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Truth? Justice? Accountability?

Modern Challenges of

Major Inquests & Inquiries

2018

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MAJOR INQUIRIES AND INQUESTS –

LESSONS AND WARNINGS FROM BLOODY SUNDAY AND HILLSBOROUGH

Matthew Hill

Introduction

1. On 30 January 1972, 13 people were shot and killed in Derry/Londonderry by members of the Parachute Regiment. An inquiry was established into the circumstances of the deaths, chaired by Lord Widgery, then the Lord Chief Justice. His conclusions, which included a "strong suspicion" that some of those who had died had been handling weapons, were widely condemned as a whitewash. The events of the day remained an open sore in the city and beyond. A lengthy campaign by the families, adopted by academics, politicians and journalists, followed. A quarter of a century later a fresh inquiry was ordered. The conclusions exonerated all of those who died, laid blame at state actors for the deaths and vindicated those who had campaigned over the decades. Sadly, many relatives of those who died did not live to see the outcome for which they had fought.

2. On 15 April 1989, 96 people received fatal injuries during a crush at a football match at Hillsborough Stadium, Sheffield. An inquiry was established into the circumstances of the deaths, chaired by Lord Justice Taylor, later the Lord Chief Justice. His conclusions on the causes of the disaster were broadly accepted, with some important exceptions. However the inquests that followed, which returned verdicts of accidental death, were condemned by the families of the deceased, particularly because of the suggestions made in evidence that drunken supporters had caused or contributed to the crush that resulted in the deaths. A lengthy campaign by the families, adopted by academics, politicians and journalists, followed. A quarter of a century later fresh inquests were ordered. The conclusions exonerated the supporters, laid blame at state actors for the deaths and vindicated those who had campaigned over the decades. Sadly, many relatives of those who died did not live to see the outcome for which they had fought.

3. This paper does not seek to present a comprehensive critique of any of the inquiries, inquests and investigations that took place into the events of either of those dreadful days; still less does it seek to present "the truth" of what happened. Instead, it considers the similarities and – more importantly – the differences between the various proceedings that have followed the tragedies, seeking to assess which proved effective, which did not, and why.

4. The paper, and the talk that it accompanies, are presented to lawyers and others with an interest in the role of inquiries and inquests play in contemporary Britain. I am acutely aware that the matters that I approach from a professional, structural and legalistic perspective are points of enduring pain and sensitivity for those who lived through the events concerned. All views expressed are mine alone.

5. The paper considers the following matters in the context of the inquiries, inquests and investigations that took place into the events of Bloody Sunday and the Hillsborough disaster:

a. A summary of the events of 30 January 1972 and 15 April 1989, and the inquisitorial processes that followed;
b. The fundamental purpose of an inquiry or inquest;
c. The importance of the independence of, and trust in, the relevant tribunal;
d. The terms of reference and their interpretation;
e. The engagement and involvement of the families of the deceased;
f. The evidence adduced before the inquiry or inquest;
g. The importance of considering the individual within a major public disaster;
h. Some thoughts on common themes that may be of general application.

Bloody Sunday: the events and the investigations

6. On 30 January 1972 a large civil rights march took place in Derry/Londonderry, in contravention of a ban on marches and processions. The organisers intended this to culminate in a rally at Guildhall Square, but the security forces erected barriers, manned largely by soldiers, to prevent access. Rioting broke out when the march reached the barriers, as had been widely anticipated. While some of the crows threw stones, far more proceeded peacefully along the re-arranged route towards Free Derry Corner in the Bogside area of the city. As part of a planned arrest operation, soldiers from 1st Battalion the Parachute Regiment ("1 PARA") passed through the barriers. The nature and limitations of the order that they were given are disputed, but in any event soldiers from 1 PARA entered the Bogside. Those who had been rioting at the barriers fled, catching up with the thousands of marchers who had gathered to hear speeches at Free Derry Corner. The complex series of events that followed were the subject of intense controversy for several decades. Gunshots were fired. In general military witnesses claimed that they were fired upon by members of the Official or Provisional IRA, that they faced individuals throwing potentially lethal nail and petrol bombs, and that they returned fire appropriately. Civilian witnesses, in general, claimed that the soldiers opened fire first and without justification. Within ten minutes, the soldiers of 1 PARA had fired over a hundred rounds. 13 people were killed. A

fourteenth casualty who had been injured by gunfire slightly earlier in the day died some months later. A similar number of people were injured.

7. The evidence of the firing soldiers as a whole would suggest that each of those who died was either armed with a life-threatening weapon or were hit by a round intended for such a target. The civilian evidence provided a very different picture: that Jim Wray was shot in the back as he lay on the ground; that Alexander Nash was wounded as he held his dying son, William; that Hugh Gilmour was shot as he ran away from the soldiers; that Gerard McKinney had both of his arms raised when a soldier fired and killed him.

8. An inquiry into the events of 30 January 1972 was established under the Tribunals of Inquiry (Evidence) Act 1921 ("the 1921 Act"). The Tribunal comprised Lord Widgery alone. His terms of reference were taken from the Resolution adopted by both Houses of Parliament, namely:

"That it is expedient that a Tribunal be established for inquiring into a definite matter of urgent public importance, namely the events on Sunday 30 January which led to loss of life in connection with the procession in Londonderry on that day."

9. He heard the evidence of 114 witnesses in 17 sitting days between 21 February and 14 March 1972. There followed three days for closing speeches, concluding on 20 March 1972. Lord Widgery published his report on 19 April 1972, 80 days after the events that he was investigating. Among his findings were the following.

a. "To those who seek to apportion responsibility for the events of 30 January the question 'Who fired first?' is vital. I am entirely satisfied that the first firing in the courtyard [of the Rossville Flats] was directed at the soldiers." [§54]

b. "I would not be surprised if in the relevant half hour as many rounds were fired at the troops as were fired by them. The soldiers escaped injury by reason of their superior field-craft and training." [§95]

c. "Those accustomed to listening to witnesses could not fail to be impressed by the demeanour of the soldiers of 1 Para … With one or two exceptions I accept that they were telling the truth as they remembered it." [§97]

d. There was a “strong suspicion” that some of those who were killed or wounded “had been firing weapons or handling bombs in the course of the afternoon and that yet others had been closely supporting them.” This conclusion was based on expert scientific evidence concerning firearm discharge residues. [Summary of conclusions, §10]

10. Lord Widgery did make criticisms of the actions of soldiers but these were muted, sometimes almost to the point of silence. The number of rounds fired were “sometimes excessive” and “unjustifiably dangerous for people round about.” The identified breaches of the standing order on when to open fire “do not seem to point to a breakdown in discipline or to require censure.” In the circumstances that the soldiers faced “it is not remarkable that mistakes were made and some innocent civilians hit”.

11. The evidence of Soldier H provides one example of the difficulties of Lord Widgery’s report. Soldier H said that while in the car park of a housing development called Glenfada Park, he saw a gunman at a window. Soldier H fired and the gunman withdrew. He reappeared a few moments later and Soldier H fired again. On Soldier H’s account this cycle repeated itself 19 times in succession. Yet the physical and photographic evidence showed only one bullet hole in the relevant window. The evidence of the residents of the flat, which was accepted by Lord Widgery, was that the room had been empty at the relevant time. Lord Widgery concluded that the events did not happen as Soldier H had claimed and that there were 19 shots that were “wholly unaccounted for”. However, he made no further reference to these shots, or Soldier H’s failure to account for them, other than to conclude that some of the firing in this area had “bordered on the reckless”. Eight people were shot dead by soldiers firing into or from Glenfada Park.

12. The Widgery Report was immediately branded a whitewash. Public criticism was informed by the work of the Sunday Times Insight team, which published a lengthy article on the events of the day shortly after Lord Widgery reported. This pointed to very different set of conclusions.

13. Inquests were held into the circumstances of each of the deaths on 30 January 1972. The Coroner, Major Hubert O’Neill, returned open verdicts. At the conclusion of his hearings, on 21 August 1973, he also made a statement. In this he gave his opinion that the deaths had been “quite unnecessary”, that the Army had “run amok” and that innocent people had been shot and killed. He concluded: “I would say without hesitation that it was sheer, unadulterated murder. It was murder.” The Coroner’s statement was challenged as being an improper exercise of his

powers by the barrister for the Ministry of Defence, Brian Hutton QC (later Lord Hutton). The Reverend Ian Paisley called for Major O'Neill to be dismissed.

14. There followed decades of campaigning led by the families of those who died. In 1997, Professor Dermot Walsh wrote a report entitled "The Bloody Sunday Tribunal of Inquiry: A Resounding Defeat for Truth, Justice and the Rule of Law". This drew upon the statements made by soldiers to the Royal Military Police ("RMP") and the Treasury Solicitor in the days and weeks after Bloody Sunday. These had not been made available to the counsel for the families at the Widgery Inquiry. In Professor Walsh's view, they demonstrated material inconsistencies, discrepancies and alterations. The following year the Irish Government called for a new public inquiry and submitted a dossier to the UK Government in support of its position.

15. On 29 January 1998 the then Prime Minister, Tony Blair, announced that a new inquiry would be set up under the 1921 Act. The Tribunal originally comprised Lord Saville of Newdigate (an English Law Lord), William Hoyt (formerly Chief Justice of New Brunswick), and Sir Edward Somers (a former member of the Court of Appeal of New Zealand). Sir Edward resigned for health reasons and was replaced by John Toohey (former Justice of the High Court of Australia). The terms of reference were to inquire into:

> "the events of Sunday 30th January 1972 which led to the loss of life in connection with the procession in Londonderry on that day, taking account of any new information relevant to the events of that day."

16. In contrast to Lord Widgery's 80 days, the new inquiry took 12 years to produce its report. Oral evidence was obtained from 922 witnesses, with the written accounts of a further 1,562 being read by the Tribunal. The core bundle of materials ran to some 160 lever-arch files. The final report, published on 15 June 2010, comprised ten lengthy volumes and one comparatively short document entitled "Principle Conclusions and Overall Assessment of the Bloody Sunday Inquiry". The latter was longer than Lord Widgery's entire report, which had run to a mere 104 paragraphs and 11 summary points of conclusion. Lord Saville's inquiry was reported to have cost £195 million.

17. Among the conclusions reached by Lord Saville, Mr Hoyt and Mr Toohey were the following:

a. "The soldiers of Support Company who went into the Bogside did so as the result of an order by [their commanding officer] which should not have been given and which was contrary to the orders that he had received [from his superior officer]." [§5.2]
b. The first shots fired following the launch of the arrest operation were fired by a soldier. This initiated a mistaken belief among other soldiers that that republican paramilitaries were responding in force to their arrival in the Bogside. [§5.3]
c. There was a "serious and widespread loss of fire discipline among the soldiers of Support Company." [§5.4]
d. "The firing by soldiers of 1 PARA on Bloody Sunday caused the deaths of 13 people and injury to a similar numbers, none of whom was posing a threat of causing death or serious injury." [§5.5]
e. "What happened on Bloody Sunday strengthened the Provisional IRA, increased nationalist resentment and hostility towards the Army and exacerbated the violent conflict of the years that followed. Bloody Sunday was a tragedy for the bereaved and the wounded, and a catastrophe for the people of Northern Ireland." [§5.5]

18. Dealing with the events in Glenfada Park – where according to Lord Widgery some of the firing had "bordered on the reckless" – Lord Saville and his colleagues were forthright:

> "[3.108] In our view none of these soldiers [in Glenfada Park] fired in the belief that he had or might have identified a person in possession of or using or about to use bombs or firearms … We are sure that these soldiers fired either in the belief that no-one in the areas towards which they respectively fired was posing a threat of causing death or serious injury, or not caring whether or not anyone there was posing such a threat…
>
> [3.109] All four soldiers denied shooting anyone on the ground. However, Jim Wray was shot for a second time in the back, probably as he lay mortally wounded in the south-western corner of Glenfada Park North. Whichever soldier was responsible for firing the second shot, we are sure that he must have known that there was no possible justification for shooting Jim Wray as he lay on the ground.
>
> [3.110] Private G shot Gerard McKinney in Abbey Park. As we have already noted, his shot passed through this casualty and mortally wounded Gerald Donaghey … Private G falsely denied that he had fired in Abbey Park. He did not fire in fear or panic and we are sure that he must have fired knowing Gerard McKinney was not posing a threat of causing death or serious injury."

