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A Hillsborough legacy: the government's response to Bishop James Jones' report (accessible)

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A Hillsborough Legacy: the Government's response to Bishop James Jones' report to ensure the pain and suffering of the Hillsborough families is never repeated

Presented to Parliament by the Secretary of State for the Home Department by Command of His Majesty

December 2023

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Foreword

The Hillsborough disaster on Saturday 15 April 1989 was a devastating tragedy compounded by decades-long injustices. 97 people were unlawfully killed and hundreds were injured as a result of the awful events of that day. Its impact continues to be felt, most acutely by the families and friends of those who tragically lost their lives who have been forced to endure some of the most unforgivable forms of institutional obstruction and obfuscation in recent memory. This Government response sets out how we will ensure those failures will never happen again.

The report, The patronising disposition of unaccountable power,[footnote 1] produced by the Right Reverend James Jones KBE in 2017, laid bare the experiences of the Hillsborough families, both in the immediate aftermath of the disaster and in the decades since. The families had to live through the pain and distress of two sets of inquests, the Hillsborough Independent Panel, and multiple criminal proceedings over the past 34 years, and maintained their

determination and dignity throughout. We remain committed to ensuring that any victims or families bereaved through future national tragedies do not have to endure a similar experience.

Fans attending the Hillsborough stadium on 15 April 1989 bear absolutely no responsibility for the terrible events that occurred. Instead, those vested with the power to take action demonstrated inexcusable institutional defensiveness and acted only in their own self-interest. This was nowhere more evident than within the police and wider criminal justice system. As Bishop James states, change is required in 'attitude, culture, heart, and mind' by organisations and their leaders to prevent similar behaviour happening in future – and Government ministers have a responsibility to ensure organisations are held to account. Although it is clear that policing[footnote 2] and other organisations in the criminal justice system have applied some of the lessons from the Hillsborough disaster, there is evidence that some of the faults raised by Bishop James risk being repeated today.

In order to avoid prejudicing the outcomes of criminal trials, the Government held back from responding to Bishop James' findings. Nevertheless, our response has taken too long, compounding the agony of the Hillsborough families and survivors. For this we are deeply sorry. We met with some of the families in June this year to share the steps we have taken, and intend to take, in response to Bishop James' report. We were deeply moved by their personal experiences, their courage in sharing them, and their continued drive to enact change for others.

The Government is clear that those affected by the Hillsborough disaster suffered a 'double injustice'.[footnote 3] The actual event; the failure of the state to protect their loved ones and the indefensible wait for the truth, and then the injustice of the blaming of the deceased – that they were somehow at fault for their own deaths. Chapter 1 of Bishop James' report sets out the families' experiences of their treatment in the immediate aftermath of the disaster, and the false public narratives that quickly formed. We must accept responsibility for this and we must learn from it. As public servants we must place the public interest above our own reputations, and never seek to defend the indefensible when we have fallen short.

In particular, the national policing response has acknowledged that the police must learn the lessons of Hillsborough and must avoid the defensiveness and obfuscation that damaged public confidence in the police, and in other public bodies that responded to the Hillsborough disaster.

The first point of learning in Bishop James's report is a Charter for Families Bereaved Through Public Tragedy or, as it will be known, the 'Hillsborough Charter'. The Hillsborough Charter is inspired by the experiences of the Hillsborough families and is made up of a series of commitments. Bishop James has drawn on the principles underpinning draft legislation that has come to be known as the 'Hillsborough Law' in the Hillsborough Charter. The Government strongly agrees with the principles of the Hillsborough Charter and

the importance of organisations acting responsibly, honestly, and transparently following a major disaster. We have signed the Hillsborough Charter, signalling our ongoing commitment to being open to challenge and reaffirming our commitment to lasting cultural change.

The testimony of the Hillsborough families made clear how the difficulties following a major disaster are compounded by having no single person to turn to for support and advice. To change this, we are legislating in the Victims and Prisoners Bill to establish a permanent Independent Public Advocate (IPA) to support bereaved families and victims in the immediate aftermath of a major incident. We have engaged with bereaved families to design the IPA. The legislation is clear that the IPA will help victims and families to navigate the justice system in the wake of a public disaster, ensure that they know their rights, and that their needs are supported. This IPA design flows directly from the difficulties that the Hillsborough families faced and our commitment to ensure that other families do not face the same injustices.

A fundamental point of learning from the Hillsborough families is that the Government must ensure the proper participation of bereaved families at inquests and address the 'inequality of arms' between families and the State. The Hillsborough families funded their own legal representation, a single barrister, at the first inquests, and were provided with government funding at the second inquests. To address this, and to build upon the progress we have made by removing the means test for exceptional case funding, the Government will consult on expanding the provision of legal aid for inquests following public disasters where the IPA is deployed, and in the aftermath of a terrorist incident. This means that no family involved in such cases in future will ever face an inquest without proper legal representation. We will also seek to further understand the experiences of bereaved families at other inquests where the state is represented.

Importantly, this Government supports the principle, campaigned for as part of what has become known as the 'Hillsborough Law', that public bodies should not be able to spend limitless public funds on legal representation. Spend should be proportionate compared to what is available to bereaved families and should not be excessive. The Cabinet Office will therefore set out, through guidance, its expectation that central government public bodies and their sponsoring department publish their spend on legal representation at inquests and inquiries, and reaffirm that this spend should be proportionate compared to that of bereaved families and should never be excessive.

The Hillsborough families had to endure two sets of inquests before it was determined that their loved ones had been unlawfully killed. Inquests are designed to establish the facts surrounding a death and the coroner can report on concerns about the risk of future deaths. Changes to legislation introduced in 2013 mean that individuals and public bodies now face a fine or imprisonment for not complying with a requirement from the coroner to disclose information. But it is essential that public bodies engage with inquests in a way that places the search for truth ahead of their reputation, and we need to

ensure this happens in practice, to further drive the cultural change we want to see. The Cabinet Office guidance will therefore also set out the expectation that public bodies and their sponsoring departments ensure that their lawyers engage with inquests in accordance with the principles of the Hillsborough Charter, and with the protocol published in 2020[footnote 4] to guide the Government's approach when it holds interested person status at an inquest.

A further point of learning from the Hillsborough families, set out in Bishop James' report, is introducing a duty of candour for police officers. This Government agrees that openness and transparency in the police is of the utmost importance. Last month, we introduced legislation to place a statutory duty of candour on policing. Our legislation requires a Code of Practice for ethical policing which is designed to promote a culture of openness, honesty and transparency within the police. Chief Officers will be held to account for their forces' performance against the Code. This builds on legislative changes introduced in 2020 that mean that officers who fail to cooperate with inquiries, inquests or investigations could face disciplinary action and potentially dismissal. We are doing this to ensure that the culture of defensiveness and self-interest seen in the aftermath of the Hillsborough tragedy does not occur again.

Then finally, the 'Hillsborough Law' calls for, amongst other things, a duty of candour on all public bodies. It is our view that the duties and obligations that have been created since the Hillsborough disaster, combined with actions set out in this response – including signing the Hillsborough Charter, consulting on the expansion of legal aid, and placing a statutory duty of candour on the police – broadly achieves the aims and upholds the principles of what has come to be known as the 'Hillsborough Law'. However, it is paramount that we monitor how these changes embed. While legislation alone cannot ensure a culture of openness, honesty and candour, we will not rule out bringing further legislation if we think this is needed to drive further improvements.

Connected to this, and in response to issues on openness in healthcare, the Government will conduct a review into the effectiveness of the duty of candour for health and social care providers. The review will consider the application of the duty of candour for health and social care providers and its enforcement. We will publish the terms of reference for this review shortly.

We want to put on record the Government's thanks to Bishop James for his commitment and many years of work to shine a light on the experiences and suffering of the Hillsborough families, with his 2017 report, his continued support with both the ongoing forensic pathology review and family engagement, and previously as Chair of the Hillsborough Independent Panel.

Last, but most importantly, we pay tribute to the incredible strength and tireless efforts of the Hillsborough families and survivors. They have experienced over 34 years of extraordinary suffering, and obstructiveness from institutions meant to serve their interests. While nothing can ever bring back those who were lost, it is our duty to ensure that the legacy that will be left behind by the families'

untiring campaigning will help to protect others at a national level from enduring similar experiences in the future.

Rt Hon James Cleverly MP Home Secretary

Rt Hon Alex Chalk KC MP

Lord Chancellor & Secretary of State for Justice

1. Introduction

The suffering experienced by victims, survivors and bereaved families in the wake of a public disaster is almost inconceivable. But in the hours, weeks and even years that follow, the actions of those intervening on behalf of the state can make their experiences even more difficult. Those affected by such tragedies often have to contend with multiple legal and official processes around the disaster itself, as well as complex, overlapping investigations that can extend for years afterwards. Given these difficult circumstances, victims of disasters, and families bereaved by them, need exceptional care and considerable support to navigate those processes and to pursue answers for themselves and their loved ones.

Bereaved families and survivors of the Hillsborough disaster have endured over 34 years of extraordinary suffering in seeking the truth about what happened on the day of the disaster and justice for their loved ones. The Government fully recognises their pain at not only having to undergo the Taylor Inquiry,[footnote 5] two sets of inquests,[footnote 6] the Hillsborough Independent Panel,[footnote 7] and multiple criminal proceedings in that time, but also that the system failed them so badly they had to fight incredibly hard to ensure that some of those proceedings even took place. We are committed to ensuring that victims and bereaved families do not have the same experiences in the future.

After the publication of the Hillsborough Independent Panel's report in September 2012, the original inquest findings were overturned and new inquests were established which, in April 2016, resulted in the jury's majority determination of 'unlawful killing'. Following the conclusion of the second inquest the then Home Secretary, Rt Hon Theresa May MP, commissioned the Right Reverend James Jones KBE, the former Bishop of Liverpool, as her independent advisor on Hillsborough. Theresa May asked Bishop James to conduct a review to ensure that the experiences of the Hillsborough families over the years since the disaster were not forgotten, and the emerging lessons not lost.

Bishop James' resulting report, "'The patronising disposition of unaccountable power' – a report to ensure the pain and suffering of the Hillsborough families is

not repeated",[footnote 8] was published on 1 November 2017. The report details the experiences of the Hillsborough families during the aftermath of the tragedy and the lasting impact that this had on them. Bishop James drew directly from testimony by many family members, putting their perspectives at the heart of his review. The report demonstrated that the experiences of many of the Hillsborough families were reflected in the experiences of families bereaved in subsequent public tragedies. From these shared or similar experiences, he identified 25 points of learning for the Government, the police, pathologists, coroners, and other agencies involved in responding to public disasters. The text of the points of learning has been summarised throughout this response and the full text of each can be found at Annex A.

This response is structured to broadly follow the journey a bereaved family may take after a public disaster; from the immediate aftermath of a tragedy, accessing support services, to the various formal processes that may follow a public disaster – including inquests, inquiries and police investigations. This response therefore addresses the points of learning in an order to broadly follow this timeline.

Beyond addressing the points of learning from Hillsborough, this response addresses a number of themes in the Bishop James' report related to the experiences of victims and the bereaved as they navigate the aftermath of a public disaster. The Bishop notes in particular that some of the Hillsborough families' experiences have been felt by other families who have lost loved ones in circumstances in which public bodies have been involved, including through deaths in police custody and deaths in NHS care. This response therefore also identifies broader work which has been undertaken to improve those experiences.

