore recommend that the Chief Coroner considers this issue in detail and issues guidance on the matter in due course.

The Chief Coroner and Ministry of Justice have already done a great deal to improve the recruitment and training of coroners, but more needs to be done. In addition to the ongoing programme of training already planned or in place, I suggest:

- The Chief Coroner should make it clear that it is part of a coroner’s role to place the bereaved family at the centre of proceedings. As a practical example, coroners should not describe an inquiry into the death of a family’s loved one as ‘my inquest’.
- Training should also make it clear that coroners have a responsibility to ensure that family members are treated at all times with respect and dignity. Coroners should be trained to

intervene to protect family members from unfair and hostile questioning. A similar robust line should be adopted by coroners in response to attempts by legal representatives to disparage the deceased.

- Bereaved families with experience of inquests, including Hillsborough families, should be invited to contribute to the training given to coroners. They have a vital perspective to share. Lawyers with experience of representing families should also be invited to contribute.
- Finally, the Chief Coroner is due to publish guidance on the issue of disclosure. I believe that he should develop this guidance in consultation with legal practitioners, relevant charities and other stakeholders. The guidance should emphasise the importance of full disclosure by interested persons in good time prior to inquest proceedings, as well as recommending that coroners take a comprehensive approach to onward disclosure to bereaved families. In addition to the publication of effective guidance, I would support amendment of the current coroner's rules to extend a coroner's duty to disclose to families all documents 'potentially relevant to the inquest'. Currently, a higher bar of 'relevant to the inquest' is set, meaning that families and their lawyers are prevented from seeing documents to make their own assessment and submissions about possible relevance. The Hillsborough inquests demonstrate the importance of maximum possible disclosure.

Point of learning 10 – Evaluating coroners' performance

The absence of a coroners' service inspectorate creates the risk that a lack of clarity about current performance acts as a barrier to improvement. Since there are, I understand, no plans to create a relevant inspectorate, I suggest that the Chief Coroner explores alternative mechanisms for allowing coroners' performance to be evaluated and for the relevant performance data to be made public.

At a basic level, this should include the use of standardised feedback forms for interested persons and juries at inquests, the results of which could be simply and inexpensively collated and the headline data published on the Chief Coroner's website. The Chief Coroner should then draw on this data in developing training and guidance, as well as in identifying local performance issues and national strengths and weaknesses.

Point of learning 11 – Learning the lessons from an inquest

An inquest should be an opportunity to learn the lessons of a death in order to help the living. A key tool for achieving this should be through the coroner's power to issue Prevention of Future Deaths (PFD) reports.

I have been told by the legal representatives of the families that PFD reports are currently under-utilised and that practice among coroners as to the circumstances in which they make PFD reports varies considerably. Distribution of PFD reports is too limited. There is no follow up to ensure that an organisation's response to the issues identified in a PFD report is adequate. The Chief Coroner publishes the reports but does not have the resources to spot widespread or thematic issues and to draw attention to them.

Point of learning 12 – Applications to the Attorney General

Utilising the legal routes available in the absence of an appeal process, Anne Williams, mother of Kevin Williams, made three Section 13 applications to the Attorney General asking him to apply to the High Court for the original inquests to be quashed. Each application failed. Anne Williams' applications to the Attorney General were based on medical analysis of a similar nature to that undertaken by the Hillsborough Independent Panel. As is set out elsewhere in this report, the Panel's analysis ultimately did lead to the Attorney General making an application to the High Court for new inquests. In order that the Hillsborough families' perspective is not lost, and to understand whether changes are needed, I believe that the Attorney General's Office should review its processes for consideration of Section 13 applications to ensure that they are fit for purpose.

Point of learning 13 – The 'Hillsborough Law'

A great deal of excellent work has gone into producing the draft Public Authority Accountability Bill, or 'Hillsborough Law'. I agree with the Bill's aims and with the diagnosis of a culture of institutional defensiveness which underpins it. I have drawn heavily on the Bill's principles in the drafting of the charter and in my proposals for 'proper participation' for bereaved families at inquests... I agree with the view that while legislation isn't the answer to creating a culture of honesty and candour, it is part of the answer. My proposal for a duty of candour for police officers, set out in point of learning 14 is made on the basis that it represents the clearest and best next step in putting the statutory duty of candour into place.