19. However, Lord Saville and his colleagues rejected suggestions that the events of the day were the result of a premeditated plan or conspiracy among senior military personnel or politicians.

20. Following the publication of the report the Prime Minister, David Cameron, gave a speech in the House of Commons:

> "There is no doubt, there is nothing equivocal, there are no ambiguities. What happened on Bloody Sunday was both unjustified and unjustifiable. It was wrong…
>
> what happened should never, ever have happened. The families of those who died should not have had to live with the pain and the hurt of that day and with a lifetime of loss.
>
> Some members of our armed forces acted wrongly. The government is ultimately responsible for the conduct of the armed forces and for that, on behalf of the government, indeed, on behalf of our country, I am deeply sorry."

21. The Prime Minister's speech was broadcast live to crowds that had gathered in Guildhall Square, the intended destination of the civil rights march on 30 January 1972. His words – those of a British, Conservative Prime Minister – were greeted with cheers.

Hillsborough: the events and the investigations

22. On 15 April 1989, Kenny Dalglish's Liverpool side were due to meet Brian Clough's Nottingham Forest in the FA Cup Semi-Final. The teams were to play at Hillsborough Stadium, home of Sheffield Wednesday. The same clubs had met at the same stadium at the same stage of the FA Cup the previous season. In 1988, Liverpool won 2-1. In 1989, the match was abandoned after six minutes and 96 people received fatal injuries.

23. The immediate cause of the tragedy was clear. Liverpool supporters had been directed to the Leppings Lane end of the stadium in order to enter the ground through turnstiles. Prior to kick off the crowd outside the ground grew in size to dangerous levels. Police were unable to exercise effective control and the turnstiles did not admit people sufficiently quickly to relieve the pressure. Requests were made to the match commander to open exit gates to allow the fans to enter the ground rapidly in order to retrieve the situation. At 2:52pm, the match commander gave an order that led to Gate C being opened. Over the next five minutes approximately 2,000 people entered through the gate. The majority then went through a tunnel directly opposite the

gate that gave access to the standing area, the West Terrace. The terrace was divided into "pens" by metal fences. The tunnel led to the two central pens, 3 and 4, which were already heavily populated with fans. Access to the pitch was prevented by a high, overhanging fence that was designed to stop pitch invasions. As a result of the movement of fans through Gate C, down the tunnel and onto the terraces, the fatal crush occurred.

24. Beyond those basic facts lay the question of what had caused or contributed to the disaster. Why had there been no order to prevent access to the tunnel once the decision to open Gate C had been made? How had the crush outside the stadium developed? Had the planning and preparation for the match been adequate? What role did the design and inspection of the stadium play – the number and efficacy of the turnstiles, the signage, the gradient of the tunnel, the assumed capacity of the West Terrace, the layout and height of the crush barriers and the construction of the fences that formed the "pens"? Was the response to the unfolding emergency by the police, club officials and ambulance staff present at the ground, and those called to it, adequate? Most controversially: what, if any, responsibility did the spectators themselves have for the disaster? Had they arrived unforeseeably late, or tried to enter the ground without tickets? Were they – to use the archaic expression that lingered through the proceedings – "in drink" such that they failed to respond to the reasonable requests of the police?

25. On 17 April 1989, Lord Justice Taylor was appointed by the then Home Secretary, Douglas Hurd, to carry out an inquiry into the events of 15 April 1989. He was assisted by two assessors, Brian Johnson, the Chief Constable of Lancashire, and Professor Leonard Maunder, an engineering professor. His terms of reference were:

> "To inquire into the events at Sheffield Wednesday Football Ground on 15 April 1989 and to make recommendations about the needs of crowd control and safety at sports events."

26. Lord Justice Taylor divided his inquiry into two stages. The first concerned the events on the day itself. He heard evidence from 174 witnesses between 15 May and 29 June 1989 and also considered written evidence through submissions and letters. He presented an Interim Report on 1 August 1989, and made interim recommendations about preventing further disasters and improving safety in the short term. The speed at which the Interim Report was produced – some 108 days after the disaster – is in part explained by the fact that the 1989/1990 football season was due to kick off a few weeks later.

27. Among the findings made by Lord Justice Taylor in his Interim Report were the following:

a. "The main reason for the disaster was the failure of police control" [§278].

b. The decision by the match commander to open Gate C without closing the tunnel giving access to the West Terrace was "a blunder of the first magnitude" [§231].

c. The "quality of the police evidence" was "in inverse proportion to their rank" [§279], with some officers being "defensive and evasive witnesses" [§280].

d. With some "notable exceptions" the senior officers were criticised in the following terms: "neither their handling of problems on the day nor their account of it in evidence showed the qualities of leadership to be expected of their rank" [§280].

e. The allegations that the fans had caused the disaster due to misbehaviour and drunkenness was rejected. However, Lord Justice Taylor found that "the police case was to blame the fans for being late and drunk and to blame the Club for failing to monitor the pens. It was argued that the fatal crush was not caused by the influx through gate C but was due to [a crush barrier] being defective. Such an unrealistic approach gives cause for anxiety as to whether lessons have been learnt. It would have been more seemly and encouraging for the future if responsibility had been faced." [§285]

28. The Prime Minister, Margaret Thatcher, described the report in (then) confidential Cabinet documents as a "devastating criticism of the police."

29. Lord Justice Taylor concluded that "no valid criticism" could be made of South Yorkshire Metropolitan Ambulance Service ("SYMAS"). His investigation into the emergency response was limited, a point that is discussed further below. He did, however, criticise other organisations and individuals including Sheffield Wednesday (notwithstanding what he found to be a "responsible and conscientious approach to its responsibilities" over the years), Dr Wilfred Eastwood, the engineer who advised the club about the stadium, and Sheffield City Council, who oversaw the safety certification of the stadium.

30. Lord Justice Taylor published his final report on 19 January 1990. The most prominent of its recommendations was for all-seater stadia for grounds above a designated size, a proposal that was subsequently implemented. The effect of this change on the culture of domestic football – the atmosphere of the grounds, the costs of tickets, the causative association with the formation of the Premier League and subscription television services – is keenly contested and

outside the scope of this paper. There is also dispute about whether such a dramatic step was necessary then, or remains necessary now. It is, though, perhaps worth noting two points. First, the recommendation for all-seater stadia was only one of the far-reaching proposals made by Lord Justice Taylor about the way that football should be organised. Second, his report came in the context of a sorry litany of stadium tragedies and near-misses in the years before Hillsborough – Wembley in 1923, Burnden Park in 1946, Ibrox in 1902 and 1971, Valley Parade in 1985. As he wrote:

> "I hope … I have made it clear that the years of patching up grounds, of having periodic disasters and narrowly avoiding many others by muddling through on a wing and a prayer must be over. A totally new approach across the whole field of football requires higher standards both in bricks and mortar and in human relationships."

31. Lord Justice Taylor's inquiry was the first of many investigations into the events of 15 April 1989 and their aftermath. This paper does not touch on the disciplinary, civil and criminal proceedings that took placed between 1989 and 2000 other than to note that no individual was successfully prosecuted in this period and none was subject to a formal professional disciplinary sanction. This was a source of intense disappointment and anger for the families of those who died and others, including many of those who had been caught in the crush and had survived.

32. Lord Justice Taylor's inquiry did not consider the individual circumstances of each of those who died following the crush at Hillsborough. This was left to the inquests conducted by the Coroner for South Yorkshire (West District), Dr Stefan Popper. These proceedings were to prove highly contentious for a number of reasons.

a. On the evening of 15 April 1989, Dr Popper ordered blood alcohol tests to be taken for each of those who had died, regardless of age. Many of the deceased were teenagers. The youngest, Jon-Paul Gilhooley, was 10. This decision was part of what was felt by many to be a grossly insensitive process by which the deceased were handled and identified in the aftermath of the disaster. This was compounded by the tortuous way in which their loved ones found out about their loss. Further, the decision to test for alcohol in the context of the claims about "drunken fans" caused distress and hostility.

b. At an early stage, Dr Popper ruled that those who died could not have been assisted by medical treatment after 3:15pm and hence that he would not investigate beyond that point. He based this conclusion on the pathology evidence that was available to

him, but the decision was nevertheless controversial then, and subsequently. The effect of this "3:15 cut-off" was that the emergency response to the disaster again went largely unexamined.

c. Dr Popper convened "mini inquests" in which the specific circumstances of each of the individual deaths were considered removed from the context of the wider events of the day. These took place ahead of the "generic" hearings, with the agreement of the lawyers then representing the families. They were completed quickly. They consisted mainly of a pathologist presenting the autopsy findings (including the blood-alcohol test results) and a police officer summarising the evidence of other witnesses. Contentious evidence was excluded, with the indication being given that it would be considered at a later stage. The "mini inquests" were considered to be perfunctory and insensitive. Professor Phil Scraton, author of "Hillsborough: The Truth", wrote that they had a "devastating effect" on most families, quoting one family member as saying that "Any trust I had went out of the window … like many other families I thought the mini-inquests insufficient."

d. The generic inquests proved still more controversial. The first evidence that was heard came from local pub owners and residents who were asked questions about the alcohol consumption and alcohol-related behaviour of the fans. They were followed by junior and senior police officers, many of whom also spoke about the fans' drinking and behaviour. The supporters' block of evidence came after these accounts. The tone throughout was adversarial.

33. At the conclusion of the inquests, the jury were left two verdicts: accidental death or unlawful killing. By a majority of 9 to 2 then returned verdicts of accidental death – those two words forming the entirety of their findings. That determination, and the manner in which the inquests had been conducted and perceived, caused immense anger and frustration among the families and their supporters. According to Professor Scraton, "the overwhelming shared feeling was that a serious miscarriage of justice had occurred." This was compounded by a sense that a false narrative had gained currency among the media and the public that – contrary to Lord Justice Taylor's conclusions – the behaviour of the fans had caused the disaster, as exemplified by the infamous Sun headline: "The Truth".

34. Dr Popper conducted 95 inquests. The 96th person to die as a result of physical injuries sustained on 15 April 1989 was Tony Bland, who had been left in a permanent vegetative state. He died in 1993 after lengthy legal proceedings concerning the withdrawal of treatment, culminating in the decision of the House of Lords in Airedale National Health Service Trust v

Bland. It is unknown how many other premature deaths have been contributed to by the physical and mental trauma suffered by those who were present at the stadium on that day.

35. In 1997 the Home Secretary, Jack Straw, established a review of the existing evidence concerning the Hillsborough disaster, to be conducted by Lord Justice Stuart-Smith. This became known as the Stuart-Smith Scrutiny. The Scrutiny was a response to the ongoing campaign led by the families to re-open the investigation of the disaster and to the emergence of fresh evidence, including suggestions that video evidence had been suppressed and that some police statements provided to the Taylor Inquiry had been amended prior to being submitted. The terms of reference were as follows:

> "To ascertain whether any evidence exists relating to the disaster at the Hillsborough Stadium on 15 April 1989 which was not available
>
> (a) to the Inquiry conducted by the later Lord Taylor; or
> (b) to the Director of Public Prosecutions or the Attorney General for the purpose of discharging their respective statutory responsibilities; or
> (c) to the Chief Officer of South Yorkshire Police in relation to police disciplinary matters;
>
> and in relation to (a) to advise whether any evidence not previously available is of such significance as to justify establishment by the Secretary of State for the Home Department of a further public inquiry; and in relation to (b) and (c) to draw to their attention any evidence not previously considered by them which may be relevant to their respective duties; and to advise whether there is any other action which should be taken in the public interest."