Some of the themes around enhancing support for families were also identified by the Rt Hon Lady Elish Angiolini DBE KC in her 'Report of the Independent Review of Deaths and Serious Incidents in Police Custody'.[footnote 9] This contained a number of recommendations for the Government and other agencies relating to processes following deaths in custody in all settings. The Government published its response to the Review on 31 October 2017[footnote 10] and published an update on progress against Lady Elish's recommendations on 20 July 2021.[footnote 11] The Home Office continues to monitor progress and make improvements where possible, and work to prevent deaths in detention, including in police custody, continues to be overseen by the Ministerial Board on Deaths in Custody.[footnote 12]

Since the publication of Bishop James' report, there have sadly been other public tragedies. The appalling attack at the Manchester Arena on 22 May 2017 took the lives of 22 people. The following month, on 14 June 2017, the fire at Grenfell Tower tragically cost 72 people their lives. This response will not look to repeat all the work undertaken since those tragedies. This response will instead build on what we have learned about how to better support bereaved families and survivors in the wake of public disasters.

The Government's response to Bishop James' report is based on information provided by relevant government departments, including the Home Office, Ministry of Justice, Cabinet Office, Department for Culture, Media & Sport, Department for Science, Innovation & Technology, Department for Levelling Up, Housing & Communities and Department of Health & Social Care. In addition, information has been provided by the National Police Chiefs' Council, College of Policing, Chief Coroner's Office, General Register Office, Attorney General's Office, Crown Prosecution Service, and the Independent Office for Police Conduct.

Bishop James' report also identified points of learning solely for the police and Chief Coroner, bodies which are independent of government. The police response, led by the National Police Chiefs' Council (NPCC) and the College of Policing, was published on 31 January 2023.[footnote 13] The Chief Coroner's Office is publishing its own independent response alongside this response.

In June of this year, the previous Home Secretary and the Lord Chancellor met with some of the bereaved Hillsborough families, to share with them the steps that the Government has taken, and intends to take, in response to Bishop James' report. They wrote jointly to the families after this meeting to inform them that the Government was considering measures that would allow us to go further to deliver on the issues that clearly matter most to the families, and to make sure that similar injustices are never repeated.

2. The Charter for Families Bereaved Through Public Tragedy

> Point of learning 1 – Charter for Families Bereaved Through Public Tragedy: Leaders of all public bodies should make a commitment to cultural change by publicly signing up to the Charter for Families Bereaved through Public Tragedy

Bishop James' report is built upon the testimony of the Hillsborough families who provided a courageous account of their experiences. They have done so in the hope that others will not have to suffer in the way in which they did, and to drive cultural change in all public bodies involved in the aftermath of public tragedy. To help bring about that change, Bishop James proposed a 'Charter for Families Bereaved Through Public Tragedy' or, as it will be known, the 'Hillsborough Charter'. The Hillsborough Charter is a series of commitments to act transparently and in the public interest. It is a benchmark for public bodies to ensure that they will not repeat the failures that caused such pain and suffering for the Hillsborough families. The Deputy Prime Minister has signed the Hillsborough Charter on behalf of the Government.

The Hillsborough Charter
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.

The Government recognises that in the aftermath of public tragedy it is of the utmost importance that organisations act responsibly, honestly and transparently. In signing the Hillsborough Charter, the Government is reaffirming its commitment to a continuing culture of honesty and transparency in public service and the wider public sector. This is in line with existing frameworks and the underpinning values of the Seven Principles of Public Life (the Nolan Principles).

The Deputy Prime Minister will write to all departments, to ensure that everyone who works in government is aware of the Hillsborough Charter and what it means for the way they work. The Government has also published a ministerial statement that sets out how the commitments in the Hillsborough Charter are reflected in existing rules, obligations and codes that apply to those who work in government, many of which have been put in place since the Hillsborough disaster.

To ensure that the principles of the Hillsborough Charter are properly understood and embedded, a reference to the Charter and a link to further resources will be added to the central Induction to the Civil Service course that

all new joiners to the Civil Service are expected to take. We will also update our propriety and ethics training to include references to the Hillsborough Charter.

We acknowledge the many other organisations that have already signed the Hillsborough Charter, including the National Police Chiefs' Council, College of Policing, Crown Prosecution Service, Fire Service, and Kensington and Chelsea Council. This Government will encourage and work with other public bodies to adopt the Charter and commit to learn the lessons of the Hillsborough disaster, to ensure that the failings we saw in its aftermath are never repeated.

3. The immediate aftermath of a public disaster

3.1 Supporting bereaved families and victims

The Independent Public Advocate

The experiences of the Hillsborough families demonstrate the devastating and lasting impact a public tragedy resulting in mass fatalities can have on those affected. More than 34 years later, they continue to feel the impact of their mistreatment by multiple agencies in the aftermath of the disaster. Their distress at losing loved ones in such terrible circumstances was compounded by the events that followed over many years.

The aftermath of public tragedy will be traumatic and difficult in many ways. Survivors may be recovering in hospital and bereaved families will be processing unimaginable trauma. The legal and administrative processes that follow are often complex and unfamiliar, involving multiple agencies, and we know that victims of past disasters have felt unable to participate as easily as they should be able to. A number of improvements have been made since 1989, but despite this, the system can still be difficult to navigate and bereaved families and victims won't immediately know what support is available to them and how to access it.

That is why on 1 March 2023, the Ministry of Justice (MoJ) announced its intention to create an Independent Public Advocate (IPA) and brought forward measures to achieve this in the Victims and Prisoners Bill, which was introduced into Parliament on 29 March.[footnote 14] Although not a discrete point of learning, Bishop James' endorsed the IPA and the model has been developed in consultation with the Bishop and families.

The MoJ is committed to listening and reflecting on the experiences of the bereaved and those who have championed them. Following the strong and powerful points made during evidence sessions and during the House of Commons Committee Stage of the Victims and Prisoners Bill, the MoJ recognises the importance of speed in IPA deployment, and as such, have introduced measures to create a permanent IPA, who can be on the ground within hours following a major incident.

We heard from the Hillsborough families just how important those first few hours after major incident are, when the need for support and information is possibly greatest. The permanent IPA will be a strong advocate for victims, the bereaved and the whole affected community. They will enable us to hear everyone, including those who, in their grief, may find it difficult to speak up for themselves. The IPA will work on behalf of victims and will support them to access essential services, to understand and participate in complex state processes such as inquests and inquiries, and help them to understand and exercise their rights. The IPA will be a crucial conduit between victims and public authorities and will focus on what victims actually need, not what others might assume that they need. We expect public authorities to cooperate with the IPA and the IPA to champion victims' voices. We believe the IPA will also play a critical role in ensuring that false public narratives do not emerge, like we tragically saw in the aftermath of the Hillsborough disaster.

The IPA will be supported by a secretariat and, should the scale of the incident require bolstered support, additional advocates can be appointed to respond to the emerging needs of the victims as necessary. To achieve that, we will set up a register of individuals from a range of different professions, backgrounds and geographical areas to ensure that the bereaved can be properly represented and are placed at the heart of the processes that follow public tragedies.

The IPA is a positive step in addressing the gaps and failures identified in Bishop James' report, and elsewhere in more recent public tragedies.

Support and counselling in the aftermath of a public tragedy

> Point of Learning 4 – Support and counselling in the aftermath of a public tragedy: Support and counselling should be made available to bereaved families at the earliest opportunity after a public tragedy.

The experiences of the Hillsborough families demonstrates the need for support services to be available in the immediate aftermath of a public disaster. The IPA will play a pivotal role in maintaining links with support services, even when they are not actively supporting victims of a major incident, so that they stand ready to signpost victims and the bereaved to these essential services.

Since the Hillsborough disaster, the Government has introduced changes to ensure that victims are better supported in the criminal justice system. The

Government's Victims Strategy, published in 2018,[footnote 15] sets out how Government will continue to improve the support offered to victims of crime.

The Government strengthened the Code of Practice for Victims of Crime (Victims' Code) in 2021 to clearly set out the services, and a minimum standard for these services, that should be provided to victims of crime by criminal justice agencies, including the police. We are putting the key principles of the Victims' Code in law for the first time through the current Victims and Prisoners Bill to underpin and strengthen victims' entitlements. The Victims' Code includes a range of entitlements, including Right 4, which specifically provides victims of crime with the entitlement to be referred to services that support victims and to have services and support tailored to their needs.

More broadly, core funding provided by the Ministry of Justice to Police and Crime Commissioners (PCCs) in England and Wales allows for victim support services to be commissioned according to local need. Where a person has suffered physical, mental, or emotional harm or economic loss because of a major criminal incident, they can access local support to help them cope with the impact that crime has had on them. This is in addition to support available through the National Homicide Service for England and Wales, which provides emotional, practical, advocacy and specialist support to individuals impacted by homicide, and which supported bereaved families following the Manchester Arena attack. Furthermore, since 2020 the Home Office's Victims of Terrorism Unit have funded three support services to provide practical and emotional support tailored specifically to victims and survivors of terrorist attacks.

The National Homicide Service, backed by £5.27m of funding, now provides support to families bereaved by major criminal incidents where it has been confirmed that a crime has caused fatalities. The service also offers support across England and Wales for eyewitnesses who have directly witnessed a homicide or major criminal incident. In addition, Outreach Support is available to children and young people in the community in the immediate aftermath of a homicide or major criminal incident, ensuring that more people receive access to this vital support when they need it. This forms part of a wider range of support for victims of crime, and we are quadrupling funding for victim and witness support services by 2024/25, up from £41m in 2009/10.

Whilst victims of non-criminal major incidents, such as accidents or natural disasters, would not be referred to support services tailored for victims of crime, they would be able to access other services such as those provided by the NHS.

The families and survivors of the Hillsborough tragedy have suffered long lasting effects. Since Hillsborough, society's awareness of the need for mental health support after a bereavement has improved. The stigma around seeking support has reduced, with people more aware of their own mental health needs and are now much more likely now to seek help. Services provided by the NHS and the voluntary community and social enterprise sector for the bereaved have expanded significantly and the transformation and improvement of mental

health services in England is taking place under the NHS Long Term Plan. [footnote 16]

In the aftermath of a public tragedy, government works with NHS England, local authorities and others to ensure that the physical, mental and emotional health needs of survivors, bereaved families and anyone else affected are being met, with valuable learning taken from previous tragedies such as the attack on Manchester Arena and the Grenfell Tower fire.

Since 2019, the Government has significantly increased the support available from mainstream NHS mental health services, including establishing all-age 24/7 urgent mental health helplines for people experiencing a mental health crisis and providing at least £2.3 billion funding growth a year for mental health services in England by March 2024.

In July 2018, the National Quality Board published national guidance for NHS trusts on working with bereaved families and carers which advises trusts on how they should support, communicate and engage with families following a death of someone in their care.[footnote 17] The guidance responds to a recommendation in the Care Quality Commission's (CQC) report: 'Learning, Candour and Accountability'.[footnote 18] [footnote 19] The guidance forms part of a national policy framework on learning from deaths being implemented by trusts, compliance for which is assessed by the CQC.

Recognising Bishop James' points that further support and signposting is essential for bereaved families specifically, the Department of Health and Social Care (DHSC) has also been working closely with other agencies and government departments such as NHS England, the Home Office and MoJ, as well as victims' units and teams across government, to ensure that appropriate support is available to bereaved families and survivors. DHSC supports efforts to ensure that local health professionals are aware of and sensitive to the impact that inquiries and investigations might have on the mental health of bereaved families and survivors. Also, where the IPA has been deployed following a major incident, they will play a crucial role in signposting victims to appropriate support services in their local area and helping them to access that support.

DHSC published guidance for the social care workforce,[footnote 20] which includes further resources and signposting to bereavement support organisations.

For those identified as having prolonged grief disorder (PGD), DHSC, through the National Institute for Health and Care Research, has commissioned a review of the evidence. PGD describes abnormally persistent and intense symptoms of grief that significantly interfere with daily functioning, and is thought to be more common following sudden, unexpected or violent death. The findings from this research will support DHSC in better understanding the needs of people affected by PGD and interventions to prevent PGD.