The Bill proposes amendments to a complex and changing area of law. In particular, the Law Commission's detailed work aimed at reforming the offence of Misconduct in Public Office is – at the time of writing – ongoing. Once the Law Commission's work is complete, and Government has agreed the detail of the reform the Commission sets out, full consideration should be given by government to the Public Authority Accountability Bill.

Point of learning 14 – A duty of candour for police officers

One specific element of the Public Authority Accountability Bill is a proposed 'duty of candour' for all public officials. Such a duty has already been introduced in the NHS, following Sir Robert Francis' inquiry into Mid-Staffordshire NHS Foundation Trust. In my view, the Hillsborough families' experiences make the case that the next extension of the duty of candour should be in respect of police officers. Just as the NHS duty of candour is tailored to healthcare, so the police duty of candour should recognise the particular issues facing policing.

As a minimum, the duty of candour should require police officers – serving or retired – to cooperate fully with investigations undertaken by the Independent Police Complaints Commission or its successor body, the Independent Office for Police Conduct. But there is also scope for a wider duty of candour in respect of policing.

In a Guardian article published in May 2016 (Accept blame, then learn from it: this should be a police credo) Sara Thornton, Chair of the National Police Chiefs' Council, wrote that:

'The Hillsborough inquest verdict raises the gravest concerns about the leadership culture in policing. While many officers will argue that 1989 was long before they joined the service and some will argue that everything is different now, I do not think we can ignore the central issue of a culture that can be defensive and closed – a culture that struggles to learn from failure.'

Hillsborough was not unique. Despite all our efforts to run a service in which our officers and staff behave honestly and ethically, the tendency to avoid straight answers at best, and to hide the truth at worst, can still be a problem for us.'

Having made this powerful admission, Sara Thornton suggested that a duty of candour for police officers might form part of the remedy. She wrote:

'We will learn from other professions and consider a police service duty of candour. We will listen to our staff to ensure they feel able to challenge their leaders and colleagues when they are behaving unethically. No one wants to protect bad cops, but we cannot have officers fearful that if they do tell the truth, they will become that single point of blame.'

I commend this commitment to explore how a wide ranging police duty of candour would operate, and encourage the Home Office, National Police Chiefs' Council and the College of Policing to work together to publish detailed proposals.

Point of learning 15 – Pathology failures at the first inquests

It is difficult to overstate the impact of the failures of pathology at the first inquest. The impact is deeply personal for those families who feel they will now never know how their loved one died, but it also has a wider resonance – leading as it did to the necessity for new inquest proceedings 25 years after the disaster occurred.

Given that impact, that there should be proper consideration of the potential for learning from the failings of the pathology evidence to the original inquests. A review should be commissioned by the Pathology Delivery Board, which oversees the provision of forensic pathology services in England and Wales, and delivered independently. As well as reviewing how the evidence at the first inquests came to be misleading and why, the review should also consider whether there are adequate safeguards to prevent it happening again, including clinical governance and revalidation processes that are made more difficult by the small size of the subspecialty of forensic pathology and its distinctive employment mechanism. This review should also consider whether a process of accountability is appropriate in respect of the misleading evidence presented at the original inquests. Finally, the review should consider how to embed the lessons from the Hillsborough experience in the continuous professional development training of pathologists.

Point of learning 16 – Using the medical evidence from the fresh inquests

It has been submitted to me that the medical evidence presented at the fresh inquests may make a useful contribution to the content of additional training for police officers, prison staff and others whose job can involve the restraint of others – in particular in order to reduce the incidence of deaths and significant hypoxic injuries from restraint asphyxia. The Ministerial Board on Deaths in Custody should consider how best to ensure that the medical evidence from the recent inquests contributes to training in the prevention of restraint asphyxia, and I have written to the Council to invite it to do so.