36. Lord Justice Stuart-Smith did conduct meetings as part of his Scrutiny but it was principally a paper-based exercise. He reported in February 1998 and concluded, among other matters, that allegations concerning the suppression of video evidence were unfounded, the 3:15pm cut-off time imposed at the original inquests had not limited the proper inquiry into the deaths, and that while some police statements had been amended prior to their submission to Lord Justice Taylor this did not in any way inhibit or impede the Inquiry's work (as was demonstrated by the adverse findings made against the police). He concluded that there was no basis for a further public inquiry, or for the quashing of the inquests. This outcome was another bitter disappointment to the families.

37. In the years that followed, the campaign for further investigation into the Hillsborough disaster continued. In particular, the families and their supporters pushed for the full disclosure of official papers relating to the disaster ahead of the usual 30 year closed period. On 15 April 2009 a memorial service was held at Anfield Stadium, Liverpool, to mark the 20th anniversary of the disaster. Andy Burnham, then the Secretary of State for Culture, Media and Sport and an Evertonian, spoke at the service on behalf of the Government. His speech was interrupted by a shout of "Justice for the 96". This was picked up by many thousands in the crowd who took up the chant, in what had come to be seen as a turning point. The Government, influenced by Mr Burnham and others, establishing an independent panel to oversee the disclosure of the papers and to produce a report based on them.

38. The Hillsborough Independent Panel ("HIP") was established in January 2010. It was chaired by the Right Reverend James Jones, then the Bishop of Liverpool. The other members were: Raju Bhatt, founding partner or Bhatt Murphy solicitors; Christine Gifford, an expert in the field of access to information; Katy Jones, a television producer and journalist who had worked on the influential film "Hillsborough" (1996); Dr Bill Kirkup, a consultant in public health and former Associate Chief Medical Officer in the Department of Health; Paul Leighton, a former Deputy Chief Constable of the Police Service of Northern Ireland; Professor Scraton, a criminologist who had researched and written extensively on Hillsborough; Peter Sissons, a journalist and television presenter who had been born and raised in Liverpool; and Sarah Tyacke, who had served as Chief Executive of the National Archives of England and Wales between 1992 and 2005 (among other posts).

39. HIP's terms of reference were as follows:

- oversee full public disclosure of relevant government and local information within the limited constraints set out in the Panel's disclosure protocol
- consult with the Hillsborough families to ensure that the views of those most affected by the tragedy are taken into account
- manage the process of public disclosure, ensuring that it takes place initially to the Hillsborough families and other involved parties, in an agreed manner and within a reasonable timescale, before information is made more widely available
- in line with established practice, work with the Keeper of Public Records in preparing options for establishing an archive of Hillsborough documentation, including a catalogue of all central Governmental and local public agency information and a commentary on any information withheld for the benefit of the families or on legal or other grounds

- produce a report explaining the work of the Panel. The Panel's report will also illustrate how the information disclosed adds to public understanding of the tragedy and its aftermath.

40. The HIP website contains an extensive and searchable archive of the disclosed papers. The Panel published its report in September 2012. Among its conclusions were the following:

a. The main cause of the disaster was the lack of police control.
b. The Liverpool supporters were in no way responsible for the disaster.
c. For the first time the ambulance service, SYMAS, was criticised for its response to the disaster.
d. There was evidence from the post mortem reports that indicated that as many as 41 of the victims might have survived had the emergency response been quicker.

41. Following the publication of the HIP Report, the Attorney General successfully applied to the High Court to have the verdicts of the original inquests (including that of Tony Bland) quashed under s.13 of the Coroners Act 1988. Fresh inquests were ordered by the Lord Chief Justice, Lord Judge. Investigations were also established into criminal and disciplinary matters, to be undertaken by Operation Resolve and the Independent Police Complaints Commission.

42. The inquests that were held between March 2014 and April 2016 at Birchwood Park, Warrington. Sir John Goldring, a Court of Appeal Judge, was appointed to conduct the inquests, which were heard before a jury. They concluded with a narrative verdict that contained critical findings in respect of the police planning for the match, the way in which the match was policed on the day, the decisions made by the match commander in respect of the opening of Gate C, the design and construction of the stadium, the certification and oversight of the stadium, the conduct of Sheffield Wednesday prior to and on the day, the conduct of Eastwood and Partners (the engineering firm instructed to advise on the stadium), and the response of both the police and the ambulance service to the emergency. Two findings above all others were given particular prominence in the coverage and discussions that followed. First, all 96 supporters were found to have been unlawfully killed. Second the jury were asked to consider whether any behaviour on the part of the football supporters may have caused or contributed to the dangerous situation at the Leppings Lane turnstiles. They answered: “No”.

43. The jury also considered the individual circumstances of each of the 96 people who died. They made findings on the medical cause of death and the time of death. The latter was generally

given as a period of time. At one end was the last point at which it could be said that the person was probably alive, and at the other was the point at which it could be safely concluded that they were dead. In many cases, this "window" extended beyond 3:15pm.

44. At the time of writing, six individuals have been charged with criminal offences relating to the disaster. These include the match commander, the club secretary for Sheffield Wednesday, senior police officers, and a solicitor instructed on behalf of South Yorkshire Police.

The fundamental purpose of an inquiry or inquest

45. Before turning to the question of what has and has not proved effective, it is worth considering the fundamental purposes of inquiries and inquests, and how they have been construed during the investigations considered above.

Inquiries

46. Lord Widgery wrote in his 1972 report that:

> "The Tribunal was not concerned with making moral judgments; its task was to try and form an objective view of the events and the sequence in which they occurred, so that those who were concerned to form judgments would have a firm basis on which to reach their conclusions."

47. In April 1998, Lord Saville opened his inquiry into the same events by stating that:

> "The Tribunal, Counsel, the Inquiry Solicitor and the Inquiry Secretary all have the same duty. That duty, and the object of the Inquiry, is to seek the truth about what happened on Bloody Sunday. We intend to carry out that duty with fairness, thoroughness and impartiality."

48. Lord Justice Taylor, opening his inquiry into the Hillsborough disaster in 1989, stated:

> "This is an Inquiry to discover, first, what happened, secondly, why it happened and thirdly, what lessons can be learned and recommendations made. If criticisms are levelled at organisations or individuals which are relevant to these issues I shall of course consider them and make any necessary finding. But it is not the purpose of the enquiry to apportion blame."

49. The leading text book on public inquiries, Public Inquiries [Beer et al, 2011] records the following more ambitious aims, accurately reflecting the greater expectations that now surround such investigations:

> "The purpose of a public inquiry may include to establish the facts, to ensure accountability, to learn lessons to prevent recurrence of events in the future, to restore public confidence (or allay public concern), and to discharge the State's investigative obligations."

50. Public inquiries also perform a further role, namely putting the evidence and materials that they gather into the public domain. When done effectively, this increases transparency in the inquiry's procedures and outcomes and – it is hoped – informs the wider public debate about the issues at stake. The rise of the internet, and the decline in deference to judicial opinion, have increased the importance of this element of an inquiry's work. Lord Saville's inquiry broke new ground in this respect, reflecting its chair's interest in information technology and the law. More recently HIP has developed this element further. The resulting websites are an invaluable source of information for journalists, historians, academics and members of the public. An interesting, and welcome, corollary is that the provision of such information in accessible form can lead to informed debate and indeed criticism of an inquiry's conclusions, as was shown in particular in respect of the reaction to the Hutton Inquiry into the death of Dr David Kelly.

Inquests

51. Lord Bingham provided the classic statement of the purposes of an article 2 inquest in the case of Amin:

> "to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others."

52. This oft-cited passage must, however, be read in light of the four statutory questions that an inquest must address: who died, when where and how. These are specific, limited questions that revolve around the causes of the death of an individual. The statute provides that the coroner or a jury (if there is one) may not "express any opinion" on any other matter, save for the information required for the death to be registered. An inquest is forbidden from returning a determination that is framed in such a way as to appear to determine any question of criminal

liability on the part of a named person, or civil liability on behalf of anyone at all. The tension between how to reach the destination plotted by Lord Bingham in a vehicle manufactured by the Coroners and Justice Act 2009 is considered further below.

53. It is also relevant to note that Lord Bingham's words came a decade after Dr Popper's original inquests into the Hillsborough disaster. That decade had seen substantial developments in legislation and case law concerning the role of inquests, particularly in response to the developing jurisprudence on Article 2 ECHR and the passage of the Human Rights Act.

Analysis

54. Much more is expected of an inquiry or inquest in 2017 than in the early seventies or late eighties. Lord Widgery's purist desire for a judge to simply set out an "objective view of the events and the sequence" in order to inform public debate remains at the heart of any investigation. However, the chances of achieving that Olympian goal to broad satisfaction have diminished due to a paradoxical raising and lowering of expectations. On the one hand, "judge-led inquiries" have become a screen onto which a vast number aspirations have been projected, by the judiciary (as per Amin), by politicians, and by the public. There is an expansionist trend in terms of the scope of public inquiries, the nature and extent of their investigations, representation before them, the disclosure that should be provided to parties and the public, and the results expected of them. At the same time, there is far less deference to the opinion of an individual judge; or put another way, a greater scepticism of the objectivity and abilities of the tribunal charged with investigating and reporting at an inquiry. Both trends are – to a degree – to be welcomed. Yet they undoubtedly make the task facing a major inquiry or inquest harder. There is a danger that in some instances they could make it impossible.

The Tribunal: Trust and independence

55. Public disquiet about the selection and suitability of a chair for a public inquiry is not a new phenomenon. In 1972 concerns were raised that that actions of 1 PARA would be considered by a former British Army officer, Lord Widgery. His military service was unsurprising given that senior members of the judiciary at that time would have been of fighting age during World War II. Major O'Neill had also been a British officer, and yet he came to very different conclusions about the events of the day. In the example of Hillsborough, three Court of Appeal judges oversaw three processes that received very different receptions. There is no evidence of which this author is aware that the socio-economic background of these individuals played any material part in determining the outcome.

56. What does emerge from a review of the different investigations into Bloody Sunday and Hillsborough is that trust is hard won and easily lost. While some steps can be taken to encourage confidence – for example, the use of two Commonwealth judges on the tribunal for the second Bloody Sunday inquiry – it is the work of the inquiry or inquest that will determine the respect that it commands. Here, the role of the tribunal's legal team is essential. Counsel and solicitors for the inquiry/inquest will undertake the vast majority of the "front of house" work both before and during the hearings: liaising with parties and participants, identifying witnesses, structuring the preliminary and evidential hearings, overseeing disclosure, receiving and responding to formal and informal submissions from the interested parties, and ultimately making submissions and questioning witnesses.

57. Missteps, be they or style or substance, can have a devastating effect both at the time and retrospectively. The Stuart-Smith Scrutiny was undermined at an early stage by a comment made by the judge to a bereaved father. The event is described by Professor Scraton:

> "Unexpectedly, the judge turned to Phil Hammond and, with a wry smile, asked: 'Have you got a few of your people or are they like the Liverpool fans, turn up at the last minute?' Phil Hammond was taken aback, not believing his ears. But there was no mistake. Stuart-Smith's outrageous comment was on tape, word for word. The remark spread among the families like wildfire. Jaws dropped open and there followed a collective outpouring of anger. How could a senior judge come to Liverpool to meet bereaved families and make such a crass and insensitive comment? It had taken over eight years to successfully combat the hurtful and unsubstantiated rumour that Liverpool spectators deliberately conspired to arrive late at Hillsborough; yet there it was, the judge's first words to the families."

58. Lord Justice Stuart-Smith subsequently apologised, in person, to many family members. Yet the damage had been done. Views of the Scrutiny were also shaped retrospectively by the discovery of an official memorandum stating that at the outset of the process, the view of the then Home Secretary, Jack Straw, was that:

> "[he] does not believe there is sufficient new evidence for a) a new inquiry, b) re-opening the inquest or c) prosecution of individuals. However, he believes that this is not publicly acceptable unless it comes from an independent source."

59. Twenty-five years earlier, Lord Widgery was invited to No. 10 Downing Street following his appointment as the judge hearing the inquiry into the events of Bloody Sunday. The official minute of that meeting recorded the then Prime Minister. Edward Heath, telling him:

> "It had to be remembered that we were in Northern Ireland fighting not only a military war but a propaganda war."