The Government has set up a working group with representatives from over 10 government departments to better collaborate on issues relating to bereavement.[footnote 21] The Government is working with the UK Commission on Bereavement, following the publication of its report last year, to ensure bereavement is incorporated into future policy making. In May 2023, DHSC updated and improved the signposting information available to bereaved people on GOV.UK to make it more visible.[footnote 22]

Lessons from HMG's response to the 2015 Bardo and Sousse terrorist attacks, resulted in the establishment of a cross-government coordination unit called, based in the Home Office, for victims of terrorist attacks. The team - Victims of Terrorism Unit (VTU) was established in 2017.

Since 2020, the VTU has funded support for victims and survivors of terrorist attacks. This includes immediate emotional and practical support for victims and survivors, a full assessment based on the individual's needs, specialist clinical mental health support, and a long-term peer-to- peer support network and one to one support. Victims and survivors can access this support at any time after an attack.

[footnote 23] The VTU, via its website, also provides victims and survivors with information on where to seek advice and assistance following a terrorist attack.

Police and other bodies' support for bereaved families

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

In Bishop James' report, all police forces, the College of Policing, coroners and the Chief Coroner were asked to undertake honest self-appraisals of how they respond to major incidents, in particular in respect of the treatment of families. The Government fully supports this, and the ways in which police and coroners engage with and support bereaved families have rightly changed substantially over the past 34 years. The Chief Coroner will go into further detail about the support given to families in his response.

Tragic cases such as the Hillsborough disaster in 1989 and the murder of Stephen Lawrence in 1993, led policing to change and improve its service to bereaved families. The most fundamental change was establishing family liaison as a distinct and professionalised function in policing.

The use of family liaison officers (FLO) and how these are deployed are some of the most important aspects of an investigation, and this extends to police engagement with bereaved families and survivors following mass fatalities.

FLOs assist in making initial contact and advising on what families may need or want in a particular case. Their initial priorities will be to establish the needs, requirements and communication channels with the family, to allow information to be gathered and to provide the family with any information or help they require, taking the needs of the investigation into account. The IPA is intended to work in parallel with the FLOs and will not replicate or replace their role. They will complement the support that FLOs provide.

The College of Policing guidance and the Victims' Code provide that bereaved close relatives have the right to have a FLO assigned to them by the police. The role was embedded within the College's guidance in 2008 and then in Authorised Professional Practice[footnote 24] (APP) for policing since 2013, stating that FLOs play an essential role in the police's response to major disasters. In 2018 the College also updated guidance on visiting the deceased. The FLO should work with the family to facilitate visiting the bereaved, and should not discourage it. This is an essential shift in light of the trauma experienced by Hillsborough families as a result of how this process was carried out previously.

The support from FLOs to bereaved families will apply in a range of cases, including in homicide cases and deaths in custody,[footnote 25] and where there is a criminal investigation into the death of multiple victims (including where it is suspected that there may be potential evidence of terrorism, corporate or gross negligence manslaughter or other crimes with a corporate or state element).[footnote 26]

Following the attack on Manchester Arena in 2017, the families of the 22 people who were killed were each allocated a police FLO, as were some of the injured and their families. As well as their role as an investigator in the immediate aftermath of the tragedy, the FLOs continued to provide support to the families and individuals during the criminal investigations. The Kerslake Report[footnote 27] describes the importance of family liaison and some bereaved families have reported that they found the support of FLOs from Greater Manchester Police (GMP) to be invaluable.[footnote 28]

3.2 Communication with bereaved families

In the aftermath of a major disaster in which families have been bereaved, they will usually interact with agencies such as the police and coroners' officers about access to their deceased loved ones. It is imperative that communication with bereaved families and victims is transparent and sympathetic, and confirms that they properly understand their rights. The introduction of the IPA to support and advocate for victims of a major incident will play an important role in addressing failures highlighted by Bishop James. The IPA will work on behalf of victims and can raise, in real time, issues around communication between public authorities and victims. The Chief Coroner will also ensure

communication is transparent and sympathetic by making it clear that a body of a loved one can never be described as 'the property of the coroner', a pledge made in person by the Lord Chancellor to those Hillsborough families who attended a meeting in Liverpool in June. It is also vital that police interviews immediately after a disaster are conducted with the necessary empathy and respect.

> Point of learning 3 – Interviewing family members, especially minors, after public tragedy: Changes to be made to the approach taken by the police when interviewing bereaved family members, especially minors, after a public tragedy.
>
> Point of learning 5 – 'Property of the coroner': Guidance should be introduced to 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.

In recognition of the pain caused to Hillsborough families throughout the process of identifying their deceased loved ones, guidance is now in place from the Chief Coroner[footnote 29] which makes it absolutely clear that the body of a loved one can never be described as the 'property of the coroner'. The Chief Coroner makes clear that this is one of the issues which was rightly highlighted by Bishop James and which can cause great and unnecessary distress to bereaved people. The Chief Coroner's Office will continue to monitor the impact of the revised guidance and will keep the position under review. The Lord Chancellor wrote to the Chief Coroner in June 2023 to ask that he reaffirms the guidance to all coroners that this language should never be used.

Coroners and their officers should also keep the bereaved family advised of the likely timescales for release of the body of a deceased family member, and any reasons for retaining it. Coroners are also reminded to advise bereaved people of their rights in terms of having a medical representative present at a post-mortem examination if they wish.

Training has been introduced for coroners' officers to make sure that the language they use with bereaved families is always sensitive and appropriate. In direct response to the experiences of the Hillsborough families, the College of Policing worked with the Chief Coroner's Office in 2018 to produce an updated APP on Disaster Victim Identification[footnote 30] which includes revised guidance on the viewing of loved ones' bodies and repatriation of the deceased. This is now the approved practice for all police officers in England and Wales and makes up an essential part of all police officers' training.

To ensure that police interviews with family members of the deceased are conducted with empathy, respect, and awareness of the potential impact they may have, new College of Policing guidance was issued in 2019 on "obtaining initial accounts from victims and witnesses".[footnote 31] This guidance requires

officers to consider the vulnerability of the victim or witness and do a needs assessment. For example, children and vulnerable adults will be referred to specialist officers if they are to be interviewed. This supplements the MoJ's 2022 guidance on interviewing victims and witnesses, "Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses".[footnote 32]

It is critical that communications with families and the public are as transparent as possible when somebody dies in state custody. This is critical to reducing distress and confusion for those affected as well as instilling trust and confidence in the end-to-end process following a death in custody. In the Government's 2021 update on deaths in police custody, we set out measures and guidance which are in place to ensure better communication with families in such circumstances.[footnote 33] The Independent Office for Police Conduct (IOPC) has produced guidance for families and friends of someone who has died following contact with the police. This includes how it will investigate and communicate with families following a death. [footnote 34] The IOPC's guidance has been translated into other languages to ensure this information is available to families when needed.

Together with the charity INQUEST,[footnote 35] the Home Office, MoJ, IOPC, NPCC, and the Chief Coroner published a leaflet in December 2018 for families that sets out their rights, the roles of key organisations and the post- incident processes.[footnote 36] This leaflet is available in 20 languages and, as set out in published Home Office guidance,[footnote 37] is shared with the next of kin, in addition to the offer of practical support from a trained family liaison officer.

3.3 Media handling and reporting after public disasters

> Point of learning 7 – Media and ethics training: An assessment 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.
>
> Point of learning 8 – False public narratives: 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.

In the aftermath of a public tragedy, the existence of a free press is essential in holding agencies to account via independent scrutiny. But the experiences of families in the wake of some recent major incidents, however, highlight the distress that can be caused by intrusive media practices, and the negative impact they can have on families and victims. As highlighted in Lord Kerslake's report of his review of the attack on Manchester Arena,[footnote 38] victims felt

overwhelmingly negative about how the media behaved in the aftermath of the bombing, demonstrating the need for further improvements to be made.

There now exists a strengthened and independent self-regulatory system for the press and media practices to ensure that bereaved families and victims are better protected, including during and after police investigations and proceedings. The press self-regulators – the Independent Press Standards Organisation (IPSO) and the Independent Monitor for the Press (IMPRESS) – have developed Codes of Practice covering harassment and intrusion into grief and shock. In addition, both IPSO and IMPRESS have developed processes for people to complain if they believe they are being harassed by journalists.[footnote 39] If the regulators find that a newspaper has broken the code of conduct, they can order corrections. IPSO can also order critical adjudications and IMPRESS can levy fines, and both regulators also offer arbitration schemes for legal claims relating to defamation, privacy and harassment, which the Hillsborough families encountered.

During the MoJ's consultation, views were sought on the role of the IPA in liaising with bodies responsible for other investigations related to a disaster. This could include bodies such as IPSO and IMPRESS. The IPA, once appointed, may have a role in making public recommendations to the press or press regulators to draw attention to issues in on press conduct, reporting, or regulatory issues (although any recommendations will be non- binding due to the independence of the press and press regulators). The IPA may include observations in its reporting on the experiences of the victims of major incidents, including engagement with the media.

In recognition of the need for great care to be taken in making public comments before facts are known, media training and changes to guidance have been introduced to ensure that the police and other bodies always have the experiences of victims and families front of mind while engaging with the media. The Government published guidance on 3 January 2018 for victims and their families on handling media attention in the aftermath of major incidents.[footnote 40] The guidance outlines for those engaging with the media after a major incident what needs to be considered when speaking with the media, including what to do if anyone is being pressured or harassed by the media.

The behaviour of the media after a public tragedy can lead to the development of inaccurate information and narratives, which can in turn encourage toxic cultures and behaviours. Examples of this are the increased occurrence of incidents of 'tragedy chanting' at football matches, and the prosecution in June 2023 relating to an offensive shirt which mocked those affected by the Hillsborough disaster.

Sections 4A and 5 of the Public Order Act 1986 can already be used to prosecute those engaging in chanting about tragedies and death at football or displaying any writing, sign or other visible representation which is threatening, abusive or insulting. The police and prosecuting authorities can use these powers to take action where this contemptible conduct has occurred. The

Government will continue to work with the police and the CPS to ensure that the perpetrators of these offences feel the full force of the law and that this vile and distressing behaviour at football matches is stamped out.

These toxic behaviours can also increasingly be seen online, with individuals shielding themselves behind the anonymity of a keyboard. The Online Safety Act 2023 is a significant step forward in protections against online abuse. Companies will now have to take proactive measures to tackle content and activity that amounts to priority offences listed in the Act's Schedules 5, 6, and 7. This includes several offences under the Public Order Act such as harassment. Companies must also ensure that their services are not used to commission or facilitate these offences. All platforms in scope of the Act will be required to swiftly remove all illegal content once made aware of its presence. This includes illegal content from anonymous accounts.

We are also taking steps to educate and empower users with the skills and knowledge they need to make safer choices online through our work on media literacy. The Online Safety Act 2023 will address media literacy, including via the Government's recently tabled amendments to update Ofcom's statutory media literacy duty under the Communications Act 2003 to introduce new objectives relating specifically to regulated services. This includes building public resilience to disinformation and misinformation, and requiring Ofcom to publish a media literacy strategy every three years, with annual reports on progress towards the strategy.

This issue is something that some of the Hillsborough families expressed particular concern about when they met with the Home Secretary and Lord Chancellor this summer. Given the importance of ensuring current and future generations recognise the significance of the Hillsborough disaster and have access to the facts, we are establishing what cross-government initiatives already exist to tackle divisive and harmful culture and false narratives, and assessing what more we can do through education. The Lord Chancellor and previous Home Secretary also wrote to relevant departments in the summer regarding the the toxic cultures and behaviours that can develop as a result of inaccurate information and narratives, such as those that develop in the aftermath of public tragedies like the Hillsborough disaster.

In July 2019, IPSO published corresponding guidance for journalists and editors on the reporting of major incidents (which includes natural disasters and terror attacks) and other such events.[footnote 41] This guidance reiterates the need for journalists to take care to distinguish between claims and facts when reporting on major incidents, given the false media narrative that adversely affected the experiences of many of the Hillsborough families and survivors.