Point of learning 17 – Pathology services in England and Wales

The government has not responded publicly to warnings about the state of pathology provision in England and Wales made in a 2015 Home Office-commissioned review conducted by Professor Peter Hutton, or to warnings made by the Chief Coroner in his 2015-2016 annual report. Both raise important concerns which government should now address.

Point of learning 18 – Toxicology and alcohol testing

I would encourage the Chief Coroner to ensure that all coroners are made aware of the experience of the Hillsborough families as set out in this report. Coroners should ensure that the decisions they make on toxicology – especially in respect of children – are made in a sensitive way, driven by necessity. Special care should be given to the way in which toxicology results are made public.

Point of learning 19 – Right to information

Families bereaved through public tragedy too often face a vacuum in respect of information about their rights and the process of an inquest. The Ministry of Justice's Guide to Coroner Services seeks to address this vacuum, but the evidence I have seen in producing this report demonstrates that more needs to be done. Families I listened to who had recent experience of inquests told me that their route to obtaining specialist advice, practical support and legal representation was often a matter of luck and word of mouth. Justice should not depend on happenstance.

In particular, I suggest that:

- Families should be informed of their rights to legal advice and representation and the availability of public funding. Families should also be told that if the death involves a public authority then it is highly likely that the organisation in question will be represented by lawyers at the inquest.
- Specialist information should be given to families where a death involves a public body - as well as in other complex cases - so that these families receive appropriate guidance rather than the usual information provided to families in respect of more routine inquests. This should include information about sources of specialist support and advice, including organisations such as INQUEST. This information should be passed immediately to the bereaved family by the coroner's office following a death involving a public body.
- All bereaved families should be given clear information immediately following death concerning the post-mortem procedure and a family's full rights under the Human Tissues Act, including the right to a second post mortem.
- The government should review the level of funding support it provides to charities such as the Coroners' Courts Support Service, whose volunteers give emotional and practical support to families and other witnesses attending inquests. It has been submitted to me that the funding granted to such support services is inadequate, meaning that the support they are able to give falls seriously short of that provided to victims and witnesses in criminal cases.

In addition, I warmly welcome the government's commitment – expressed in the recent Conservative Party manifesto – to the creation of 'an independent public advocate, who will act for bereaved families after a public disaster and support them at public inquests'. I would anticipate that a key part of the advocate's role will be ensuring that bereaved families are kept properly and fully informed at all times.

Point of learning 20 – Issuing death certificates

Families told me that they felt that the way in which death certificates were issued following the fresh inquests – with no covering letter and in some cases unexpectedly – caused great pain and distress. I accept the assurance provided to me by the Home Office's that

death certificates are in normal circumstances only issued on request, and that they should not therefore arrive unexpectedly. However, it is my view that for death certificates to be issued without the courtesy even of a short covering letter is inherently disrespectful to the deceased and to the bereaved, and that this practice should be stopped.

Point of learning 21 – Police approach to public inquiries

The response of South Yorkshire Police to criticism over Hillsborough has, over the years, included several examples of what might be described as ‘institutional defensiveness’. The force’s repeated failure to fully and unequivocally accept the findings of independent inquiries and reviews has undoubtedly caused pain to the bereaved families.

I consider that there is a point of learning here to be developed by the College of Policing. The College should consider what training and guidance is provided to senior police officers to assist them in ensuring an open and transparent approach to public inquiries and other independent investigations. This should include training and guidance on how forces can encourage its officers to accept and learn from adverse inquiry findings. There may, for example, be a role for a ‘restorative justice’ style approach, in the sense of police officers and those affected by the issue in question having an opportunity to meet to discuss how they have been affected by events and what should be done to repair the harm. In considering what training and guidance is necessary, the College should have regard to the other points of learning identified by this report – in particular those relating to the proposed Charter for Families Bereaved through Public Tragedy.