60. Fairly or otherwise, these official minutes have undermined assessments of the processes that followed. As Beer et al identify, the announcement of a public enquiry may be the source of scepticism as well as optimism – a belief that virtue is being signalled, or that issues are being kicked into the long grass, or passed on to another member of "the Establishment" who will do the right thing.

61. The conclusion that those heading a public inquiry or inquest must be independent and open-minded, and be seen to be such, is trite but fundamental. It is also a matter that cuts both ways. Independence, if is to mean anything, means freedom from undue influence from any of those involved in and participating with the inquiry or inquest, including the victims, their families and supporters.

62. The exemplar of the independent investigative tribunal is an inquest jury. A jury in any major inquiry will (in theory at least) be a cross-section of society, selected randomly save for the exclusion of those with a potential bias (real or perceived). At the recent Hillsborough Inquests, for example, the hearings were held in a neutral venue, Warrington, and among those excused from jury service were Liverpool supporters and those with close connections to institutional interested persons.

63. Juries are uniquely well-placed to provide binary answers to fundamental questions. However, if their answers are to command respect, they must hear potentially relevant evidence, have that evidence summarised effectively and fairly, and – where the evidence satisfies the relevant evidential threshold – be asked the relevant question in non-leading terms. It is submitted that this is demonstrated by the force of the recent Hillsborough jury's conclusion that the Liverpool supporters did not cause or contribute to the disaster. The jury must be asked the question and left to weigh the evidence without lawyerly thumbs being placed on the scales.

The terms of reference: an effective and comprehensive investigation

64. Inquiries are bound by their terms of reference, just as violinists are bound by the four strings at their disposal. Both inquiries into Bloody Sunday were convened under the same legislation, with strikingly similar terms of reference (which are set out above). Lord Widgery described his approach in the following terms:

> "I emphasised the narrowness of the confines of the Inquiry, the value of which would largely depend on its being conducted and concluded expeditiously. If considerations not directly relevant to the matters under review were allowed to take up time, the production of the Tribunal's Report would be delayed. The limits of the Inquiry in space were the streets of Londonderry in which the disturbances and the shooting took place; in time, the period beginning with the moment when the march first became involved in violence and ending with the deaths of the deceased and the conclusion of the affair."

65. Thus Lord Widgery investigated the events of approximately 30 minutes, taking place within an area of less than one square mile. Lord Saville and his colleagues took a markedly different approach:

> "We found it necessary not to confine our investigations only to what happened on the day. Without examining what led up to Bloody Sunday, it would be impossible to reach a properly informed view of what happened, let alone why it happened."

66. The latter inquiry considered, among other matters, the historical, political and military context of the events of the day, the planning for the operation, intelligence concerning the role of paramilitary organisations, the legality of the planned arrest operation, the treatment of those arrested on the day, and the manner in which evidence was gathered in the aftermath of the events. Witnesses included those who had served as Prime Minister, Cabinet Secretary, Foreign Secretary, and the Chief of the General Staff.

67. The quid pro quo is obvious and was identified by Lord Widgery. The wider the terms of reference, and the wider their interpretation, the longer the inquiry will take and the more it will cost. This is not just a matter of budget and convenience. Public confidence is undermined both by the expense involved and the external perception, however unjustified, that it is all taking too long and is simply not worth the effort. Where inquiries have arisen because an acute public concern, their ability to allay it will be undermined by a delay in reporting. The Taylor Inquiry demonstrates the conflicting tensions. There was an urgent need to report in light of the possibility that other football stadia may be unsafe. In meeting that need, and producing an interim report within a remarkable 108 days, the Taylor Inquiry inevitably had to rely on the evidence then available and to focus on those areas that seemed to be of greatest significance. Other areas, such as the emergency response and the process by which evidence was gathered, received less attention. This in turn led to criticism of the inquiry for failing to investigate them adequately.

68. Those inquiries and inquests that take place many years after the events in question face different pressures. In the intervening time much will have been said, written and theorised about the contentious events. There will be more matters of public concern to be investigated. This is particularly so when an earlier investigation has been subjected to criticism. Historic inquiries are, to greater or lesser extent, trapped by the processes that preceded them. They may also be accompanied by a greater pressure to make the new investigation "comprehensive" or "definitive" in order to justify the decision to reopen the matter.

69. Even where a wide remit is pursued, its boundaries will be controversial. There will always be other events that could, arguably, be considered: the deaths in Ballymurphy in August 1971 in respect of Bloody Sunday, the policing of the miners' strike at Orgreave in respect of Hillsborough. In essence this is a function of history being "just one ****** thing after another", to use (most of) the words of Rudge in the History Boys. The decision as to where to draw the line will always be difficult and fact-specific. It is, though, worth keeping in mind the limits of the tribunal. The usual role of judges is to find facts, establish causation, and (in public inquiries) make recommendations arising from the evidence. The further they move away from those core duties, the less expertise they bring to the role. Others will be better placed to put the events that they consider within a wider historic or cultural context. Judicial inquiries can inform public debate. It is unwise and unrealistic to expect them to resolve it.

70. The same point applies with still greater force to inquests. In England and Wales coroners and juries are proscribed by law from giving opinions on matters beyond the four statutory questions of who died, when, where and how. Any coroner who sought to issue a statement akin to that of Major O'Neill after Bloody Sunday would inevitably face a successful judicial review and no doubt also calls to resign. The question of "how" an individual died has been broadened in recent years. First, the decision in Middleton and the related provisions of the CJA 2009 require that where there is an arguable breach of the deceased's rights under article 2 ECHR the inquest must determine "by what means and in what circumstances" the death occurred. Second, and as is discussed above, the wider jurisprudence on article 2 has led to a broadening of coronial horizons. Third, the decision in Lewis, and the way in which it has subsequently been interpreted by coroners, has resulted in many inquests commenting on factors that may possibly have caused deaths as well as those that probably did so, in essence loosening the standard of proof. Yet the determination of a coroner or a jury is still, in general, limited to matters that are causative of death. Inquests are not public inquiries, or indeed criminal or civil proceedings.

Engagement and involvement of the families and victims

71. One of the more resonant of common themes between the investigations into Bloody Sunday and Hillsborough is the sense among the families of those who died in the disasters that the initial investigations were stacked against them. In part this was a function of the amount of representation made available to them, particularly at the original Hillsborough Inquests. Yet it was also about how the inquiries and inquests interacted with them: how much material was disclosed, the opportunity to make submissions, and the extent to which they were engaged in the various processes.

72. Disclosure may be among the driest of topics, but in this context it is also one of the most important. At the Widgery Inquiry the failure to disclose statements taken from the soldiers by the RMP and the Treasury Solicitor plainly hampered the degree of examination that they could face and adversely affected both the quality of the report and its reception. In Hillsborough, the retrospective knowledge that some police witness statements had been subject to amendment led some to question Lord Justice Taylor's conclusions, notwithstanding his withering criticism of the police. In both case, the limitations of disclosure and the way in which controversial evidence was handled by the original inquiries were central to the calls for new investigations.

73. The antidote adopted both by the Saville inquiry and the recent Hillsborough Inquests was to make the process of disclosure as complete and transparent as possible. In the latter case, this was building on the work of HIP, as referred to above. The result was, in both case, an enormous amount of material being made available to interested parties. The recent Hillsborough Inquests even went to the lengths of providing schedules of material that had been considered but assessed as irrelevant, so as to allow interested persons to make representations on that which they had not seen as well as the material that they had.

74. While this approach was broadly welcomed it comes at considerable cost, measured in money and time. The process of obtaining, reviewing, redacting and disclosing thousands of pages of material is painstaking and labour-intensive. Electronic databases will only be as effective as the material and coding that is placed onto them. "De-duplication", in other words efforts to ensure that the same document does not appear multiple times, is enormously helpful, but equally enormously time-consuming. The resources required are not just those of the inquiry or inquest, but also the many public and private organisations that may hold relevant materials. These organisations will of course have other pressing demands upon them. Much of the work involved is invisible to those outside of the inquiry or inquest, potentially a cause of mutual frustration that regular updates can only go so far to resolve. Disclosure is the principal reason why modern inquiries take much, much longer than their predecessors. It is a price that is to be

paid for a more transparent, inclusive process. In some instances, including Bloody Sunday and Hillsborough, it is an unavoidable and potentially useful way of seeking to overcome decades of mistrust.

75. To return to a theme, even the broadest of approaches to disclosure will still lead to disappointment at its margins. Material that may be of interest to participants but which is not relevant to the investigation may not fall to be disclosed. Sensitive personal details, including but by no means limited to medical issues, may be withheld. Where an inquiry or inquest draws upon intelligence sources there will almost inevitably be frustration at materials being withheld on the grounds of public interest immunity or because of concerns over the safety and well-being of the source of the information. In historic investigations, the sense that evidence is still be kept from the families can be particularly difficult to manage. Inquests face particular difficulties in dealing with secret information given the requirement that all evidence is heard in public. As a result, it has proved necessary in some instances to convert an inquest into a public inquiry in order to allow for "closed" sessions, as occurred for example in the inquests into the death of Alexander Litvinenko.

76. Beyond disclosure, the legal team for the inquiry/inquest will again play a critical role in seeking to engage and liaise with all interested parties, including the families and victims. Regular meetings and ongoing dialogue assist, as does a transparent approach to the work that is being undertaken. This is, of course, a mutual process. The lawyers for participants in inquiries and inquests are not (or should not be) passive recipients of the efforts of others. They have their own roles to play in managing expectations, explaining legal arguments and the processes involved, advising as to what can and cannot be achieved by the investigation, and assisting those who are required to give evidence. The importance of this last role, both for the individuals concerned and the efficacy of the inquiry/inquest as a whole, cannot be overstated. It should never be forgotten that many witnesses are being asked to recount the traumatic events of the worst day of their lives, events that may have affected them deeply for years and decades thereafter.

77. The question of how those who survived public disasters should participate in the subsequent inquiries and inquests remains a difficult one. In many cases the events will have a profound, life-changing effect on those who were injured and those who narrowly escaped death. Understandably survivors will be interested in the outcome of the investigations that follow and will, in many cases, wish to take part in them. In the Saville inquiry, those who were injured had legal representation. In the recent Hillsborough Inquests they did not, in part reflecting the fact that the latter process was by law constrained to examining the causes of deaths.

78. Survivors will have a role to play in providing evidence of the events in question. Such evidence will no doubt assist the relevant tribunal in addressing the central questions of what happened and why. It will also play a wider role in educating the inquiry or inquest and the public at large about the disaster, telling the story of what it was like on a human level to have been caught up in it. The selection and questioning of such witnesses should be undertaken with care and with regard to best practice on obtaining evidence from potentially vulnerable people.

79. Beyond this, there is a tension between the core role of an inquiry or inquest in forensically finding facts, and the task increasingly projected on to it of allaying wider public concerns and acting as a forum for those affected by the events. The former is likely to require only a relatively small number of survivors to be called to give evidence publicly and then for a relatively limited purpose – something that may cause immense disappointment among the wider group. Further, where the evidence of survivors makes or implies criticism of others fairness demands that they are given an opportunity to respond in evidence and, where appropriate, through questions and submissions at the hearings. The risk of an adversarial or unsympathetic atmosphere thereby increases, as does the possibility of the investigation being drawn into satellite matters that may be of limited relevance to its overall conclusions.

80. There is no simple way of squaring this circle. The most common solution proposed is more lawyers. It is suggested that this will rarely be an effective answer. The underlying interests of those who survived the disaster and the families of those who died in it will, in most cases, be so similar as to make separate representation at best duplicative and at worst unfair. In either case further representation means more expense and longer proceedings. However, there is also a strong argument that those who have survived disasters should be supported and assisted by the inquiry or inquest in providing evidence where they wish to do so. Not all of that evidence will be given at the hearings, but a public function may be served by providing a process through which individual accounts are obtained, retained and – subject to the consent of the individuals concerned and relevant legal considerations – disclosed.