In respect of the police's communication with the media, in 2017, the College of Policing issued new Authorised Professional Practice (APP) on media relations, [footnote 42] which aims to ensure that, at every level of the service, police communication meets the highest standards of integrity, accountability and openness.[footnote 43] The APP, which was updated in 2022, replaced earlier

guidance and draws on learning from a range of sources including the findings of the Leveson Inquiry[footnote 44] and the report of His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), 'Without Fear or Favour' (2011).[footnote 45] The APP was developed in collaboration with media professionals and representative organisations, as well as wider consultation with the public, broadcast and print media and police forces. It provides a framework to help all in policing make decisions around how to engage with the media in an open, accessible and professional way. It provides guidance on how to appropriately balance the duty to safeguard the confidentiality and integrity of police information, against the police duty to be open and transparent, as set out in the College of Policing's Code of Ethics.

For major incidents, the APP should underpin any plans and procedures forces have in place for media engagement and any specific strategies that are developed. The APP requires that such media strategies should be agreed at senior operational level and include the appointment of a dedicated police spokesperson and a specific communications officer. All media statements in high-profile investigations should receive approval by the Senior Investigating Officer (SIO) or gold commander before release.

This can give assurance that other police officers or staff will not divulge information that goes beyond the agreed media strategy.

In respect of investigations of those most serious and sensitive cases that are investigated independently by the IOPC, a protocol has been in place between the IOPC and NPCC since June 2018 which sets out the roles and responsibilities of police forces and the IOPC when communicating with the media and the public.[footnote 46] The purpose of such communication is to preserve the dignity of the public who can be adversely affected by police action when there is a real risk of false and damaging narratives propagating within the community, and broadcast across mainstream and social media channels.[footnote 47] This will also ensure public confidence in the police is maintained. The protocol makes clear that the IOPC has the media lead on independent investigations and is responsible for releasing into the public domain information relevant to those investigations. It also allows forces, however, to provide certain limited factual information publicly, both prior to and after the IOPC declaring an independent investigation. It states that, before an independent investigation is declared, forces should restrict their comments to matters of fact, which cannot become disputed during any IOPC investigation. The NPCC Complaints and Misconduct Portfolio will work to refresh the IOPC-NPCC joint media protocol to ensure it is maintained as a live and evolving document.

Policing will additionally strive to learn lessons from other high-profile incidents and ensure that those lessons are shared across the policing community. Following the missing person inquiry and tragic death of Nicola Bulley this year, the College of Policing was commissioned by Lancashire Police and Crime Commissioner to conduct a review into Lancashire Constabulary's handling of the case, focusing on the police investigation, search and the media

engagement and communication strategy. The review was published on Tuesday 21 November 2023 with recommendations for the force and policing nationally being taken forward.

Bishop James emphasised in his report that organisations and individuals should take great care in making public comments before the facts of events in question are known. The Government is committed to upholding high ethical standards and integrity for those who work within government and may be called on to respond publicly to matters related to tragedies. There are already existing codes which govern the way in which those in Government behave, the principles of which flow from the Seven Principles of Public Life (Nolan Principles).[footnote 48]

In particular, the Civil Service Code and Code of Conduct for Special Advisers require civil servants and special advisers to act with honesty and integrity. Similarly, the Ministerial Code requires that ministers maintain high standards of behaviour and behave in a way that upholds the highest standards of propriety. To reaffirm commitments to transparency and acting in the public interest after major tragedies, the Government has signed the Hillsborough Charter.

4. Inquests

4.1 Inquests and investigations

Following a public tragedy, it is critical that steps are taken to understand what went wrong, how the tragedy could have been prevented, and to hold people to account. These processes, which include inquests and other investigations (or where circumstances require it, public inquiries, see Section 5), can be difficult to understand and navigate, and victims of major incidents can find it hard to participate in them as fully as they may wish. It is crucial that bereaved families and victims are able to access clear, accurate and timely information to support them through the investigation and inquest processes, as well as any criminal proceedings. The Government has taken action to clarify and streamline support for them.

The IPA will support and facilitate engagement between bereaved families and those responsible for investigating the disastrous events that resulted in the deaths of their loved ones. They will ensure that bereaved families and victims understand their rights and can access relevant and appropriate information in order to fully participate. We are determined that experiences such as those of the Hillsborough families are never repeated. The IPA will therefore help ensure that the voices of the bereaved are heard and understood, and will work to

make sure public authorities are responsive to their needs. Should issues be experienced or concerns arise, the IPA can advocate for change including through its reporting function. The IPA will not need to be commissioned by the Secretary of State to produce reports; it will be able to do so independently, based on the work that it has done to support victims. The reports the IPA publishes will be laid before Parliament and available for the public to see.

4.2 The coroner's inquest

> Point of learning 19 – Right to information: All bereaved families should be given clear information immediately following death concerning the coronial processes and their associated rights.

Bishop James' report drew attention to the devastating impact on bereaved families of going through an inquest process which, in many cases, felt callous and impersonal and did not prioritise their needs. Both the Government and the Chief Coroner are clear that the bereaved should be placed at the heart of the process. The Chief Coroner provides national leadership for coroners in England and Wales and coroners are independent judicial office holders, and separate from government. The Chief Coroner has published guidance for all coroners on coronial processes and matters relating to the bereaved families.

As acknowledged in the MoJ's 2019 report on the Review of Legal Aid for Inquests,[footnote 49] there are a range of difficulties which families may face during coroners' investigations and inquests. Where a death is reported to the coroner and is to be investigated, the bereaved family's first contact with the process will typically be from the coroner's office. They will be grieving the loss of their loved one and their distress may be exacerbated if, for example, the death was violent or unnatural. They need to know what to expect and when, including issues like access to, and release of, their loved one's body; any post-mortem examination that is needed and the form this will take; and the form of the inquest itself. The whole process is potentially very stressful, upsetting and confusing.

Bereaved families need timely and clear information about coronial processes and their rights. This supports Bishop James' desire for the families to be truly placed at the centre of the process. In 2014 the MoJ published its 'Guide to coroner services' for those needing to know about what to expect from the coroner service and the inquest process, and what to do if their needs and expectations were not met. In 2020, the MoJ published its refreshed Guide to Coroner Services for Bereaved People, which is better tailored specifically to the needs of bereaved people. The Guide includes information on the post-mortem examination and when a second post-mortem examination may be undertaken (for example in criminal cases); and what action bereaved families

may wish to consider if they have concerns about the post-mortem report. The Chief Coroner has also issued guidance on post-mortem examinations, including second post- mortem examinations and the Lord Chancellor wrote to the Chief Coroner in June 2023 to ask him to reaffirm this guidance. The guide also contains information on when a bereaved family member may wish to consider seeking legal advice, and how inquests may be different when the state is an interested person.

In 2018, the Home Office, the MoJ and the Chief Coroner's Office, working closely with INQUEST which supports bereaved people after state-related deaths, developed and published a short and simple two-side leaflet for families whose loved ones died in police custody.[footnote 50]

Historically, the Government has provided some financial support for the Coroner's Courts Support Service (CCSS) which currently operates in around half of coroner areas, and also provides an online and telephone helpline for the bereaved and others coming into contact with the inquest process. As set out in the February 2019 'Final Report of the Review of legal aid for inquests', [footnote 51] the MoJ will look at extending support services to cover all coroner areas, subject to affordability.

Furthermore, where the IPA has been deployed, they will work to ensure that bereaved families are given clear information that is easy to understand. The IPA will be knowledgeable of, but independent from, the inquest process.

4.3 Proper participation and legal representation for bereaved families during inquests

Point of Learning 9 – 'Proper participation' of bereaved families at inquests: The state must ensure 'proper participation' of bereaved families at inquests at which a public body is to be represented.

Bishop James recommended:

- 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.
- Legal representation for public bodies: the Government 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.
- Cultural change: cultural change is needed in order to tackle the increasingly adversarial nature of many inquests – and to instead embed

a culture of openness and lesson learning.

- Inquest processes and training for coroners: 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. The Chief Coroner should also ensure that the practice of allowing a photograph to be shown is widely adopted. The Chief Coroner and MoJ should consider whether the use of position statements – particularly in contested or complex inquests – has the potential to make the inquest process more efficient. 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. More needs to be done to generally improve the recruitment and training of coroners.

As Bishop James' report shows, the Hillsborough families' experience of the inquest process was one that felt deeply adversarial as legal teams representing the state sought to put their reputation first. The families received no public funding for representation at the first inquests, and at the second inquests, the Rt Hon Theresa May MP made bespoke funding available to the families for legal representation.

The inquest process is intended to be inquisitorial and establish specific facts – who died and, where, when and how they died. However, the Government acknowledges that the reality can feel very different, especially when the state is represented as an interested person. We will therefore seek to further understand the experiences of bereaved families at inquests where the state is represented.

There have been calls for changes to the availability of legal aid for bereaved families at inquests. Legal representation for bereaved families at inquests may be funded through the Exceptional Case Funding (ECF) scheme in cases where there is a possible breach of rights under the European Convention on Human Rights, or where there is likely to be a significant wider public interest. We are determined to make this process as straightforward as possible, so, in January 2022, we removed the means test for ECF cases for legal representation and for associated legal help. In September 2023, the means test was also removed for applications for legal help at inquests. The removal of the means test ensures that legal advice becomes means-free, alleviating families from the burden of providing financial information during challenging times.

The Government acknowledges that more is needed to respond to Bishop James' full recommendation concerning legal representation at inquests. The MoJ will therefore build on the removal of the means test for ECF at inquests by consulting on expanding legal aid so that it is available to bereaved families at inquests following major incidents where the IPA is deployed, and following terrorist attacks. This means that no family involved in such cases in future will

have to face an inquest without proper legal representation and would not need to apply for ECF.

Bishop James also recommended as part of his report, to help ensure proper participation of the bereaved, that the Chief Coroner should ensure that families are offered the opportunity to read a pen portrait of their loved one at all inquests. Recent guidance published by the Chief Coroner sets out the position on pen portraits, and the use of such materials in inquests to help everyone understand who the person was and the effect their life had on those around them, to make that process more personal.[footnote 52] Families can let the court know important things about their loved one – what they did, their interests and hobbies, and details about their wider circle of family and friends. The Chief Coroner endorses and welcomes this approach.[footnote 53]

Bishop James further described the widespread adoption of position statements in his report whereby lawyers acting on behalf of the Hillsborough families in the fresh inquests suggested that the coroner requires a statement be made by each interested person as to the stance they intended to take during proceedings.[footnote 54] This would be inconsistent with the inquisitorial jurisdiction of an inquest; this is because the coroner does not have a role in adjudicating between the positions of litigating parties.

Position statements cannot replace the coroner's statutory duty to ascertain what happened in an individual case, and it is the role of interested persons to assist the coroner in this process. As a consequence, the MoJ does not consider that there is scope for position statements to be used more than they are at present.

4.4 State representation during the inquest

At some inquests, the state or public body will count as an interested person. This may occur because the person died in circumstances in which the state or public body had a duty of care, for example where someone died in police custody. In these cases, the state or public body may have legal representation at the inquest. The police and other public bodies had legal representation at both the first and second Hillsborough inquests.

The Government recognises that state legal representation at inquests can add to the adversarial experience of an inquest and exacerbates the 'inequality of arms' that Bishop James highlights in his report. It is right that public bodies have access to legal representation at inquests and that individuals can access legal representation in situations where their job could be at risk. But public bodies should not have limitless access to public funds to spend on legal representation, and their spend should be proportionate compared to that of bereaved families. The Government will therefore set out, through guidance, its expectation that central government public bodies and their sponsoring

department publish their spend on legal representation at inquests and inquiries, and reaffirm that this spend should be proportionate compared to that of bereaved families and should never be excessive.