Point of learning 22 – Setting up public inquiries

The bereaved families’ experience of the various public inquiries which have taken place into Hillsborough points to a number of points of learning. In particular:

- The Hillsborough Independent Panel demonstrates that formal inquiries under the Inquiries Act 2005 are not the only option available to government when it is considering external public scrutiny. A number of investigative Panels have since been set up by government and the panel model is likely to be suitable for the scrutiny of other issues of public concern in the future. In order that the panel model is applied appropriately and successfully, we believe that the time has come to evaluate the various panels created to date in order to establish criteria for the model’s future use.
- Chairs and secretaries to public inquiries and other forms of independent scrutiny should give careful consideration to the pain, stress and emotional damage that such processes can cause bereaved families – even in cases where they ultimately consider the result of the inquiry to be positive – and should ensure that adequate support for family members is put in place.

Point of learning 23 – Home Office approach to historic inquiries

It is not within my terms of reference to comment on calls for a public inquiry into Orgreave or other historic issues involving the police.

Elsewhere in this report I suggest that the Attorney General’s Office should review its processes for consideration of Section 13 applications for inquests to be quashed, to ensure those processes are fit for purpose. In my view, the Home Office should also consider whether it has appropriate systems in place to ensure that it is able to make informed and transparent decisions in respect of requests for public inquiries or other forms of independent scrutiny of matters of public concern.

I also agree with David Conn, who wrote in his submission to this report that the Home Office should also set out publicly ‘what its policy is on historic inquiries into police malpractice and other injustice, and consider a principled policy of intervention to help people who might find themselves in a similar terrible situation as that of the Hillsborough families’. In doing so, the Home Office should have regard to one of the lessons of the Stuart-Smith Scrutiny: that if it is to commission independent examination of an issue it should not seek to internally pre-judge the findings of that examination.

Point of learning 24 – Police records

In 2012, the Hillsborough Independent Panel made the following recommendation:

‘The Panel recommends that police force records are brought under legislative control and that police forces are added to Part II of the First Schedule to the Public Records Act 1958, thereby making them subject to the supervision of the Keeper of Public Records.’

This recommendation was intended to address the current legal framework, which – among other things – has the effect that police forces are under no obligation to keep records of historical interest. The recommendation has not been taken up by government.

It is a fundamental principle of accountability that public records are subject to proper rules relating to retention and inspection. Where this is missing, a key element of accountability is removed. The issue identified by the Hillsborough Independent Panel in 2012 and repeated here should now be addressed as a matter of urgency.

Since the Panel’s report was published it has been suggested to me that even if police forces were to be brought under the Public Records Act, this may not be sufficient to address the issues the Panel identified. I therefore suggest that the Home Office and the Department for Culture, Media and Sport, as the department responsible for the National Archives, work together to determine and deliver an appropriate solution to the issue. Given the changes to policing since the Panel’s report, I recognise that an approach involving Police and Crime Commissioners may now be appropriate and desirable.

Point of learning 25 – Police complaints and discipline

Policy and practice in respect of police complaints and disciplinary proceedings have been reformed substantially – largely in response to public concern following the publication of the Hillsborough Independent Panel’s report in 2012. I welcome those changes but recognise that it is too early to assess their effectiveness.

The fresh criminal and disciplinary investigations have been very significant in scale. They represent the largest homicide investigation in British history, as well as the largest investigation ever conducted by the Independent Police Complaints Commission. Once the investigations and any prosecutions which flow from them are concluded, they should be the subject of a lessons learned exercise. This exercise should be led by the College of Policing, working with the Crown Prosecution Service, Operation Resolve and the IPCC, and consultation with the Hillsborough families. This exercise should consider the effectiveness of the Family Forums and the Article 2 Reference Group as well as the administration and performance of the investigations themselves. In doing so, it should consider whether similar mechanisms would be of use as part of the investigation into future major incidents.

Appendix 1 – Acknowledgements

The purpose of this report is to provide an insight into the experiences of the Hillsborough families over the past 28 years since 1989 and to identify where those experiences illustrate an ongoing need for change. As the report's terms of reference put it, the aim has been:

'...to ensure that the full perspective of those most affected by the Hillsborough disaster is not lost.'