The evidence

81. At the heart of any judicial or quasi-judicial process is the evidence that is adduced. Numerous criticisms were made of the past investigations in both Bloody Sunday and Hillsborough in this respect. Some of these are considered below, together with the efforts made by more recent proceedings to overcome them.

82. One of the first questions to arise will be that of who should perform the investigative function to obtain the evidence in the first place. When considering major public disasters involving agents of the state, the ancient question of who guards the guards will almost inevitably arise. Much of the evidence before Lord Widgery came from the RMP, one part of the Army investigating another at a time when, in the then Prime Minister's words, a "propaganda war" was ongoing. In Hillsborough, Lord Justice Taylor had to rely on the work of the West Midlands Police who, in the days before the IPCC, were conducting an investigation into the actions of the South Yorkshire force – i.e. one set of police officers investigating another. The more recent proceedings drew on more structurally independent investigators. Lord Saville and his colleagues instructed solicitors to take statements on behalf of the inquiry. The recent Hillsborough Inquests worked with Operation Resolve, a bespoke criminal investigation into the disaster, and the IPCC to obtain evidence. Memoranda of understanding between the inquests and these bodies were circulated. Notes and transcripts of interviews were disclosed. Transparency and access to materials were again adopted as the best means of overcoming the legacies of previous investigations.

83. A further common critique of earlier investigations was the order in which evidence was heard. At the Widgery Inquiry and the original Hillsborough Inquests the tribunal heard a block of evidence from the soldiers or police officers before hearing from those civilians caught up in the disaster. In the Hillsborough Inquests a further complaint was that the evidence of local residents and pub landlords, principally concerning the drinking and behaviour of Liverpool supporters, was also heard before any of the supporters' own accounts.

84. In contrast, Lord Saville and his colleagues heard civilian witnesses before the soldiers, although the contemporary accounts of the latter group had been fully summarised in Counsel to the Inquiry's opening statement and were in any event available to the tribunal from the outset of the hearings. For a professional tribunal the order of evidence is unlikely to influence outcome. Whether the same is true for a law jury is less clear. The recent Hillsborough Inquests, conscious of the previous approach, avoided arranging "blocks" of police and supporter evidence, and instead called witnesses in broadly chronological order. Given the length of the inquests, and the complexity and volume of the evidence, this aided clarity as well as fairness.

85. The role of counsel for the families in examining witnesses is a problematic area. Inevitably, and understandably, the families will want their lawyers to make their case to the witnesses who attend. Equally inevitably, this will mean that the hearings take longer and cost more. This attracted criticism in the case of Bloody Sunday and contributed to the provisions of the Inquiries Act 2005 that now limit the rights of core participants in statutory inquiries to participate in questioning. In theory, the "non-adversarial" nature of inquiries and inquests

means that questioning will come predominantly from counsel to the inquiry/inquest ("CTI"). From their neutral perspective CTI are well placed to obtain the factual answers required to provide the tribunal with the knowledge it requires to come to its conclusions and to do so efficiently and effectively. In practice, different participants will have different perspectives that they wish to bring to examination, and closing them down risks limiting or skewing the evidence and alienating the participants. This is particularly so in inquests where no submissions on the facts are allowed. The balance will always be a difficult one to strike. Two observations that may be worth noting are, first, that self-restraint from barristers is at least as important, if not more so, than intervention from the bench, and second, that the efficiency and focus forced on advocates by timetabled questioning can result in more effective advocacy.

86. The role of expert evidence was central to the criticisms of past investigations into Bloody Sunday and Hillsborough. In the former, analysis of firearm discharge residues led Lord Widgery to his conclusion that there was a "strong suspicion" that several of those who had been killed on Bloody Sunday had been firing weapons or handling bombs. This finding, perhaps above all others, caused intense distress and resentment among the families of those who died and the wider critics of the inquiry. The scientific basis on which it rested was comprehensively dismantled during Lord Saville's inquiry. Having considered all of the relevant evidence, the tribunal concluded that none of those who were killed on Bloody Sunday had been posing any threat to soldiers at the time they were killed and that with one exception, they had not been carrying firearms or bombs.

87. As has been noted above, the pathology evidence in the original Hillsborough Inquests led Lord Justice Taylor and Dr Popper to conclude that all of those who died were beyond medical help within a very short period of time following the crush. This resulted in a relatively limited inquiry into the emergency response, and the imposition of the highly contentious "3:15pm cut-off" in respect of evidence heard at the original inquests. Twenty years later, the HIP report concluded that as many as 41 of those who had died may have survived for more than an hour after the crush. This conclusion was based on evidence contained in some post mortem reports that the victims had developed cerebral oedema, a swelling of the brain that indicates ongoing but compromised blood and oxygen supply over a period of at least an hour – in other words, that they were alive but in a very vulnerable condition.

88. The challenge for the recent Hillsborough Inquests was to seek to re-assess the medical, pathology and witness evidence from first principles, at a distance of more than a quarter of a century. This was achieved by obtaining the best possible evidence of each individual's movements and treatment (on which, see below), and then seeking comment on this from a panel of experts who worked co-operatively to an agreed pattern. The inquiry drew on experts

in pathology, neuropathology, emergency response and intensive medicine. Experts instructed by the families met with those instructed by the inquiry and evidence was "hot-tubbed" – meaning that usually four experts from two disciplines gave evidence together, commenting and building on each other's findings. The result was that in respect of almost all matters of significance, a consensus emerged and could be explained with clarity to the jury and the wider public. The approach that led to the "3:15pm cut-off" was rejected. However, the experts also found that the references to oedema in the original post-mortem reports were too inconsistent and imprecise to allow for a conclusion that those in whom it had been noted had survived for over an hour. In general, a window for the time of death was adopted, reflecting the limits of the available evidence. Critically, each of those who died was assessed individually. No generic assumptions were made.

The importance of the individual

89. Every public disaster comprises many private tragedies. The inquiries and inquests that follow must balance the need to provide timely answers to questions concerning the fundamental causes of the catastrophe with their role in assessing the circumstances of each individual's death. The task is never straightforward. Where the balance is not found the effect on the credibility and the efficacy of the investigation can be disastrous. The many criticisms of the original inquests into the Hillsborough stem not just from the outcome but from the process that was followed, and in particular from a perceived failure to devote sufficient time and attention to the unique events experienced by each of those who died

90. The recent inquests sought to address this in a number of ways. The inquests opened with "pen portraits" of each of the 96 who died. In most cases these were prepared and read by family members. They contained information about the person's life, their families, their jobs, their interests, and their plans for the future. These memorials were deeply moving and, rightly, placed the victims at the heart of the proceedings. They also served a practical purpose in helping the jury to understand who each person was; at various points throughout the hearings the evidence given about a nickname or particular hobby could be used to help remind the jury of which individual was being discussed. The process also helped to establish a relationship between the inquests and the families. This approach had previously been used in the 7/7 Inquests and has since been adopted by other proceedings. It is important to note that the "pen portraits" were limited to matters of fact about the person who died. Fairness required that they did not contain opinion about the contentious issues that the inquests would address, or evidence about the effect of the loss of the loved one on the family.

91. The inquests were then split into three parts. In the first phase, evidence was called on the generic causes of the disaster. In phase two the individual movements and experiences of each of those who died were explored. In the third phase, the medical and experts considered the evidence adduced in phase two and gave their opinion on the causes and time of death.

92. A collegiate and innovative approach was taken to phase 2. Counsel to the Inquests prepared "evidence proposals" that set out the witnesses and evidence that they considered to be most relevant to each individual. These were circulated to all interested persons, who were invited to comment and contribute to them. A "further evidence proposal" was then prepared, and circulated in the same way. In a few cases further iterations were also required, until a broad consensus was reached. This approach contained a number of advantages. It helped to present a relatively comprehensible narrative to the jury about what happened to each person, and prevented or minimised the dangers of mistaken identifications. It ensured that the focus of each witness would be on the individual who died; repetitive questions about generic events were discouraged or stopped by judicial intervention. It assisted the experts by presenting them with a collection of evidence that was, for the most part, agreed to be relevant to the individual. Finally, it helped to engage the families – and other interested persons – in the process of the inquests.

93. This approach inevitably required huge amounts of time and resource. The identification of relevant witnesses was a painstaking process that required the officers of Operation Resolve and – crucially – family members to view television footage of the events of the crush and its aftermath in order to identify their loved ones. The footage was then used in interviews of witnesses who saw or treated those who died. Great care had to be take not to re-traumatise those involved. While many found giving evidence cathartic, the pain involved in watching images of a son, daughter, sibling, spouse or parent in the awful circumstances of the crush at Hillsborough is unimaginable.

Conclusions

94. This paper does not suggest that the more recent investigations into Bloody Sunday or Hillsborough are exemplars, or that the methods set out above are applicable to other inquiries or inquests. Both set records for the amount of time taken and the amount of public money spent. Many of the approaches described above were only possible because this. And of course many still dispute some or all of the findings reached, and criticise the process by which they were obtained.

95. There are, though, a few common themes that may have some general resonance.

96. First, holding a public inquiry or an inquest into a major disaster is an enormous undertaking. The task is a complex, difficult one. It will take time and cost money. All of these points apply with still greater force if the events in question took place many years earlier, particularly where previous investigations have proved unsatisfactory. Such projects should not be undertaken unless there is a compelling public need for them.

97. Second, independence is the most important characteristic that the tribunal must possess, be it a judge or jury. If that is compromised the whole process will be undermined, prospectively or retrospectively. Any attempt, whether well intentioned or otherwise, to achieve a pre-ordained outcome by loading the dice is potentially disastrous to the credibility and efficacy of the investigation.

98. Third, setting the boundaries of an inquiry or inquest is as important as it is difficult. Too narrow a remit risks leaving relevant areas unexamined, which may in turn distort the historical record and cause lingering resentment. Broad terms of reference carry their own risks. Excessive delay and cost undermines public confidence, the evidence and outcome may lack focus, and the tribunal's authority will diminish the further it strays from its core role of making findings of fact. Wherever the line is drawn there will always be an argument that it should be extended. Inquiries and inquests should contribute to a public debate about the issues on which they touch, but it is unwise and unrealistic to strive to be the final word.

99. Fourth, inquiries and inquests must earn the trust and respect of participants and the public alike. They cannot be assumed and should never be taken for granted. Fairness and transparency will assist. Like a student sitting an exam, showing the workings as well as presenting the answer will earn credit.

100. Fifth, and related, a broad approach to disclosure will in most cases assist in building confidence and should improve the quality of the evidence adduced. Where possible, making the disclosure publicly available fulfils an important function in its own right. However, the inevitable quid pro quo is that such a disclosure exercise will make the proceedings longer and more expensive than they would otherwise have been. No modern inquiry will ever produce an interim report within 108 days for this reason alone. Enormous burdens are placed on statutory bodies and other organisations that are already hard-pressed to perform their public duties.

Further, there is a danger that expectations of disclosure may have been raised to unrealistic levels, particularly in respect of access to highly sensitive intelligence materials.

101. Sixth, inquiries and inquests are most effective when they are inquisitorial rather than adversarial. The tribunal and its legal team can do much to engage the families and other participants in the process. However, they cannot achieve this goal on their own. All of those participating in an inquiry or inquest have a role to play, if they chose to do so, in making it a success.

102. Finally, inquiries and inquests are arduous, draining events for all involved in them. Perspective is easily lost. In historic cases families, victims and survivors may have campaigned for decades to establish the investigation. They will have extremely detailed knowledge of the events in question, and firm views on them. Huge amounts of hope and expectation may be invested in the outcome. Then, at the very point when they have achieved their goal after years of being ignored or rejected, they have to hand control of the process over to a deliberately dispassionate group of lawyers who seem obsessed with process and procedure. For those lawyers, it is easy to feel battered into a defensive posture. Being fair to all will inevitably mean disappointing some. The responsibility of "getting it right" can seem overwhelming. Frustrations can develop at what feel like unrealistic requests and misplaced criticisms. At darker moments, the sentiment expressed by Charles Babbage can develop:

> "Propose to an Englishman any principle, or any instrument, however admirable, and you will observe that the whole effort of the English mind is directed to find a difficulty, a defect, or an impossibility in it. If you speak to him of a machine for peeling a potato, he will pronounce it impossible; if you peel a potato with it before his eyes, he will declare it useless, because it will not slice a pineapple."