The MoJ has held round-table meetings with government departments and with three leading third sector organisations – Cruse Bereavement Care, the Coroners Courts' Support Service and INQUEST – to explore current practice across departments, to better understand the impact on bereaved people where state agencies are legally represented, and to consider potential solutions. The round-tables were clear that it can seem to families as if the Government has unlimited lawyers at its disposal at inquests.

There is also the perception that public bodies' focus can be on minimising or denying what went wrong and handling reputational damage, rather than trying to get to the bottom of what happened.

The MoJ is clear that public bodies should instruct their lawyers to assist the coroner to achieve the statutory purpose of the inquest process and to enable learning from inquest findings. However, we understand that the perception of families can be different, and we want to address this. That is why the 2020 Guide to Coroner Services for Bereaved People now includes a protocol titled 'Principles guiding the Government's approach when it holds interested person status at an inquest'. The protocol was developed in response to Lady Elish Angiolini's report of her independent review of deaths and serious incidents in police custody; Bishop James' 2017 report; and the Government's 'Final Report of the Review of legal aid for inquests'. It sets out how the Government and the lawyers it instructs will act when it has interested person status at inquests. The key principles include supporting an inquisitorial approach which assists the coroner to find the facts, helps identify learning for the future, and keeps in mind that the bereaved should be at the heart of the inquest process. The protocol means that bereaved families and others involved in inquests as witnesses, as well as coroners themselves, will be aware of the principles that should be followed, will feel that this is supporting an inquisitorial and not adversarial approach, and can speak out if they feel standards have not been met.

To help embed these changes with the legal professions, in January 2020 the MoJ held a conference for lawyers who practise in inquests to hear first-hand the experiences of families, and those of other speakers involved in the coronial system, in order to emphasise the importance of the inquisitorial approach. Building on the protocol, the MoJ has supported the legal services regulators – the Bar Standards Board and the Solicitors Regulation Authority - in their work to develop inquest specific information and toolkits to guide lawyers who represent at inquests. This includes the competencies framework which sets out the skills expected from lawyers practising in the coroner's court. The skills include communication, working with other agencies, and keeping knowledge up to date.

To further emphasise that public bodies should instruct their lawyers to assist the coroner and to further drive the cultural change we want to see, the

Government will reaffirm the principles in the protocol that sets the expectation on how government instructs its lawyers, but also to now do so in accordance with the principles of the Hillsborough Charter.

Whilst we reaffirm the principles of proportionality in legal representation and how lawyers are instructed, there are practical difficulties in, for example, placing a cap on the number of lawyers that can act for the state. It must be right that, for example, police or prison officers have representation at inquests, as any employee would expect, where there is the potential for their job to be at risk. Further, the Civil Service Management Code[footnote 55] has a commitment to provide staff called as a witness at an inquest with legal representation. What we will do is ensure public bodies are very much aware of the cost of instructing lawyers and consider the number of lawyers instructed, bearing in mind the commitment to support an inquisitorial approach and improve the experience of bereaved families. We expect lawyers acting for interested persons in an inquest to operate in accordance with their underlying professional obligation to the court and to support the coroner's investigation, including with the disclosure of documents and in the approach to witnesses. However, different bodies may have different interests and positions, and it is not always possible for one lawyer to represent some or all of these without a conflict of interest arising. While we do not consider there should be a numerical cap on the number of lawyers who can represent public bodies at inquests, we will continue to keep this issue under review.

4.5 Pathology evidence at inquests

The coroner will undertake an investigation where they believe that a death was not from natural causes, or the cause is unknown. They may ask a specialist doctor (usually a pathologist) to carry out a post-mortem examination to help find out the cause of death, such as in cases of homicide or suspicious death.

> Point of learning 15 – Pathology failures at the first inquests: 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.

Since the Hillsborough disaster, the model of forensic pathology delivery has changed considerably following two national reviews, and systems of scrutiny of the work of forensic pathologists have been put into place. Pathologists on the Home Office register now work to a formal Code of Practice and Performance Standards document, and their work is regularly audited by stakeholders from

the coronial and criminal justice community. They are also subject to a statutory General Medical Council appraisal and revalidation regime.

In light of the changes to forensic pathology service delivery since Hillsborough, and following the recommendation in Bishop James' report regarding pathology, it will be important to test if lessons have been learned in more recent responses to mass fatalities.

In response, therefore, to point of learning 15 in Bishop James' report, the Home Office has commissioned an independent review of the forensic pathology service in response to the Hillsborough disaster. The review, which commenced in November 2022 and is led by Mr Glenn Taylor, a retired forensic scientist, will identify any necessary learning from the original Hillsborough pathology response to ensure that similar issues will not be repeated in the future. The terms of reference for the review were published on GOV.UK on 5 October 2022.[footnote 56] It is anticipated that the review will submit its report to the Home Secretary by July 2024. The Government is grateful to Mr Taylor for his work to date and engagement with the Hillsborough families and others.

The review is forward-looking and seeks to identify learning on whether the pathological evidence given at the first inquest was misleading; establish whether there are now adequate safeguards in place to ensure that the same issues will not be repeated in mass fatality incidents in the future; and consider how to embed the lessons from the Hillsborough families' experiences in the continuous professional development training of Home Office-registered forensic pathologists.

4.6 Pathology services in England and Wales

Professor Peter Hutton's 2015 review of forensic pathology set out a number of recommendations, one of which was the introduction of a 'National Autopsy Service, combining both forensic pathologists and non-forensic 'coroners' pathologists. The Government recognised the longer- term merits of this proposal but considered that issues in coronial pathology should be addressed first.

In 2021, the Justice Committee published the report of its Inquiry into The Coroner Service.[footnote 57] The Committee made three recommendations in relation to coronial pathology provision – that the fees paid to coronial pathologists should be reviewed; that coronial post-mortems should be planned within pathologists' NHS contracts; and that an agreement should be brokered between relevant government departments and the NHS to establish and co-fund 12-15 regional pathology centres of excellence.

The Government recognises the need to address the shortage of coronial pathology provision and is committed to finding solutions to the cross- cutting

issues contributing to the pressures experienced by the sector as a matter of priority. A cross-departmental group has been established, overseen by ministers, and has agreed a cross-departmental action plan targeted at establishing sustainable solutions to the issues seen within the coronial pathology sector.

As a first step, the MoJ is reviewing the statutory fees paid for post-mortem examinations. The review has commenced with a targeted call for evidence. The plan also addresses issues around autopsy training and NHS contracting. The cross-departmental group is working to identify a timeline for action on these issues.

4.7 Using medical evidence from inquests

> Point of learning 16 – Using medical evidence from the fresh inquests: The Ministerial Board on Deaths in Custody should consider how best to ensure that the medical evidence from the fresh Hillsborough inquests contributes to training in the prevention of restraint asphyxia.

Bishop James recommended that the medical evidence presented at the fresh inquests be used to support police officers, prison staff and others whose job can involve the restraint of others. In response to the recommendations from Lady Elish Angiolini's review into serious incidents and deaths in police custody, the Ministerial Board on Deaths in Custody oversaw a range of work on restraint, including on alternatives to the use of prolonged physical restraint against detainees and especially in the context of mental health crises (both at the initial point of arrest in the street and in the custody suite).

Police and prisons officers may have to use restraint in certain situations, including where responding to crimes and emergency situations. Police leadership have taken a number of steps to improve the training officers receive when using restraint and ensuring the health of those in custody are monitored throughout the process.

As the Home Office set out in its update in 2021 on work undertaken to prevent deaths in custody, the NPCC and College of Policing have embedded risk assessments and best practice associated with restraint, positional asphyxia and acute behavioural disturbance (ABD) in national police training through the National Personal Safety Manual the APP on Detention and Custody, the new assessment criteria for the National Refresher training package and the piloted New Student Officer public and personal safety training course. Nationally, all officers and staff attending training will be assessed practically in dealing with positional asphyxia and ABD. This has been reinforced by the NPCC's '60

seconds to save a life' campaign,[footnote 58] which helps officers recognise a medical emergency and act quickly to resolve it.

The College of Policing has also introduced a 'safety officer' role into its National Personal Safety Manual, which has specific responsibilities to oversee the use of restraint. The safety officer is responsible for monitoring the detainee's conditions, particularly the airway and response, protecting and supporting the head and neck. That person should lead the team through the physical intervention process and monitor the detainee's airway and breathing continuously. Whilst this role is not specific to the custody environment it equally applies within custody suites and applies to all front- line officers.

The College of Policing, in close consultation with the NPCC, has developed a 1-day national training course looking at "high risk" custody themes. The modules focus on attitudes and behaviours in relation to police custody provision. The training is suitable for new staff and as Continuing Professional Development (CPD) refresher input. The training has now been released with a series of sessions already held, to support forces in incorporating this content into their custody training. The overriding aim is to ensure an individual approach is taken to each detainee, to best manage their welfare and minimise risk. Although ABD is not specifically referenced within this learning product, detainee vulnerability is. Themes that are promoted throughout the training include:

- ensuring that every interaction is as positive as possible to achieve greater cooperation of detainees; and
- managing conflict effectively by recognising stressors, seeking de-escalation, and tailoring responses to gain cooperation wherever possible.

In September 2020, the College of Policing published national evidence- based guidelines for policing on conflict management, including de- escalation and negotiation skills. These are aimed at resolving conflict in everyday police-citizen encounters without using force by encouraging safer resolutions and therefore reducing the risks of assaults to the public and officers. The recent NPCC and College of Policing Officer and Staff Safety Review encouraged Chief Constables to implement these guidelines. The Home Office supports this activity and expects forces to follow best-practice guidance in their use of restraint and in conflict management.

For prisons, His Majesty's Prison & Probation Service annually refreshes all prison officers in use-of-force training, which is regularly updated and includes the medical considerations around restraint, including the risks of restraint asphyxia. It is the responsibility of all staff to monitor for the signs of medical distress. Where available, a Registered Healthcare Professional attends restraint incidents to monitor the condition of the prisoner and to intervene if necessary, should there be any concerns.

For mental health services, the Mental Health Units (Use of Force) Act, also known as Seni's Law,[footnote 59] received Royal Assent in November 2018 and has been partially commenced. The majority of provisions of the Act were commenced in 2022, requiring every mental health unit to have a 'responsible person' to ensure requirements of the Act are carried out including publication of restraint reduction policies, provision of information to patients about their rights, and requirements around training that staff must receive. The Act also stipulates that if a police officer is going to a mental health unit on duty that involves assisting staff who work in that unit, the officer must wear a body camera if reasonably practicable.

The Restraint Reduction Network (RRN) has worked with Health Education England to produce a set of ethical training standards that protect human rights and support the minimisation of restrictive practices. From April 2022, the Care Quality Commission expects services across health and social care to have certified training that complies with the RRN Training Standards. This supports services to ensure that their training complies with the requirements of section 5 of the Use of Force Act. The standards apply to all training that has a restrictive intervention component and is applicable across all health settings where training on restrictive practices is provided.

4.8 Toxicology and alcohol testing

> Point of learning 18 – Toxicology and alcohol testing: 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.

The process, operational framework, and approach by coroners to dealing with mass fatality incidents has changed significantly since the Hillsborough disaster, and the Chief Coroner has addressed this in his own independent response to the Bishop James' report.

As judicial office holders, coroners are independent of government and the Chief Coroner is responsible for ensuring that coroners and their officers have appropriate training. The MoJ has, however, been engaging with the Chief Coroner's office on training coroners, ensuring inquests remain focussed and that coroners have the skills to control proceedings. Training for coroners' officers has been updated to incorporate learning from the Hillsborough disaster, and the Chief Coroner circulated a copy of Bishop James' 2017 report to all coroners to ensure they learned lessons from the disaster and its aftermath. Mandatory continuation training for all coroners delivered in 2019/20 addressed the vulnerability of bereaved people and witnesses, communication with families, the behaviour of counsel and general control of the court room.