The key work of this report has been to listen to the bereaved Hillsborough families, which I have done both through group meetings and by meeting individually any family member who wished to see me. I have also invited and received written contributions from family members, including letters, journals, poetry and other personal reflections. Everything provided to me has been read and analysed. I am grateful to all those family members who have contributed to this important work.

The report's terms of reference also invited me to identify points of learning: ideas for changes to policy and practice in order to address those issues which we consider remain unresolved. To inform this aspect of my work, I have met a number of senior leaders and practitioners in the areas of policing and inquests in particular, and invited and received a number of detailed written contributions. I am grateful to all those who contributed to this report in this way, and in particular to the charity INQUEST, who arranged a number of valuable meetings with bereaved families and with relevant practitioners.

In producing this report, I have been supported by a team made up of Home Office civil servants with experience of having worked on Hillsborough related issues. Academic research support has been provided by Brett Crumley, a PhD candidate at the University of Liverpool's School of Law and Social Justice. I thank the whole team for their outstanding support.

Appendix 2 – Terms of reference

REVIEW AND REPORT OF THE HILLSBOROUGH FAMILIES' EXPERIENCES BY THE RT REV BISHOP JAMES JONES KBE TERMS OF REFERENCE (PUBLISHED 18 January 2017)

96 men, women and children died as a result of injuries suffered at the FA Cup semi-final at Hillsborough stadium on 15 April 1989. This disaster was a personal tragedy for hundreds of people and an event of major national and international significance. It was the worst disaster in British sporting history. In December 2012, following the publication of the Hillsborough Independent Panel report in September 2012, the High Court quashed the original inquest verdicts. It ordered fresh inquests, which opened in Warrington on 31 March 2014 and concluded on 26 April 2016. The jury decided that the 96 Liverpool supporters who died as a result of the crushing were unlawfully killed which replaced the verdicts of the original inquests.

The then Home Secretary, the Rt Hon Theresa May MP, in her oral statement to the House of Commons on 27 April 2016 announced that she had asked the Rt Rev Bishop James Jones, the former Bishop of Liverpool and Chair of the Hillsborough Independent Panel, to produce a report on the Hillsborough families' experiences. The then Home Secretary said:

'I am keen that we understand and learn from the families' experiences. I have therefore asked Bishop James, who is my adviser on Hillsborough, to write a report which draws on these experiences. This report will be published in due course to ensure that the full perspective of those most affected by the Hillsborough disaster is not lost.'

The remit of the Review and Report will be primarily to hear directly from the families about their experiences over the past 27 years. Bishop James Jones will also hear from representatives of the families and other relevant experts. He will also consider any written submissions which are submitted.

The Review and Report will cover the history of the Hillsborough families' experiences throughout the whole period, ranging from the conduct of past police investigations through their engagement with public authorities, to the current investigations.

The Report will have to be mindful not to prejudice the ongoing criminal investigations into events at Hillsborough and its aftermath which are being conducted by the Independent Police Complaints Commission and Operation Resolve.

Bishop James Jones will present his final report to the Home Secretary, including any points of learning that he may choose to highlight for the Home Secretary's consideration. The Hillsborough families will be given the opportunity to see how the report reflects their recorded experiences, ahead of publication.

It is envisaged that Bishop James Jones will complete his Review and produce his Report in spring 2017.

Appendix 3 – The Public Authority Accountability Bill

Public Authority (Accountability) Bill

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- 1 Duties on public authorities, public servants and officials and others
- 2 Code of Ethics
- 3 Offences and penalties
- 4 Assistance for bereaved persons and core participants at inquests and public inquiries
- 5 Definitions
- 6 Short title, commencement and extent

Schedule – Amendment of the Legal Aid, Sentencing and Punishment of Offenders Act 2012

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Set a requirement on public institutions, public servants and officials and on those carrying out functions on their behalf to act in the public interest and with candour and frankness; to define the public law duty on them to assist courts, official inquiries and investigations; to enable victims to enforce such duties; to create offences for the breach of certain duties; to provide funding for victims and their relatives in certain proceedings before the courts and at official inquiries and investigations; and for connected purposes.