There is no ready solution to this tension, save perhaps for remembering that both sides will almost certainly have a point.

103. These are dangerous times for public inquiries and inquests. They face a paradox: on the one hand, there are ever greater expectations of what they can do; on the other, a growing scepticism of their ability to do it. There are good reasons for both of these pressures. Inquiries and inquests should be transparent, disclosure and engagement are central elements of their work, and it is welcome that they are recognised as important but not sacrosanct processes in our public life. Yet it is very easy to undermine or over-burden an inquiry, thereby making it harder to construct a robust and enduring outcome. This can be done with good intentions, such

as may happen when terms of reference are drawn too widely or too ambitiously. It may be the result of a lazy cynicism that denounces the process as a "stich up" from the start, on the basis of prejudice, politics or ad hominem attacks. And it can happen through carelessness (or worse), where efforts to obtain a preferred result compromise the independence of the body charged with providing it. The study of past endeavours may or may not assist in producing lessons for the present. What it does show, unequivocally, is that where inquiries or inquests fail in their tasks the effect can be devastating both to the individuals involved and the wider public good.

MAJOR INQUESTS AND INQUIRIES –

HANDLING SECRET AND SENSITIVE INFORMATION

Emma-Louise Fenelon

Publicity is justly commended as a remedy for social and industrial diseases. Sunlight is said to be the best of disinfectants; electric light the most efficient policeman.

Former Supreme Court Justice Louis D. Brandeis

Introduction

1. 68 public inquiries have been established since 1990, eight of which are currently live. [1] These include the inquiry into the deaths of 71 people in the Grenfell Tower fire in West London, an inquiry into 50 years of undercover policing, an inquiry into allegations of institutionalised child abuse and an inquiry into blood contamination leading to the deaths of an estimated 2,400 people. Notable live or recently concluded inquests include investigations into the Birmingham Pub bombings, the death of Alexander Perepilichnyy, Hillsborough and the Northern Ireland 'Legacy' Inquests. The subject matter of such investigations makes it plain that by their nature public inquiries and inquests involve acutely sensitive and occasionally secret information.

2. For a more comprehensive review of this topic see the detailed coverage in The Inquests Book by Garnham and Cross and Public Inquiries by Jason Beer QC. The more limited objective of this paper is to:

    a. recap some of the principles underpinning the use and restriction of secret and sensitive information in inquiries and inquests; and

    b. consider some recent issues that these principles have thrown up in practice in several ongoing major public inquiries and recent inquests.

Generally in Public

3. The presumption, for both inquiries and inquests, is that full proceedings will take place in public. The Inquiries Act 2005 ('the Inquiries Act') requires the Chairman to ensure members of the public, including the media, are able to attend the inquiry or to see and hear a simultaneous transmission of proceedings at the inquiry, and to obtain or to view a record of evidence and documents given, produced or provided to the inquiry.[2]

4. Similarly, an inquest and any pre-inquest hearing must be held in public. However, where issues of national security (and in the case of pre-inquest hearings, the interests of justice) apply, a Coroner can

[1] How Public Inquiries Can Lead to Change, Emma Norris and Marcus Shepheard, Institute for Government, December 2017

[2] s18, Inquiries Act 2005

direct that the public (but not interested parties) be excluded.[3] In *Re (Coker) v HM Coroner for South London* [2006] EWHC 614 Sullivan J stated; "*…it is difficult to see why a pre-inquest hearing should be in private and not in public…Article 2 does support the proposition that pre-inquest hearings should be held in public unless there are cogent reasons in any particular case for holding them in private*."[4]

5. The public-ness of inquiries and major inquests is important. It ensures the broadest possible range of information is considered before conclusions are reached and reports written; enhances public confidence in the process of the investigation itself; facilitates public accountability for disasters and other serious failings; and as was persuasively argued by Mason J in the High Court of Australia; "*By virtue of the publicity which usually attends the proceedings and ultimately the report when it is made public, the commission of inquiry serves the beneficial purpose of enlightening the public, just as it enlightens government.*[5]

Production of Evidence

6. The Inquiries Act enables a Chairman to compel provision or production of evidence, and limits the grounds on which it is permissible to withhold information.[6] No person, however, can be compelled to provide information that they would not be required to provide in civil proceedings.[7] Exemptions include, for example, information subject to duties of confidence, privilege against self-incrimination, legal professional privilege, public interest immunity, and parliamentary privilege.[8]

7. In addition, the presumption that an inquiry will proceed in public is subject to certain constraints, including limits on attendance and disclosure or publication of any evidence provided to an inquiry.[9] These can be imposed by: 'Restriction Notice' given by the Minister or Chairman at any time before the end of an inquiry; or, a 'Restriction Order' made by the Chair during the course of an inquiry.

8. The Inquiries Act outlines several permissible grounds for a Restriction order or Notice: the restriction is required by a statutory provision, EU obligation or rule of law; or, the minister or chairman considers the restriction to be conducive to the inquiry fulfilling its terms of reference or to be necessary in the public interest. Consequently, when a statute, EU obligation or a rule of law requires it, a Restriction Order *must* be made. However, when a restriction appears conducive to the inquiry investigation or necessary in the public interest, the decision involves a balancing exercise, having regard in particular, but not exclusively, to the matters outlined in Section 19(4) as follows:

    a. *the extent to which any restriction on attendance, disclosure or publication might inhibit the allaying of public concern;*

    b. *any risk of harm or damage that could be avoided or reduced by any such restriction;*

[3] The Coroners (Inquests) Rules 2013 (the Inquest Rules 2013)

[4] Citing *R (D) v SSHD* [2006] 3 All ER 946

[5] *Victoria v Australian Building Construction Employees' and Builders' Labourers' Federation* [1982] 41 ALR 71

[6] s21 and 22, Inquiries Act 2005

[7] s22, Inquiries Act 2005

[8] See Public Inquiries by Jason Beer QC Chapter 5 for a comprehensive explanation

[9] s 19(1), Inquiries Act 2005

c. *any conditions as to confidentiality subject to which a person acquired information that he is to give, or has given, to the inquiry;*

d. *the extent to which not imposing any particular restriction would be likely—*

(i)to cause delay or to impair the efficiency or effectiveness of the inquiry, or

(ii)otherwise to result in additional cost (whether to public funds or to witnesses or others).

9. It is common for inquiries to publish rulings or protocols on how they propose to approach the use of sensitive information. The Chairwoman of the Independent Inquiry into Child Sexual Abuse for example, outlined the following reasons why complete/part documents provided to the Inquiry should be withheld from wider dissemination and/or redacted prior to disclosure as follows[10]:

a. *the information in question is sensitive and irrelevant to the Inquiry's work;*

b. *the information in question constitutes personal data within the meaning of the Data Protection Act 1998, further disclosure of which is prohibited by that Act;*

c. *the information in questions is covered by a Restriction Notice made under section 19(2)(a) of the Inquiries Act 2005;*

d. *the information in question would cause harm or damage to the public interest such that it is contended that a Restriction Order should be made by the Chairman for the reasons set out in section 19(3) to (5) of the Inquiries Act 2005 which include considering any conditions as to confidentiality which apply to the circumstances in which the information was obtained and avoiding:*

i. *death or injury*

ii. *damage to national security or international relations*

iii. *damage to the economic interests of the United Kingdom or any part of the United Kingdom*

iv. *damage caused by disclosure of commercially sensitive information;*

e. *harm or damage to the public interest on grounds of public interest immunity applies;*

f. *Prejudice to the course or outcome of any ongoing criminal investigation or prosecution into matters relating to the information proposed for release;*

g. *Publication of the information may result in a breach of the Sexual Offences (Amendment) Act 1992; and*

h. *The information falls to be redacted under the Inquiry's guidance on the redaction of the identity of individuals*.

10. In a Ruling on the approach the Undercover Policing Inquiry would take to Restriction Orders made on 3 May 2016 ('the 2016 Ruling'), the Chairman stated: "*Decisions whether to make a restriction order under section 10 of the Inquiries Act 2005 that depend on the balance of the public interest will be made*

[10] Inquiry Protocol on Redaction of Documents (VERSION 2), 21 September 2016

under section 19(3)(b) taking account of relevant public interest factors whether they are specifically mentioned in section 19(4) or (5) or not."[11]

11. The Ruling outlined the principal competing public interest factors in the Inquiry as: (1) the need to allay public concern about the subject matter, process, impartiality and fairness of the inquiry; and (2) the need to avoid or reduce a risk of harm to serving and former police officers and the need to avoid or reduce the risk of damage to effective policing. It went on to articulate specific considerations that would apply when considering restriction order applications made in the public interest. These include: the source and nature of possible harm; the identification of those who may be harmed; any medical evidence on which an officer relies; the existence and quantification of any pre-existing risk of harm, the means other than a restriction order that may be available to avoid or reduce a risk of harm; whether and the extent to which those means would, without the restriction order, avoid or reduce the risk.[12]

Confidentiality Circle

12. One of the options considered by the Chairman of the Undercover Policing Inquiry was the possibility of disclosure to a limited circle of interested persons. This would have enabled, for example, disclosure of relevant sensitive information to a prospective witness on terms as to confidentiality. This had been considered in *McGartland and another v Secretary of State for the Home Department* [2014] EWHC 2248, in which it was suggested that sensitive material could be considered by the parties and the Court in a private rather than a closed hearing from which the claimants would be excluded. The sensitivity of the material was such that leading and junior counsel, the second claimant and a solicitor would be subjected to the developed vetting process. The Court of Appeal upheld the decision declining to approve a 'confidentiality circle' in which Mitting J observed:

> *"There are a number of problems with this suggestion: the process of vetting is highly intrusive and would take months; the second claimant, whose mental health is said to be fragile, might not welcome such intrusions; and if the defendant considered that the first claimant could not be trusted with such information, someone, presumably a judge, would have to determine whether or not he could be. That would be likely to require oral evidence and it would require material which may be sensitive material, in the statutory definition, to be considered. That would require a Section 6 declaration [of the Justice and Security in itself. Such a procedure is cumbersome and may well be unattainable. In any event, it would not satisfy the defendant's proper insistence upon keeping such techniques closely guarded within the intelligence community."*[13]

13. Deciding against the operation of a 'Confidentiality Circle' in the Undercover Policing Inquiry, the Chairman stated:

> *In my view it is unrealistic to suppose that disclosure to a limited circle would answer the practical problem faced by the Inquiry. If, for example, the Inquiry traced witnesses with a view*

[11] Restriction Orders: Legal Principles and Approach Ruling, p 78

[12] *Ibid.* p 81

[13] See also *Re: an Application for Judicial Review by the Next of Kin of Gerard Donaghy (Deceased)* (unreported judgment of 8 May 2002) and *AHK and others v Secretary of State for the Home Department* [2013] EWHC

to disclosing the cover name of an undercover officer it would have no advance knowledge whether the witness would be prepared to receive information on terms of confidentiality. Even if the witness undertook to keep the information confidential the Inquiry could not guarantee that the confidentiality would be kept or that inadvertent disclosure would not be made. If a leak did take place, given the constant interest in exposure of undercover police officers it would be virtually impossible to trace its source. It seems to me that in general I should proceed on the basis that disclosure of any sensitive fact to anyone outside the Inquiry team will amount to disclosure to the public. [7-7 SEP]

Delay

14. The processing of Restriction Orders is a time consuming process, and has caused significant delays in the Undercover Policing Inquiry. Following the Chairman's 2016 Ruling, the Inquiry issued a consultation paper seeking the views of core participants in respect of a proposal to change and speed up the process of applying for and determining anonymity applications. Non-police and non-state core participants argued that if anonymity orders are granted on the unilateral account of those seeking them without public scrutiny of the underlying evidence, this would deny them the opportunity to make meaningful submissions. On 22 February 2018 the Chairman issued a statement outlining a streamlined process for anonymity applications, which precipitated a walk out on 21 March 2018. Despite much coverage in the media about this, no judicial review has been brought testing the Chairman's approach to Restriction Order applications, nor has there been a successful challenge to a decision granting anonymity.