Alongside this, the training for coroners' officers – who engage more frequently with families during the inquest process – focused on empathetic and respectful language and working with vulnerable people.[footnote 60]

Toxicology is an important part of the toolkit available to coroners to pursue an investigation into a death reported to them. It would, however, be very difficult to provide guidance to coroners that stipulated whether or not it should be used in every situation, not least because it would be likely to unlawfully restrain the judicial discretion of the coroner to make a decision appropriate to the case. At the time that Bishop James' report was published in 2017, the Chief Coroner drew the attention of coroners to the report, including a focus on the remarks on toxicology to ensure such tests are carried out properly.

4.9 Processes after the inquest

> Point of learning 20 – Issuing death certificates: The practice of issuing death certificates without a covering letter should be stopped.

The pain and distress caused to families by the way in which death certificates were issued should never be repeated. Following the conclusion of the coroner's investigation, where a death certificate needs to be issued, new guidance has been introduced to make this process more humane when communicating with bereaved families.

In light of Bishop James' recommendation in 2017, the General Register Office (GRO), in consultation with the National Panel for Registration,[footnote 61] introduced new guidance for registrars, including that a covering letter should be sent with all death certificates applied for immediately after registration where there has been no prior contact with the family of the deceased. This aims to reduce any understandable distress to bereaved families caused by the arrival of an unexpected certificate, which has been issued to them. This guidance has been successfully implemented and since used by the GRO following public tragedies.

We are also mindful of the importance for bereaved families of being able to have a role in the registration of their loved one's death following an inquest, and will be consulting on this shortly.

> Point of learning 12 – Applications to the Attorney General: The Attorney General's Office should review its processes for consideration of Section 13 applications (to the High Court for inquests to be quashed) to ensure that they are fit for purpose.

Succeeding in having the original inquests reopened was an arduous process for the families; their unwavering tenacity should never have been necessary. The Attorney General's Office (AGO) has carried out a full review of the processes in place for the Attorney General's consideration of applications for fiat (authority) to apply for a further inquest, or a first inquest, under section 13 of the Coroners Act 1988. The AGO has since streamlined processes and helped to progress cases.

After an inquest, bereaved families, or others with an interest, can apply for a further inquest under section 13 of the Coroners Act 1988 with the Attorney General's authority. The test that the Attorney General applies is whether there is a reasonable prospect of the High Court granting the application and whether an inquest or a further inquest is in the interest of justice.

The Government acknowledges the exceptionally difficult experiences of the Hillsborough families which made a number of unsuccessful applications to challenge the decisions from the inquests into death of their loved ones, before the conclusions were eventually quashed by the High Court. In response to those experiences, the AGO carried out a full review of the processes in place for the Attorney General's consideration of applications under section 13 of the Coroners Act 1988 (as amended). In 2017, over 80% of applications determined by the Law Officers resulted in a fiat (authority to proceed to the High Court) being granted.

Where officials in the AGO receive an application under Section 13, they take care to thoroughly review the information supplied and guide applicants through the process. As soon as possible after receiving an application, officials will acknowledge receipt and provide applicants with guidance which sets out the steps that the AGO will take to progress the application to a conclusion. These steps include:

- reviewing the application and assessing whether any information is missing and if so, requesting this from the applicant as soon as possible;
- identifying all parties who may have an interest in the case (i.e., who may oppose the claim if it is submitted to the High Court) and inviting those parties to make representations in response to the application;
- when representations are received by interested parties, sharing these with the applicant and further representations in response may be requested;
- once all representations have been received, an official within the AGO considers the evidence and provides a submission to the Attorney General or the Solicitor General. Both are collectively known as the 'Law Officers'; and
- a Law Officer then personally considers the case and decides whether to grant authority or issue a decision letter setting out the reasons for the refusal of the application if the test for granting authority is not met.

These processes are regularly reviewed by the AGO to ensure that the handling of section 13 applications is carried out as effectively and efficiently as possible.

Point of learning 11 – Learning the lessons from an inquest: Prevention of Future Deaths reports were under-utilised and practice among coroners as to the circumstances in which they make such reports varied considerably.

Coroners have a statutory duty to issue a Prevention of Future Deaths (PFD) report to relevant bodies when they consider an investigation has revealed that action can be taken to prevent or reduce future loss of life. A duty is placed on recipients to respond within 56 days. In 2020, the Chief Coroner published revised guidance to assist coroners with the detail of the law, standardisation of procedure and to encourage consistency of approach in the use of PFD reports. [footnote 62]

Government departments, regulators and other recipients have systems in place to consider the PFD reports they receive, and take very seriously what they say in their responses about the actions they will put in place.

The Government is clear that recipient/s of a PFD report must consider how to ensure that the lessons are learned, and should disseminate these lessons more widely, where they apply. But as acknowledged in the Government's response in September 2021 to the Justice Committee's Report, we recognise that there is more that can be done to ensure that PFD reports actively contribute to improvements in public safety, and we will consider options to achieve this.

Since 2013, most PFD reports and the responses to them are published on the Chief Coroner's webpages.[footnote 63] PFD reports are therefore the means by which coroners can highlight a need for change, and they have an important role in ensuring the transparency of the coronial system. They are also a vital tool in ensuring that lessons are learned and mitigations put in place to prevent or reduce the risk of future harm.

The publication of PFD reports on the Chief Coroner's webpages enables the reports to be used more easily by researchers and others in identifying themes and findings and ensures that the process is transparent. Since January 2023, PFD reports have been published directly onto the pages, so it is no longer necessary to open a separate attachment. Whilst this is a small technical change, it enables much more detailed searching of reports, improving the scope for learning and research. This change enhances the user experience for everyone, including those using assistive technology. In addition, the Chief Coroner has been working with researchers at Oxford University to ensure that the relevant public and academic bodies are aware of, and make use of their Preventable Death Tracker project, which uses sophisticated web-scraping techniques to aggregate data from PFD reports and produce academic analysis.

The MoJ continues to work with the Chief Coroner's Office to identify further improvements to the publication, searching and analysis of PFD reports,

including the potential for the creation of a public database.

> Point of learning 10 – Evaluating coroners' performance: The Chief Coroner should explore mechanisms for allowing coroners' performance to be evaluated and for the relevant performance data to be made public.

Coroners are required to undertake substantial annual training and this has been a significant focus of the Chief Coroner's work since 2012 when the first Chief Coroner was appointed. The approach – as with all branches of the judiciary – is for training to encourage consistency of approach where possible and continuous professional development on legal and judicial skills. All new coroners are required to attend mandatory multi-day induction training. Every coroner has to complete a residential two-day continuation training course each year. All coroners' officers are required to attend residential training and there are a range of other specialist training courses and events each year.

As with all judges, it would not be constitutionally appropriate to publicly evaluate coroner's judicial decision-making in the manner outlined in Bishop James' report. Judicial decision-making on cases is supervised by the higher courts, for example by the judicial review process. Matters related to the personal conduct of judges are dealt with by the Judicial Conduct Investigations Office.

In its 2021 report, the Justice Committee recommended that the MoJ should create a Coroner Service Inspectorate to report publicly on, amongst other things, the readiness of coroner services in case of mass fatalities and the level of associated service provided to bereaved people. The Government has accepted that there could be merit in this but has reserved the opportunity to consider it further.

5. Inquiries

5.1 Establishing Inquiries

> Point of learning 23 – Home Office approach to historic inquiries: The Home Office should 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. 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.

An inquiry may be established for independent scrutiny of issues of public concern, for example following public disasters which have resulted in fatalities. Inquiries are set up to establish the facts and learn lessons, rather than to apportion blame. Inquiries may also provide an opportunity for catharsis, to rebuild public confidence in a particular issue, and to hold people or organisations to account. The work of the Hillsborough Independent Panel paved the way for fresh inquests that determined that those who lost their lives at Hillsborough were unlawfully killed.

An inquiry should generally only be considered where other available investigatory mechanisms (e.g., IOPC investigations, inquests, police investigations, locally commissioned inquiries) would not be sufficient. Unlike many courts or tribunals, public inquiries are inquisitorial in nature and cannot determine civil or criminal liability.

Advice on whether a public inquiry should be established and, if so, how it should be constituted, may involve particularly sensitive issues. Inquiries can result from a wide range of events and each decision has to be taken on its merits. The Cabinet Office provides advice to government departments on public inquiries, and the Home Office has a dedicated team which acts as a repository of knowledge on the issues which should be considered in setting up and conducting inquiries on matters within the Department's policy responsibilities. This provides a strong platform from which robust advice can be provided to ministers in respect of public inquiries.

Sponsoring ministers, with advice from the Cabinet Office, determine what form an inquiry should take by weighing a number of factors and making a reasoned decision relating to the particular circumstances of the case. It is important that the decision on whether to establish an inquiry, including which approach is best suited to deliver it, is made on its own merits, which will include timescale and cost.

The Government recognises, however, that a factor in this reasoned decision will also be the views of victims, and it is already common practice for victims to be engaged during the process of establishing an inquiry. When the IPA is deployed in response to a major incident, they can advise ministers by feeding in the views of victims or facilitating engagement with victims to help inform ministers when they take decisions on whether to establish an inquiry; what format is most appropriate; and what the scope of any inquiry might include.

Where ministers consider there is a case for an inquiry, there are two main categories of investigation: non-statutory inquiries or statutory inquiries. Statutory inquiries are conducted pursuant to the Inquiries Act 2005[footnote 64] and Inquiry Rules 2006,[footnote 65] and have a high degree of formality and

structure. Examples of this include the UK Covid-19 Inquiry, the Undercover Policing Inquiry, the Independent Inquiry into Child Sexual Abuse, Grenfell Tower Inquiry, Manchester Arena Inquiry, and the Infected Blood Inquiry.

A non-statutory inquiry is not subject to the Inquiries Act 2005 and cannot compel evidence from witnesses or hear evidence on oath. Instead, it relies on the autonomy of the chair and the cooperation of all those involved. Where it is considered that the absence of the Inquiries Act 2005 statutory powers will not impede an inquiry's investigation, a non-statutory inquiry can be considered. Where a decision is taken to establish a non-statutory inquiry, it can be held in public or private, so may be able to offer a greater degree of flexibility to meet the wide range of circumstances for which an inquiry might be required. Several successful inquiries have operated on a non-statutory basis, including the Iraq Inquiry and the Hillsborough Independent Panel. The Home Office also established both the Daniel Morgan Independent Panel and, more recently, the ongoing Angiolini Inquiry[footnote 66] as non-statutory inquiries. Part 1 of the Angiolini Inquiry is currently expected to report in early 2024.

Consideration of whether to establish any type of inquiry to investigate particular events is done on a case-by-case basis. The test for holding an inquiry under section 1 of the Inquiries Act 2005 is that it appears to a minister that: (a) particular events have caused, or are capable of causing, public concern; or (b) there is a public concern that particular events may have occurred. There is no definitive set of criteria to consider, and ministers therefore have a great deal of discretion when deciding whether to establish an inquiry. However, broadly speaking, consideration should be given to whether there are any gaps in our knowledge, lessons still to be learned, or other public interest justifications.

There are appropriate mechanisms in place to ensure transparency and accountability of decision making for all government departments, including the Home Office, which include:

- Parliamentary scrutiny including debates, the questioning of ministers, and the investigative work of committees;
- the Freedom of Information Act 2000 provides public access to information held by public authorities, including government departments;
- government departments are subject to the Public Records Act 1958, which sets out the statutory responsibilities for the care and preservation of public records, including the requirement for information to be made available to the public where appropriate.[footnote 67] For example, in 2017 the Home Office transferred the 33 files that it held relating to the 1984-85 miners' strike to The National Archives; these are available for the public to review;[footnote 68] and
- freedom of the press to report on actions and decisions by government.