B E IT ENACTED by the Queen's most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows:—

1 Duties on public authorities, public servants and officials and others

- (1) Public authorities and public servants and officials have a duty at all times to act within their powers—
- (a) in the public interest, and
 - (b) with transparency, candour and frankness. 5
- (2) Public authorities and public servants and officials have a duty to assist court proceedings, official inquiries and investigations—
- (a) relating to their own activities, or
 - (b) where their acts or omissions are or may be relevant.
- (3) In discharging the duty under subsection (2), public authorities and public servants and officials shall—
- (a) act with proper expedition,
 - (b) act with transparency, candour and frankness,
 - (c) act without favour to their own position,
 - (d) make full disclosure of relevant documents, material and facts, 15
 - (e) set out their position on the relevant matters at the outset of the proceedings, inquiry or investigation, and
 - (f) provide further information and clarification as ordered by a court or inquiry.

- (4) In discharging their duty under subsection (2), public authorities and public servants and officials shall have regard to the pleadings, allegations, terms of reference and parameters of the relevant proceedings, inquiry or investigation but shall not be limited by them, in particular where they hold information which might change the ambit of the said proceedings, inquiry or investigation. 5
- (5) The duties in subsections (1) and (2) shall –
- (a) be read subject to existing laws relating to privacy, data protection and national security,
 - (b) apply in a qualified way with respect to private law and non-public functions as set out in subsection (6), and 10
 - (c) not be limited by any issue of insurance indemnity.
- (6) Where a public authority, public servant or official acts in a private law matter or non-public function the duties in subsections (1) and (2) will apply except where to do so might significantly and disproportionately damage the public interest. 15
- (7) Where the exception at subsection (6) is applied, including where the justification is to limit the disclosure of commercially sensitive information and contracts, the Chief Officer or Chief Executive of the public authority must give express reasons in writing to the relevant court, inquiry, investigation or individual. 20
- (8) The duties in subsections (1) and (2) shall apply to a private entity or individual as they apply to a public authority, public servant or official where the relevant activity –
- (a) is delegated or contracted from a public authority which would otherwise be subject to this Act, or 25
 - (b) is one where the private entity or individual owes a health and safety responsibility to the public or a section of it, including but not limited to sporting, leisure and entertainment events and premises, public transport systems and the provision of utilities and retail facilities. 30
- (9) The duties in subsections (1) and (2) shall be enforceable by application to the relevant court or inquiry chairperson by any person affected by the alleged breach, or the court or inquiry may act of its own motion. Where there are no extant court or inquiry proceedings, the duties may be enforced by judicial review proceedings in the High Court. 35
- 2 Code of Ethics**
- All public authorities shall have and publish a “Code of Ethics” which –
- (a) promotes ethical behaviour, transparency and candour within all areas of the organisation and its departments,
 - (b) takes express account of “The Seven Principles of Public Life” promulgated by the 1995 Committee on Standards in Public Life, 40
 - (c) provides reasonable protection for whistleblowers, and
 - (d) provides a complaints procedure accessible to members of the public.

3 Offences and penalties

- (1) The Chief Officer or Chief Executive of a public authority commits an offence if he or she intentionally or recklessly fails to discharge his or her duty under section 1(2).
- (2) A public servant or official commits an offence if he or she intentionally or recklessly – 5
- (a) misleads the general public or media,
 - (b) misleads court proceedings or any inquiry or investigation to which the duty in section 1(2) applies, or
 - (c) impedes the discharge of the section 1(2) duty, by any act or omission, or failure to provide information by witness statement, report or otherwise. 10
- (3) A person who has previously been a public servant or official commits an offence if he or she refuses to provide, or unreasonably avoids providing – 15
- (a) a witness statement, or
 - (b) other relevant material which he or she holds
- to a court, inquiry or investigation to which section 1(2) applies, relating to his or her conduct or knowledge during the period when in such employment or office.
- (4) The duties provided for in sections 1(2), 3(1), 3(2)(c) and (3) do not apply to an individual who is a suspect in a criminal investigation so far as matters related to that investigation are concerned. 20
- (5) Where the Chief Officer or Chief Executive of a public authority is a suspect in a criminal investigation he or she must delegate the section 1(2) duty to a deputy so far as matters relating to that investigation are concerned and the provisions of this Act shall apply to the said deputy as if he or she was the Chief Officer or Chief Executive. 25
- (6) No offence pursuant to subsection (1), (2) and (3) of this section is committed by an individual to the extent that he or she reasonably asserts the privilege against self-incrimination. 30
- (7) A person guilty of an offence under subsection (1), (2) and (3) of this section shall be liable –
- (a) on summary conviction, to imprisonment for a term not exceeding 6 months, or to a fine not exceeding level 5 on the standard scale, or both; and
 - (b) on conviction on indictment, to imprisonment for a term not exceeding 2 years, or to a fine, or both. 35