Protective Measures for Witnesses

15. Public inquiries have a range of measures available to enable witnesses to give evidence anonymously, including restrictions on disclosure or publication of an individual's name, identity and image, the use of screens and voice distortion, and delays in broadcasting. The common law test has been considered in an number of Northern Ireland cases.[14] The leading case is *Re Officer L and others* [2007] UKHL 36.

16. *Re Officer L* the House of Lords considered the principles to be applied to applications for anonymity in the context of a statutory inquiry. Robert Hamill died from injuries received in a violent incident that took place in Portadown, County Armagh on 27 April 1997. The public concern was that police officers on duty nearby failed to intervene to prevent the attack on him. An Inquiry was ordered under section 44 of the Police (Northern Ireland) Act 1998, and subsequently converted to an Inquiry under the Inquiries Act. Several police officers due to give evidence sought orders that they could give evidence anonymously. The refusal to grant anonymity was successfully challenged by judicial review, and the Northern Ireland Court of Appeal dismissed the Inquiry's appeal.

17. The House of Lords reviewed the obligations on the Inquiry arising under both Article 2 and the common law. Lord Carswell, in an opinion with which the other members of the House agreed, outlined the test as follows:

    a. the state must "*take appropriate steps to safeguard the lives of those within its jurisdiction*";

[14] See for example *Re A and others' Application for Judicial Review (Nelson Witnesses)* [2009] NICA 6

b. when the authorities know or ought to know of "*a real and immediate risk to the life of an identified individual*" there is a positive obligation on the state to take reasonable preventative measures;

c. the "real" risk to which the European Court of Human Rights referred is one that is objectively verified and an "immediate risk" is present and continuing;

d. the threshold for a "real and immediate risk" is constant and not variable according to the type of act contemplated;

e. the subjective fear of the applicant does not form part of the test, but it may be evidentially relevant in identifying the risk.

18. The test includes a requirement that in the event of a real and immediate risk to life the state must take *reasonable* preventative measures, which reflects the principle of proportionality by "*striking a fair balance between the general rights of the community and the personal rights of the individual.*" In *Re Officer L*, Lord Carswell observed;

> *"It has not been definitively settled in the Strasbourg jurisprudence whether countervailing factors relating to the public interest—such matters as the credibility of the inquiry and its role in restoring public confidence—as distinct from the practical difficulty of providing elaborate or far reaching precautions, may be taken into account in deciding if there has been a breach of article 2. It does appear that it may be correct in principle to take such factors into account… but I would prefer to reserve my opinion on the point*."

19. Anonymity was considered in the context of another public inquiry in *R (on the application of Associated Newspapers Ltd) v Leveson* [2012] WL 14723. In that application for judicial review, Associated Newspapers, in the course of the Leveson Inquiry, challenged the Chairman's decision to receive information from journalists who wished to provide evidence about the inner workings of news organisations anonymously for fear of losing their job or damaging their professional reputation. Unlike the situation in *Re Officer L,* in which the inquiry knew the names of the witnesses who would give direct evidence that might impact specifically on them, with regard to the anonymous journalists, nobody would know their identity and the Chairman recognised that very limited weight could be attached to such evidence as a result. Toulson LJ acknowledged the legitimate concerns of those newspaper organisations that may be subject to 'anonymous' criticism as a result, but upheld the Chairman's decision, commenting; '*the public interest in the chairman being able to pursue his terms of reference [SEP] as widely and deeply as he considers necessary is of the utmost importance*.'

20. *Re McDonnell's Application for Judicial Review* [2015] NICA 72 concerned evidence given by police officers about subjecting a man to control and restraint procedures shortly before he died from a heart attack. The real and immediate risk posed by attacks from dissident republicans prompted the Coroner to grant the prison officers anonymity and screening during the inquest. Following the verdict that there had been excessive use of force by prison officers which had caused or contributed to the death, the deceased's mother appealed the refusal of her application for judicial review of the decision to grant anonymity and screening. Her appeal was dismissed. One of the issues that arose was whether, in a case where there has been a finding of unlawful conduct on the part of an individual contributing to a death, it was appropriate to conduct a balancing exercise even where the Article 2 threshold in relation to that individual had been met. The Court of Appeal of Northern Ireland noted the observations of Lord Carswell outlined above and indicated their view that such a balancing exercise may indeed be necessary. It was held, however, that no such countervailing considerations arose in

this case where no individual or group of individuals was identified as personally responsible for any wrongdoing.

21. Reviewing these authorities, the Chair of the Undercover Policing Inquiry suggested that given the unqualified nature of Article 2 and 3; "*it would have to be a very compelling public interest that prevented a statutory inquiry from imposing a restriction whose effect would be to avoid or reduce a real and immediate threat to life by exposure of a witness' identity*."

22. Inquests are also capable of facilitating anonymity for witnesses. A Coroner may direct that a name or other matter not be disclosed except to persons specified, and may exclude specified persons from an inquest during the giving of evidence by a witness under the age of 18 if the Coroner is of the opinion that doing so would be likely to improve the quality of the witness's evidence. [15] Evidence can be facilitated by video link and given from behind a screen where this would be likely to improve the quality of the evidence or allow the inquest to proceed more expediently.[16]

Ciphers

23. Ciphers are routinely used to anonymise references to individuals during the course of inquiries and inquests. Their use is not always straightforward however. The experience of those involved in the Independent Inquiry into Child Sexual Abuse is a case in point. On 15 August 2016 the Chairwoman issued a Restriction Order granting general anonymity to all Core Participants alleging that they are the victim and survivor of sexual offences. The general guidance indicated that individuals accused, but not convicted of sexual or other physical abuse against a child, should have their identities redacted and a cipher applied except where this was so widely known that such redaction would serve no meaningful purpose.[17] However, the Inquiry also indicated that persons in authority (employees/elected members/board members/committee members) generally should *not* be redacted.

24. A problem arose when in the course of evidence during the Roman Catholic Church (English Benedictine Church) Module, it was necessary to refer to individuals about whom allegations of child abuse had been made, who were *also* persons in authority. Referring, for example, to a headmaster of a school by cipher would undermine any anonymity granted, as it would be plain on the basis of the year he was in post who was referred to and, in the course of evidence, what he had been accused of. The solution was for the inquiry to refer to persons in authority by name when in connection with their role, but by cipher when referring to the allegations against them. This was not an easy task however, as often their position of responsibility was relevant to the allegations made against them.

25. A further issue in relation to ciphers may arise at the conclusion of the Kingsmill Massacre Inquest, which concerns the killing of 10 Protestant workmen in 1976. The families of those killed argued in February this year that suspects ought to be stripped of their ciphers. This was prompted following the High Court's January ruling in *R(on the Application of Hambleton) v Coroner for the Birmingham Inquests (1974)* [2018] EWHC 56 (Admin), quashing the decision of the Coroner that the alleged perpetrators of the Birmingham pub bombings would not be part of the framework of the new inquests. It remains to

[15] s 45, Coroners rules, Coroners and Justice Act 2009

[16] s 17 and 18, The Coroners (Inquests) Rules 2013 (the Inquests Rules 2013)

[17] Protocol on Redaction of Documents, 21 September 2016

be seen whether the suspects in the Kingsmill Massacre will be named, and if not, whether the conclusion could refer to them by cipher.

Evidence in Inquests

26. Until 2013 a Coroner's power to obtain information from third parties was limited. It relied upon witnesses volunteering information, the duty of the police to supply all relevant material in their possession, and a Coroner's power to obtain a witness summons to require a witness to attend the inquest and give evidence or bring documents.[18]

27. Since the introduction of the 2009/2013 statutory scheme[19], a Coroner's powers are significantly enhanced. A Coroner conducting an investigation may now require any person, including the Crown or Agency of the Crown,[20] to provide a written statement and to produce relevant documents or other things in her custody or control that she considers relevant to the investigation.[21] In addition, a Coroner can require a person to attend at a time and place and give evidence at an inquest, and produce any document or other thing which is relevant to the inquest.

28. There are limits, however, to a Coroner's discretion to investigate, and make findings about matters of concern arising from the circumstances of a person's death. In particular, there is no mechanism by which evidence can be heard in the absence of interested parties. The difficulties arising from conducting inquests in public can lead to the conversion of an inquest into an inquiry, as occurred in the cases of Azelle Rodney, Alexander Litvinenko and Anthony Grainger. In the case of *Litvinenko* for example, following a successful claim for Public Interest Immunity brought by the Foreign Secretary, certain evidence was to be necessarily excluded from the Inquest. In the Coroner's view this evidence was essential to carrying out a full and fearless investigation, leading him to request that the Government establish a statutory inquiry, which would enable the consideration of evidence in the absence of interested parties and reaching of findings in light of that evidence.

29. The Secretary of State refused to do so. Her decision was challenged by way of judicial review brought by Mr Litvinenko's widow.[22] For the Secretary of State it was argued that since the Inquiry would have to consider the HMG material in closed session and its report would have to be drafted or published in such a way as to exclude all reference to the material. On this, Richards LJ stated;

> *"…a statutory inquiry would have to consider the HMG material in closed session and would be precluded from disclosing it; but the chairman of the inquiry would almost certainly be able to state publicly some useful conclusion based on the material without disclosing the material itself. It is extremely difficult to envisage a situation in which no conclusion could be stated publicly without infringing the restriction notice. All this applies even more forcefully in relation to an inquiry of the kind sought by the Coroner, which would look at all the open evidence as well as the closed material, not only increasing the chances that some useful finding could be made but also making it that much easier to express conclusions without revealing the closed*

[18] Jervis on Coroners, 13th Edition, Chapter 7, 7-12

[19] Schedule 5 of the Coroners and Justice Act 2009 was brought into force on 25 July 2013 per SI 2013/1869 art.2(k)

[20] *R (HMRC) v Liverpool Coroner [2014] EWHC 1586 (Admin.) DC*

[21] s 2, Schedule 5, Coroners and Justice Act 2009

[22] *R (Litvinenko) v Secretary of State of the Home Department* [2014] HRLR 6

material. The proposition that a statutory inquiry would be incapable of achieving any useful purpose is therefore in my view a bad one."

30. The judicial review succeeded and an Inquiry was subsequently established, enabling the Inquiry Chair to consider some evidence in closed session and conclude: "*Taking full account of the all the evidence and analysis available to me, I find that the FSB operation to kill Litvinenko was probably approved by Mr Patrushev and also by President Putin*."

Conclusion

31. Public inquiries and inquests rarely satisfy everyone and balancing competing and occasionally, irreconcilable interests, is not always possible. Dealing with sensitive and secret information is a significant part of the work of any public inquiry in particular, and is often cited as a reason for delay. The average inquiry takes two and a half years to publish its final report, and since 1990 nine inquiries have taken five years or more.[23] Some have suggested that greater use of Independent Panel model may be the best way forward. The lack of powers to compel evidence, however, are likely in most instances to prevent effective investigation of serious institutional failings.

[23] How Public Inquiries Can Lead to Change, Emma Norris and Marcus Shepheard, Institute for Government, December 2017

MAJOR INQUESTS AND INQUIRIES –

WHEN ARE PUBLIC INQUIRIES ESTABLISHED OR INQUESTS REOPENED?

Gideon Barth

1. Major and extraordinary events such as disasters or multiple deaths which shock the public often lead to the swift announcement of a public inquiry. This is in part the response of politicians who want to be seen to be actively responding to a disaster. More importantly, it is the framework through which the State responds to a disaster with a view to the following: (a) establishing the facts; (b) ensuring accountability; (c) learning lessons; (d) restoring public confidence; (e) reconciliation and resolution.