5.2 Conduct of Inquiries

> Point of learning 22 – Setting up public inquiries: Statutory inquiries are not the only option to HMG for external public scrutiny. The Government should 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 ensure that adequate support for family members is put in place.

The effectiveness of the Hillsborough Independent Panel showed that statutory inquiries under the Inquiries Act 2005 are not the only option available to ensure effective external investigation and scrutiny of events of public concern.

Where there is a public inquiry, there will nearly always be a group of families, victims, survivors, or other impacted individuals involved in the inquiry as core participants (in statutory inquiries[footnote 69]), or as witnesses and interested parties. In law, the decision as to who should be a core participant to a statutory inquiry rests with the Chair, rather than the Secretary of State. This may include different groups of victims, survivors, or bereaved family members, being represented by different legal teams. The nature of inquiries means that victims and families are often at the heart of proceedings, and it is of the utmost importance that the inquiry process is sensitive to, and respectful of, what may already be an emotional and stressful time for them.

The Government recognises that it is important that the processes and systems of an inquiry are designed with this in mind, including the provision of support. It is crucial we carefully consider the communications around the decision to hold an inquiry, and how best to ensure the victims and families are supported through the process. The Cabinet Office's Inquiries Team provides advice and shares best practice and learning for current and future inquiries. In doing so, they draw attention to excellent work done by the Independent Inquiry into Child Sexual Abuse and other inquiries to support victims and survivors.

> Point of learning 21 – Police approach to public inquiries: The College of Policing 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 their officers to accept and learn from adverse inquiry findings.

The police have made improvements to encourage police officers to learn from adverse inquiry findings. In addition to the NPCC and the College of Policing signing the Hillsborough Charter, the Strategic Command Course (a mandatory development programme for aspiring Chief Officers and Assistant Chief Officers) was updated by the NPCC and the College to include a strong focus on leaders creating a learning culture in forces which encourages candour

amongst all officers and staff. There are similar aims for the Chief Constable Continuing Professional Development programme – for example, Sir Robert Francis KC has presented at one such session, on his work as Chair of the Mid Staffordshire NHS Foundation Trust Public Inquiry.

> Point of learning 13 – The 'Hillsborough Law': The Government should fully consider the Public Authority (Accountability) Bill in the context of the Law Commission's detailed work aimed at reforming the offence of Misconduct in Public Office.

In his report, Bishop James endorsed the principles of the 'Hillsborough Law' or Public Authority (Accountability) Bill. The Hillsborough Law was drafted by a number of lawyers working with the Hillsborough families and has two primary functions: to legislate for a duty of candour for all public officials and to create parity in legal representation for participants in an inquest. The latter point has been discussed earlier in this response.

The Government understands the drivers for legislating for a duty of candour. The Hillsborough families and survivors are entirely justified in their frustration with the evasiveness and obfuscation they experienced from public officials. Of the senior officers providing witness at the first inquiry, Lord Justice Taylor in his 1990 report commented that they "were defensive and evasive witnesses… neither their handling of problems on the day nor their account of it in evidence demonstrated the 'qualities of leadership expected of their rank".[footnote 70] This frustration was more recently compounded with the collapse of the trial of a number of individuals charged with perverting the course of justice in relation to statements made to the Taylor Inquiry. These were just examples of the institutional defensiveness and challenges that the families faced over the years.

It is vital that those who hold public office are held to the highest standards and, if they abuse these positions, the repercussions should be clear. Much has changed in terms of expectations and requirements on public officials since 1989, and firm duties have been put in place to ensure that all officials act with candour and frankness, and in the public interest at all times. Further, the legal framework surrounding criminal investigations, statutory inquiries, inquests, and most other formal proceedings now requires all individuals, regardless of whether or not they are a public official, to cooperate with them.

Of particular note is the Inquiries Act 2005, which provides a framework for establishing statutory inquiries. Its provisions mean that any individual – including current or former public servants or officials – can be held to account for their conduct in inquiries held under the Inquiries Act, and that it is a criminal offence, punishable by a fine or imprisonment, to lie or amend information submitted to an inquiry set up under that Act.[footnote 71] Since its introduction, the Inquiries Act 2005 has provided the basis under which a number of inquiries

into major public tragedies have proceeded, with both the Grenfell Tower Inquiry and Manchester Arena Inquiry being established under this Act.

There are a limited number of formal public proceedings where there is no specific legal obligation to co-operate or tell the truth, such as non-statutory inquiries (i.e., those not established under the Inquiries Act 2005). As set out elsewhere in this response, however, the flexibility of these forms of inquiries can be beneficial and better support the public interest, like we saw with the Hillsborough Independent Panel. The sponsoring Secretary of State can also convert non-statutory inquiries to statutory inquiries if necessary, such as if there are concerns around individuals or organisations not cooperating fully, and place them on a statutory footing under the 2005 Act with all of the relevant powers.

Beyond the specific legal requirements, as referenced previously, there is also a broader framework of duties on public officials, made up of codes that govern the way those in Government behave, the principles of which are derived from the Seven Principles of Public Life (Nolan Principles).[footnote 72] Most notably, the Civil Service and Special Adviser Codes specifically require everyone in these groups to act with honesty and transparency.[footnote 73] [footnote 74] The Civil Service Code has had a statutory underpinning since 2010. The Ministerial Code also requires ministers to maintain high standards of behaviour and behave in a way that upholds the highest standards of propriety.[footnote 75] These various statutory commitments to candour and transparency have also been reaffirmed by government in adopting the Hillsborough Charter.

Where a public official wilfully neglects to perform their public duty to a degree that would amount to an abuse of the public's trust, or without reasonable excuse or justification, they can be guilty of Misconduct in Public Office, which is a criminal offence. The Law Commission was asked to review the current common law misconduct offence and published a final report and recommendations in December 2020.[footnote 76] The Government is carefully considering the recommendations in the Commission's final report and will respond to them separately in due course.

Having carefully considered the existing legal framework and ethical duties, the Government is not aware of any gaps in legislation or clarifications needed that would further encourage a culture of candour among public servants in law. However, continuing to drive and encourage a culture of candour among public servants, and others, is essential and is an important part of the Hillsborough Charter.

The Government does however believe that, given the Hillsborough families' experiences, there is a case for ensuring that expectations around candour for policing are put on a statutory footing. The Government's plans to do that are set out below.

Separately, and in response to issues on openness in healthcare, the Government intends to conduct a review into the effectiveness of the duty of

candour for health and social care providers (as set out in regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). The duty has been in place for trusts since 2014 and for all other providers regulated by the CQC since 2015 and requires providers to be open and transparent with people receiving care and treatment under their management. The review is intended to consider the application of the duty of candour for health and social care providers and its enforcement. Further details of the review will be published in due course.

6. Police investigations and prosecutions

6.1 Integrity and accountability in investigations

The experiences of the Hillsborough families revealed 'rudeness, thoughtlessness and a lack of compassion' by police officers in the tragic aftermath of the disaster.

Following publication of the Hillsborough Independent Panel's report in October 2012, two criminal investigations were set up – Operation Resolve, looking at the events leading up to and including the day of the disaster, and the IOPC's (then IPCC)[footnote 77] independent investigation into police actions in the aftermath. The scale of these investigations is unprecedented and has required new approaches to organisation, multi-agency working and gathering evidence.

> Point of learning 6 – Hillsborough, the 'touchstone': The Code of Ethics must not be treated as a box that has been ticked – it instead requires an ongoing commitment to cultural change… Empathy and integrity should be considered as central to both recruitment and professional development.

Policing and government are committed to improving systems in place to ensure that police officers are held to account for their actions, including during such investigations as those relating to Hillsborough. Since 2014 significant steps have been made to improve police accountability. These include the publication of the College of Policing's Code of Ethics in 2014; the introduction of former officer provisions and police Barred List in 2017; and governance reforms to the Independent Police Complaints Commission – now the IOPC – under the Policing and Crime Act 2017. In February 2020, the Government implemented a further package of reforms intended to focus the police complaints and discipline system more on resolution, openness and learning. These reforms also included increased powers for the IOPC, such as providing a power of initiative to enable it to investigate without having to wait for (or "call

in") a referral from the police. In January 2023, the Government launched an internal review into the process of police dismissals, to ensure that there are fair, robust and effective arrangements in place to remove those who have no place in policing. The review found that changes were needed to raise the bar on standards in policing and improve public confidence. On 31 August, the Government therefore announced a series of reforms to strengthen the disciplinary system, including greater responsibilities for chief officers, a presumption of dismissal for proven gross misconduct, streamlining of the performance system and a clarified route to remove officers who are unable to hold or maintain vetting. The review's full report has now been published by the Home Office.[footnote 78]This November the Government introduced the Criminal Justice Bill, which includes new measures to provide chief officers with a right of appeal to the Police Appeals Tribunal – with a similar right of appeal for local policing bodies, in circumstances where the hearing relates to a chief officer.

The Code of Ethics is a significant document in policing and applies to everyone working in the policing profession. The Code of Ethics was first produced by the College of Policing in 2014 in its role as the professional body for policing. The Government fully agrees that the Code of Ethics must not be treated not as a box that has been ticked; it requires an ongoing and proactive commitment to cultural change. The College has been reviewing the Code of Ethics to ensure that it effectively supports all police officers to make the best ethical decisions for the public they serve.

The Code of Ethics also plays a pivotal role in ensuring high professional standards of behaviour are met across policing, by providing guidance which underpins the statutory standards. The Code of Ethics can be used by forces – in the same way they would investigate breaches of other guidance or policy – by considering whether there were any breaches of the Standards of Professional Behaviour. The Home Office is working with HMICFRS to ensure that ministers' expectations in respect of force compliance with the Code are reflected in HMICFRS PEEL[footnote 79] inspections from 2025 onwards.

The Code of Ethics is incorporated into recruitment and promotion processes throughout the police "Competency and Values Framework" (CVF). The CVF is used in all national recruitment, development, specialism and promotion processes and also links into new National Leadership Standards, in place for every rank from June 2023. The Code of Ethics is woven into the Police Education and Qualifications Framework which sets the core curriculum and standards for initial recruit training and increasingly, for all professional training. It is also core to the National Decision Model, which is a framework designed and used to help police workforce members make ethical decisions.

Point of learning 14 – A duty of candour for police officers: A duty of candour for police officers should be introduced which 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.

As part of major integrity reforms in 2020, the Home Office introduced a duty of cooperation for police officers. This is included in the amended Standards of Professional Behaviour in the Police (Conduct) Regulations introduced in February 2020. All police officers now have an individual responsibility to give appropriate cooperation during investigations, inquiries and formal proceedings, participating openly and professionally in line with the expectations of a police officer when identified as a witness. A failure to cooperate is a breach of the statutory standards of professional behaviour, by which all officers must abide, and could result in disciplinary sanctions, including dismissal. Since December 2017, provisions have been in place for proceedings to be brought against former officers who committed serious wrongdoing when they served. These were introduced to ensure that former officers cannot evade being held accountable via formal disciplinary processes by leaving the police.

The Government agrees that openness and transparency of the police is of the utmost importance – that is why, last month we introduced a statutory organisational duty of candour for policing. This legislation will ensure that Chief Constables have a duty to ensure candour within the forces they lead. This legislation will give the Code of Practice for ethical policing the necessary prominence for policing and will require important tenets, such as candour, to be included. We expect Chief Constables will be monitored by HMICFRS and PCCs in how they adhere to the duties outlined in the Code of Practice. The aim of this is to ensure that everyone in policing is clear on what is expected of them, and to provide confidence to the public that the highest standards are being met.

Point of learning 25 – Police complaints and discipline: There should be a lessons learned exercise to consider the effectiveness of the Family Forums and the Article 2 Reference Group, as well as the administration and performance of the criminal investigations themselves. In doing so, it should consider whether similar mechanisms would be of use as part of the investigation into future major incidents.