4 Assistance for bereaved persons and core participants at inquests and public inquiries

- (1) *With respect to inquests and public inquiries relating to deaths or serious injuries, and where one or more public authority, or private entity whose relevant activity falls within section 1(8) above, are designated as “interested persons” (IPs) or “core participants” (CPs), bereaved IPs and CPs shall be entitled to publicly-funded legal assistance and representation at the same level or in proportion to the resources provided to the public authority or private entity, as set out in the Schedule to this Act.* 40 45

- (2) *Where a Coroner or Chair of a public inquiry determines that there has been a breach of the duty in section 1(2) by a public authority or private entity within section 1(8), he or she may order the relevant authority or entity to pay any costs occasioned by such breach.*

5 Definitions

5

- (1) In this Act—

“court proceeding” means all proceedings in criminal, civil or coronial courts, or tribunals set up pursuant to statute, with jurisdiction anywhere in the United Kingdom, or international courts or tribunals to which the United Kingdom government has given effect by statute or treaty; 10

“inquiry” means an inquiry under the Inquiries Act 2005 or an ad hoc inquiry set up by national or local government or any public authority;

“investigation” means any police or other investigation set up by a public authority or regulatory body to— 15

(a) detect and prosecute criminal and disciplinary offences,

(b) ensure compliance with professional standards, or

(c) the adequacy of the provision and delivery of public services and exercise of public functions,

and it also includes investigations under the Coroners and Justice Act 2009; 20

“private entity” means any corporation, partnership, business, or professional, or sole practitioner, or voluntary or charitable organization;

“public authority” means any national or local government department, or other organization, institution or agency engaged in functions of a public nature and the definition includes entities with a private structure but which are majority owned by public funds; and “public authority” is to be given an inclusive meaning where any dispute arises before a court; 25 30

“public servants and officials” means all those who work for or hold office under a public authority; and “public servants and officials” is to be given an inclusive meaning where any dispute arises before a court; and

“whistleblower” means a person who makes a disclosure of information which, if made by a worker, would be a qualifying disclosure pursuant to section 43B of the Employment Rights Act 1996. 35

- (2) Where any court or inquiry considers proportionality with regard to any part of this Act it must give high importance to the duties set out within sections 1(1) and 1(2). 40

6 Short title, commencement and extent

- (1) This Act may be cited as the Public Authority (Accountability) Act 2017.
- (2) The provisions of this Act come into force on Royal Assent, except for sections 2 and 4 and the Schedule, which come into force 6 months after Royal Assent.
- (3) The provisions of this Act apply with respect to any court proceedings, inquiry or investigation which commences or continues after the Act comes into force. 45

(4) This Act extends to England and Wales, Scotland and Northern Ireland.