As noted above, the parallel criminal investigations were of an unprecedented scale. Of particular note, as part of Operation Resolve, was the creation of the family forums (to enable the families to engage with the investigators) and the Article 2 Reference Group - an expert group to provide advice to the investigations. Both were designed to aid public confidence in the investigations without the risk of prejudice. Bishop James recommended that there was proper consideration of the lessons learned from this engagement, and wider investigations.

As set out in the NPCC and College of Policing response to Bishop James' report, those organisations undertook a lessons-learned exercise following the conclusion of the criminal trials, also drawing on learning from a number of other large-scale investigations. The lessons from this work have been shared through a number of channels, including through the Strategic Command Course (for officers to join chief officer ranks). The lessons included consideration of forms of family engagement, and the Family Forum model informed engagement with bereaved families in the Gosport Memorial Hospital and Grenfell Fire investigations.

The IOPC is conducting work to identify internal and external lessons learned as a consequence of its Hillsborough investigation. This learning is likely to be published once the IOPC has completed its final report that will bring together all of its findings on the complaints and conduct matters in relation to police officers in connection with the Hillsborough disaster.

6.2 Police records

> Point of learning 24 – Police records: The Home Office and the Department for Culture, Media and Sport, as the department responsible for the National Archives, should work together to determine and deliver an appropriate solution to the issue that police forces are currently under no obligation to keep records of historical interest.

In 1989, South Yorkshire Police were not required by law to retain the papers they held relating to Hillsborough. The Government is committed to introducing a requirement for police forces to retain records of historical interest. In response to this point of learning, the Home Office established a working group comprising stakeholders from the Home Office, College of Policing, NPCC, The National Archives (TNA) and the Information Commissioner's Office (ICO). The working group commissioned a review of this point of learning which found that the practice and standards of police records management was inconsistent across policing.

The review explored the need for police records to be subject to the Public Records Act 1958 (PRA) and concluded that adherence to the PRA would not have prevented the problems faced after the Hillsborough disaster when records were lost or destroyed. In fact, adherence solely to the PRA would have led to more Hillsborough material being lost than was ultimately retained.

The review recommended instead that the existing Code of Practice for Management of Police Information 2005, owned by the College of Policing, should be extended and updated to include corporate and wider organisational records (which it previously did not) with clearer and more comprehensive rules

and time limits on retention and disposal, and extensive retention for significant incidents or events. It additionally recommended that HMICFRS should take a more active role in reinforcing these new standards of record management through its inspection processes. The review concluded that adherence to the PRA was a desirable objective, but only after the police applied more consistent and transparent standards of records management. The working group accepted these recommendations.

The new Code of Practice, entitled Police Information and Records Management,[footnote 80] was published in July this year. It details key principles for the management of all police information and records and reflects related legislative developments such as those relating to data protection. It will mean that a broader range of police records are retained by forces in the future, meaning there is less risk of losing important records for future scrutiny.

The new Code of Practice is supported by complementary APP titled Archiving of records in the public interest, which provides specific guidance aimed at information management practitioners which defines the types of records that may be in the public interest and which forces should seek to preserve.

The updated draft Code and APP have been subject to extensive stakeholder review and consultation with the Home Office, ICO, TNA, HMICFRS, National Crime Agency (NCA)[footnote 81] and police staff representative bodies. In addition, a public consultation was undertaken by the College in 2021 along with consultation with external civil society organisations.

The new Code of Practice and APP mean that more police records will be retained than in the past, ensuring that valuable and historic documents cannot be destroyed without good reason.

As part of its obligations under the PRA, the Home Office is also working closely with Operation Resolve, the recent police investigation into the events on the day of the Hillsborough disaster, to ensure the preservation of material generated by that investigation. Much of the material holds considerable national and historical significance, and some is also especially personal to those who lost loved ones in the disaster. We recognise that some of the material is also highly emotive, and in some cases distressing, and careful consideration needs to be given to what is appropriate to be placed into the public domain. For that reason the process will take some time, however we hope that material will begin to be available via TNA's online platform from next year.

More broadly, the NPCC has also created a new police heritage portfolio which will assist in ensuring that forces are supported in understanding what records should be retained on a permanent basis, and how best to do this. The heritage portfolio was created to support forces with their heritage responsibilities, which includes the need to retain information and assets of historic significance and ensure that they are properly looked after.

Finally, national guidance to senior investigative officers (SIOs) on the use of policy files was refreshed in 2019 and is embedded in the Major Crime Investigation Manual[footnote 82] and the development programme for SIOs – this includes requirements for information retention. The primary objective of a policy file, or decision log as it is sometimes referred, is to record investigative direction, instruction, parameters and priorities for major crime investigations, while complying with the requirements of the Criminal Procedure and Investigations Act 1996. This requires that SIOs record and retain records of information and other material in the investigation. The national guidance describes the purpose of a policy file as providing:

> " a transparent, accountable and auditable record of the decisions made during the course of an investigation and will be relied upon by investigators, and others, when providing answers to victims or their families, in judicial proceedings, criminal, civil or disciplinary and internal scrutiny in the form of review or management oversight."

Final remarks

Through their tireless pursuit for the truth and accountability, the bereaved families and survivors of the Hillsborough disaster brought about full public disclosure of information about that heart-breaking tragedy and its aftermath. That exposure was a critical catalyst for the investigations and proceedings that followed and, crucially, the fresh inquests. In 2016, these inquests provided a conclusion of great public importance that the 97 people who lost their lives had been unlawfully killed. The Hillsborough families and survivors have endured so much to overcome opposition and obstruction.

The Government thanks Bishop James Jones and his team for capturing and documenting the experiences of the families. Above all the Government thanks the families for providing first-hand accounts of their suffering and injustices that expose the myriad of failings of various state actors and others. In doing so they have provided a service to the whole country, setting out the lessons that must be learned so that others do not have to fight as they have done.

This response to Bishop James Jones' report sets out a number of changes that have already been introduced to support bereaved families and survivors of major disasters – many as a direct result of the Hillsborough families' experiences. Looking forward, the adoption of the Hillsborough Charter and establishment of an Independent Public Advocate will ensure that victims and survivors' voices will be at the heart of the state's response to any future public tragedies. We hope that the actions contained in this report will mean that the pain and suffering of the Hillsborough families is never repeated.

Annex A – Bishop James Jones' 25 Points of Learning

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. 97

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:

1. Publicly-funded legal representation for bereaved families at inquests at which public bodies are represented.
2. An end to public bodies spending limitless sums providing themselves with representation which surpasses that available to families.
3. 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.
4. 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 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 prejudge 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 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.

Annex B – Timeline of Events

- 15 April 1989: Ninety-four football fans are fatally injured in a deadly crush as Liverpool play Nottingham Forest in the FA Cup semi-final at Sheffield Wednesday's Hillsborough ground.
- 17 April 1989: The ninety-fifth victim of the disaster, Lee Nicol, dies.
- April 1989: Lord Justice Taylor is appointed to conduct a public inquiry into the disaster, with the West Midlands Police force later instructed to examine the role of its South Yorkshire counterparts.
- January 1990: The Taylor Report concludes the main reason for the disaster was the failure of police control and the decision to open Gate C without blocking the tunnel to central pens, calling them "blunders of the first magnitude".
- April 1990: South Yorkshire coroner Dr Stefan Popper begins the first inquests in Sheffield. A 3.15pm cut-off point is imposed so inquiries into lack of emergency response are ruled inadmissible.
- March 1991: After the longest inquest in British history to date, lasting 90 days, a verdict of accidental death is returned by a majority verdict of 9-2.
- November 1991: Chief Superintendent David Duckenfield, South Yorkshire Police (SYP) match commander on the day of the disaster, resigns due to ill health.
- 3 March 1993: The ninety-sixth victim of the disaster, Anthony Bland, dies.
- March 1993: Families seek a judicial review of the first inquest which is initially dismissed, then appealed against, then ultimately rejected by the Royal Courts of Justice, which rules the original inquests should stand.
- May 1997: Then Home Secretary, Jack Straw, appoints Lord Justice Stuart-Smith to conduct a "scrutiny of evidence"; he concludes new inquests are not warranted.
- April 2009: Then Secretary of State for Culture, Media and Sport, Andy Burnham, is heckled whilst speaking at the 20th anniversary memorial of the Hillsborough disaster and subsequently raises the matter at Cabinet.

- December 2009 – Then Home Secretary, Alan Johnson, commissioned a non-statutory inquiry, the Hillsborough Independent Panel.
- 12 September 2012: The Hillsborough Independent Panel report is published. In the House of Commons, then Prime Minister David Cameron offers a “profound apology” for the “double injustice”.
- October 2012: The Independent Police Complaints Commission (now Independent Office for Police Conduct) launches its biggest ever investigation into police in the UK, centred on officers’ conduct over Hillsborough.
- December 2012: The High Court quashes the accidental death verdicts in the original inquests and orders new ones. The same day, then Home Secretary, Rt Hon Theresa May MP announces that new criminal investigations will be launched.
- 31 March 2014: New inquests begin at Birchwood Park, Warrington.
- 26 April 2016: The inquest jury delivers its conclusions that 96 Liverpool fans were unlawfully killed. It finds that mistakes by South Yorkshire’s police and ambulance services “caused or contributed to” their deaths, and exonerated Liverpool fans of wrongdoing.
- April 2016: Then Home Secretary, Rt Hon Theresa May MP, commissions Bishop James Jones to produce a report on the experiences of the bereaved Hillsborough families, to ensure their perspective is not lost.
- June 2017: The Crown Prosecution Service announces six men will be charged following investigations into the disaster.
- 1 November 2017: Bishop James Jones’ report of the Hillsborough families’ experiences was published titled, ‘The patronising disposition of unaccountable power’ – a report to ensure the pain and suffering of the Hillsborough families is not repeated.
- November 2018 – Then Home Secretary, Rt Hon Sajid Javid MP determined that HMG’s response to Bishop James’ report should not be published until after all the criminal proceedings had concluded, due to the risk of potential prejudice.
- 3 April 2019: Graham Mackrell, Sheffield Wednesday’s Club Secretary, is found guilty of health and safety offences on the day of the disaster. He is later sentenced with a fine of £6,500. The trial jury failed to reach a verdict on charges against David Duckenfield.
- 28 November 2019: Following a retrial, David Duckenfield was found not guilty of gross negligence manslaughter of ninety-five Liverpool fans.[footnote 83]
- 26 May 2021: The trial of two former police officers and a solicitor collapse after the judge ruled that there was no case to answer.
- July 2021: A coroner’s inquest rules that Andrew Devine, who died 32 years after the disaster, was unlawfully killed, and that he was the ninety- seventh victim of the disaster.

- 31 January 2023: Joint NPCC and College of Policing response to Bishop James' report is published.

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66. https://www.angiolini.independent-inquiry.uk (https://www.angiolini.independent-inquiry.uk/)
67. In accordance with the Freedom of Information Act 2000
68. In his report, the Bishop twice states that it is “not within [his] terms of reference to comment on calls for a public inquiry into Orgreave or other historic issues involving the police.”
69. Core participant status may be granted to an individual, group of individuals or entity under Rule 5 of the Inquiry Rules 2006.
70. Paragraph 280 of Lord Justice Taylor’s Interim Report dated 1 August 1989

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80. https://www.gov.uk/government/publications/police-information-and-records-management-code-of-practice (https://www.gov.uk/government/publications/police-information-and-records-management-code-of-practice)
81. The College must consult with the NCA before issuing or revising a Code (s39A(4))
82. Included in section on Policy files on page 43 – 46 of the https://library.college.police.uk/docs/NPCC/Major-Crime-Investigation-Manual-Nov-2021.pdf (https://library.college.police.uk/docs/NPCC/Major-Crime-Investigation-Manual-Nov-2021.pdf)
83. The law at the time of the disaster means that he was not charged with the manslaughter of the 96th victim, Anthony Bland, who passed away from his injuries in 1993.

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