SCHEDULE

Section 4(1)

AMENDMENT OF THE LEGAL AID, SENTENCING AND PUNISHMENT OF OFFENDERS ACT
2012

- | | | |
|---|---|----------|
| 1 | The Legal Aid, Sentencing and Punishment of Offenders Act 2012 shall be amended as follows. | 5 |
| 2 | After section 9 insert— | |
| | “9A Inquest and public inquiry into an incident or failure leading to death or serious injury | |
| | (1) Where an inquest is opened or a public inquiry announced into any incident or failure leading to the death or serious injury of a person or persons, and where one or more public authority or private entity whose relevant activity falls within section 1(8) of the Public Authority (Accountability) Act 2017, are designated as “interested persons” (IPs) pursuant to section 47 of the Coroners and Justice Act 2009, or “core participants” (CPs) pursuant to Rule 5 of the Inquiry Rules 2006, the bereaved or injured IPs and CPs shall be entitled to publicly-funded legal advice and representation. | 10 15 |
| | (2) The provision shall be at rates previously applied to CPs under section 40(4) of the Inquiries Act 2005, to be reviewed from time to time. | 20 |
| | (3) In cases falling within this section, public authority rates shall be capped at the rates referred to in subsection (2). | |
| | (4) The number, grades and seniority of legal advisers and advocates, and the number of remunerated hours allowed shall be the same or in proportion to provision made for the relevant public authority. | 25 |
| | (5) Where such provision is not the same, it may be more or less than that provided for the public authority, dependent upon the respective roles and burden of work and where provision is not the same the Director must provide a formal written determination setting out the basis for the disparity and certifying that in his or her view the level of funding is proportionate. | 30 |
| | (6) As soon as practicable after instruction by a bereaved IP or CP where subsection (1) applies, the solicitor shall notify the Director of an intention to apply for funding and within four weeks of such notification the solicitor shall make a provisional application for funding based upon instructions and disclosures made at that date. | 35 |
| | (7) Within seven days of receipt of a notification under subsection (6), the Director shall notify any relevant public authority that it must provide the funding information detailed in subsection (8), below, within four weeks. | 40 |

- (8) On receipt of a notification under subsection (7) the public authority shall, within four weeks, furnish the Director with a funding plan setting out the provision it is to make for the said proceedings, to include—
- (a) the number, 5
 - (b) grades,
 - (c) seniority of legal advisers, advocates and support staff (to include investigators and administrators), and
 - (d) the estimated number of remunerated hours that will be expended by each relevant person in the proper and reasonable preparation and representation of the case. 10
- (9) The funding plan at subsection (8) shall—
- (a) make clear where provision for legal advice and representation has been made by the public authority in connected proceedings, and the details of such provision, and 15
 - (b) be certified as being complete and that it includes all proper and reasonable provision made by the Chief Officer or Chief Executive of the public authority in relation to the case.
- (10) In a case of complexity the solicitor for the bereaved applicant or the solicitor for the public authority may agree with the Director that funding plans can be provided periodically or in stages and any such agreement shall be at the discretion of the Director and as directed by him or her. 20
- (11) Where any funding plan is amended or finalized the Director must be notified and provided with the amended plan within seven days. 25
- (12) Where a bereaved IP or CP is entitled to public funding under subsection (1), but there is no public authority IP or CP then the Director shall have regard to the funding plan of the solicitor for the bereaved applicant and the general circumstances of the case, including the level of representation by other IPs or CPs, in assessing the relevant provision under this section. 30
- (13) Where a bereaved IP or CP is entitled to public funding under subsection (1), it shall not be means-tested.
- 9B Application of section 9A in the interests of justice 35**
- The Director may apply the provisions in section 9A to other inquiries and investigations insofar as is in the interests of justice.”

Public Authority (Accountability) Bill

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To set a requirement on public institutions, public servants and officials and on those carrying out functions on their behalf to act in the public interest and with candour and frankness; to define the public law duty on them to assist courts, official inquiries and investigations; to enable victims to enforce such duties; to create offences for the breach of certain duties; to provide funding for victims and their relatives in certain proceedings before the courts and at official inquiries and investigations; and for connected purposes.

*Ordered to be brought in by Andy Burnham,
Caroline Lucas,
Alison McGovern,
Derek Twigg,
Steve Rotheram,
Maria Eagle,
Jess Phillips,
Bill Esterson,
Tim Farron,
Mark Durkan,
Sir Peter Bottomley and Chris Stephens.*

*Ordered, by The House of Commons,
to be Printed, 29 March 2017.*

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