2. But there appears to be a real lack of consistency or clarity as to when a public inquiry will or should be ordered. Why do some events lead to large public inquiries lasting many years and at great expense whereas other events are considered with just a private review and report? Do these examples shed light on the resumption of major inquests?

3. This paper tries to provide some coherence as to when public inquiries and major inquests are granted:

    a. The Inquiries Act 2005 and public concern;

    b. Reasons given for announcing an inquiry;

    c. Reasons given for not having an inquiry;

    d. Resumed and fresh inquests;

    e. Conclusions.

A. Inquiries Act 2005 and public concern

4. The Inquiries Act 2005 brought together various pieces of legislation to provide a comprehensive statutory framework for public inquiries.

5. Section 1(1) provides:

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

6. There is no guidance in the 2005 Act as to what counts as evidence of public concern or even what is capable of causing public concern. It is perhaps this ambiguity which causes criticism that inquiries are simply used as political tools by ministers when a difficult issue arises, or used as political footballs to win votes. But the ambiguity also gives deference

and flexibility to those that are better placed to measure whether a matter is of public concern as times progress than legislative text. Indeed, it would be close to impossible to include a more precise test or criteria in the primary legislation.

7. There are certain significant events which are clearly matters of such significant public concern that the exercise of the power to establish a public inquiry is almost inevitable. Most recently, the tragic disaster of the Grenfell Tower fire on 14 June 2017 led to the Prime Minister announcing a full public inquiry the following day. Similarly, as the concerns about child sexual abuse across various institutions continued to be exposed following the death of Jimmy Savile, given the widespread concern and apparent extent of the scandal, a public inquiry was no surprise. At the time, the outbreak of E.coli in schools in South Wales in September 2005 caused widespread concern as to merit the ordering of an inquiry which reported in March 2009[24].

8. But on other matters, despite calls from growing numbers of groups and individuals, ministers have refused to establish an inquiry[25].

B. Reasons for announcing an inquiry

9. The Cabinet Office produced draft guidance on inquiries[26] in 2010 and included the following:

> *An inquiry may be set up for one, or more, reasons. These include: to establish the cause of a major disaster, accident or other event involving significant damage or loss of life; to make recommendations as to how to learn lessons from such an event; to investigate serious allegations of general public concern which require thorough and impartial investigation, and for which ordinary civil or criminal processes may not be adequate or appropriate.*

10. Separate guidance from the Cabinet Office[27] in relation to a possible inquiry into phone-hacking suggested the following characteristics in public inquiries which have taken place:

    - *Large scale loss of life*
    - *Serious health and safety issues*
    - *Failure in regulation*
    - *Other events of serious concern*

[24] 'The Public Inquiry into the September 2005 Outbreak of E.Coli O157 in South Wales' http://gov.wales/docs/dhss/publications/150618ecoli-reporten.pdf

[25] Most notably, these include the murder of Pat Finucane and the events surrounding the so called "Battle of Orgreave". Further detail on these issues is set out below.

[26] 'Inquiries Guidance' https://www.parliament.uk/documents/lords-committees/Inquiries-Act-2005/caboffguide.pdf, page 2

[27] http://researchbriefings.files.parliament.uk/documents/SN06410/SN06410.pdf

11. In its written response to the House of Lords Select Committee on the Inquiries Act in 2014, the Government stated:

> *Ministers take a number of factors into account when deciding whether to establish an inquiry, including whether the public interest will be served by an inquiry rather than another form of investigation and whether that public interest will outweigh the costs.*[28]

12. Where an event demands an investigation, it is not simply the case that a public inquiry will be ordered. Lord Faulks, then Minister of State for Justice, stated in the House of Lords that ministers will first consider a public inquiry under the Inquires Act but[29]:

> *Ministers will, however, also want to consider whether another vehicle would be more appropriate and effective, bearing in mind time and cost. This could be a non-statutory inquiry… an independent review; a parliamentary inquiry; an inquiry of privy counsellors; an investigation with a public hearings element overseen by a judge or QC; an independent review with a public hearings element; or, in a very limited number of cases, an inquiry established under other legislation, such as the Financial Services Act 2012 or the Merchant Shipping Act 1995.*

13. In its paper, having dismissed the idea that there should be fixed criteria regulating the setting up of inquiries, the House of Lords Select Committee considered the 14 inquiries held under the Act to establish whether the Cabinet Office guidance or 'characteristics' were present. They established the following:

    - *Five inquiries involved multiple deaths (five or more people) [Mid Staffordshire, 2010; Vale of Leven Hospital, 2009; C. difficile, 2008; Penrose, 2008; ICL Plastics factory explosion, 2008];*
    - *One inquiry (ICL, 2008) was set up in relation to health and safety concerns;*
    - *Ten inquiries involved a previous investigation report and/or regulatory or investigatory body involvement [see below];*
    - *Two inquiries (Baha Mousa in 2008 and Al Sweady in 2009) were established in the context of international law or relations. One inquiry (Azelle Rodney, 2010) was established because it was not possible for the death to be adequately investigated by an inquest because there was certain intelligence material which the coroner was not permitted to be privy to; and one (E.coli, 2006) was set up due to the scale of the event.*[30]

14. The inquiries which investigated (or included investigations of) failures by regulatory or investigatory bodies are the most numerous. They are:

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[28] 'The Inquiries Act 2005: post-legislative scrutiny', House of Lords Select Committee on the Inquiries Act 2005, Para 50, https://publications.parliament.uk/pa/ld201314/ldselect/ldinquiries/143/143.pdf

[29] http://researchbriefings.files.parliament.uk/documents/SN06410/SN06410.pdf

[30] 'Inquiries Act 2005: post-legislative scrutiny', para 55

- *The Mid Staffordshire Inquiry investigated the failure by the Healthcare Commission, Care Quality Commission (CQC) and the Health and Safety Executive (HSE) to monitor the Mid Staffordshire NHS Trust.*
- *Inquiries into the deaths of Victoria Climbié and Baby P examined the combined failure of the multi-agency child protection system by the care services, NHS and the police.*
- *The Bichard Inquiry into the Soham murders examined the failure of police child protection systems.*
- *The Shipman Inquiry investigated failures by the police, the coronial system, the system of death certification, the General Medical Council (GMC) and others.*
- *The Equitable Life Inquiry examined the failure of the Financial Services Authority (FSA), the Government Actuary's Department (GAD) and the Department of Trade and Industry (DTI).*
- *The Azelle Rodney Inquiry was set up because of intelligence material which the coroner was not permitted to be privy to but examined the failure by the Independent Police Complaints Commission (IPCC) to identify any significant fault on behalf of the police.*[31]

15. The conclusion of the Select Committee, therefore, was:

> *Where deaths, injuries or other incidents have occurred which seemingly need not and would not have occurred if regulatory or investigatory bodies had properly been carrying out their duties, there will be public concern not just at what has happened but at the failure to prevent it happening. In such cases a public inquiry may well be the best and only way of alleviating public concern.*[32]

16. It appears, therefore, that while the event under inquiry is an important matter of public concern, it is the wider context of the event, whether that is the failures of regulatory powers or the knock-on impact of the event that leads to the 'public concern' triggering an inquest.

17. A similar point was made when considering whether inquests or inquiries are more appropriate in the context of individual deaths. Azelle Rodney was shot and killed by a police firearms officer in North West London in April 2005. The IPCC investigation made no findings of significant fault on the part of the police. An inquiry replaced the inquest because it could not consider certain intelligence material and ultimately found that the shooting had *"no lawful justification"*. By contrast, following the death of Mark Duggan, who was shot by police in August 2011 in Tottenham, riots spread across London and other cities in the UK. Despite the public concern surrounding the death and its effect on

[31] Ibid, para 56.
[32] Ibid, para 57.

wider related issues, which might indicate the need for a public inquiry, an inquest was held. The inquest returned a conclusion of lawful killing. The lack of an inquiry is perhaps a surprising outcome given the aftermath of his death but accords with the Select Committee's view that inquiries often arise when there is a failure of a regulatory or investigatory body.

C. Reasons not to have inquiries

18. The decision to hold an inquiry is essentially a political one. It can certainly be a useful tool to make recommendations, thoroughly investigate disasters and scandals and allay public concerns. It can also be used to gain political plaudits, champion causes, and kick awkward issues into the long grass. But they are almost always hugely expensive, time-consuming enterprises draining time, energy, resources and precious funds from the sponsoring departments. As a general rule, ministers are reluctant to concede that a public inquiry is required. The following examples include a few of the reasons given by ministers in rejecting calls for an inquiry.

Deepcut Barracks

19. Between 1995 and 2002, four soldiers (Privates Sean Benton, Cheryl James, Geoff Gray and James Collinson) died at Princess Royal Barracks, Deepcut, Surrey. There were allegations of poor supervision, bullying and violence at the base[33]. In relation to the death of Pte James Collinson, an inquest returned an open verdict and the Surrey Coroner said:

> *My own personal view… is that the MoD should take whatever steps are necessary to restore public confidence in the recruitment and training of young soldiers whether at Deepcut or elsewhere. I personally believe they should have nothing to fear from an inquiry held in public (if that is what is necessary) where the various issues outside the direct causation of the deaths of James and others can be explored in greater depth.*

20. There was a clear feeling among the families of those that died that there were endemic problems at the Barracks which had not been resolved. The Secretary of State for Defence opposed an inquiry into the deaths, stating in a debate in the House of Commons that the matter had been *"subject to thorough and detailed examination"* by Surrey Police[34].

21. However, on 15th December 2014, Nicholas Blake QC was commissioned to conduct a review of the circumstances in which these four deaths occurred. The review (released shortly after the James Collinson inquest concluded) found that the other three deaths were self-inflicted but noted a number of possible contributing factors. Calls continued

[33] https://www.telegraph.co.uk/news/2016/06/03/now-give-us-a-deepcut-public-inquiry-family-of-another-young-rec/

[34] 'Inquiries Act 2005: post-legislative scrutiny', para 97.

for a public inquiry[35] and there remains a feeling that a public inquiry would be the best way to get to the truth[36].

Mid Staffordshire NHS

22. In response to the initial calls for an inquiry into the failings at the Mid Staffordshire NHS Trust, and the high mortality rate in the Trust, the Secretary of State for Health opposed a full public inquiry in 2009 *"given the thoroughness of the reports already produced"*[37] and relied on smaller investigations into specific aspects of the hospital and local healthcare system (including the first Francis inquiry which was highly critical of the care).

23. The campaign group made up of victims, Cure the NHS, and others, continued to campaign for a wider public inquiry which was announced under the coalition government in 2010. In particular, the focus for the second Francis inquiry and the campaign groups was the systemic issues of the failure of regulators, safeguards and the culture.

Pat Finucane

24. Pat Finucane was an Irish human rights lawyer who was killed by loyalist paramilitaries in Northern Ireland on 12 February 1989. There were suspicions of collusion between the paramilitaries and the British army, a number of investigations took place indicating collusion and the campaign for an inquiry spread to Ireland and the United States.

25. Admitting collusion, the Government ordered a report (not a public inquiry) by Sir Desmond de Silva QC into the murder. In establishing the report, the Prime Minister stated in Parliament: *"I profoundly believe that the right thing … is to open up and tell the truth about what happened 22 years ago. Frank acknowledgement of what went wrong, an apology for wat happened – that is what is required."*[38] This was followed by the Secretary of State for Northern Ireland who stated:

> *Despite the clear conclusions of previous investigations and reports, there is still only limited information in the public domain. That is why my right honourable friend the Prime Minister and I have committed to establishing a process to ensure that the truth is revealed.*[39]

26. The report in December 2012 was highly critical of the extensive levels of collusion between the State and loyalist paramilitaries. The family and campaigners decried the

[35] https://www.amnesty.org.uk/press-releases/uk-deepcut-deaths-public-inquiry-needed
[36] https://www.independent.co.uk/news/uk/home-news/public-inquiry-into-deepcut-barracks-could-be-held-as-best-method-of-getting-to-the-truth-says-army-a7065566.html
[37] 'Inquiries Act 2005: post-legislative scrutiny', para 97.
[38] 'The Report of the Patrick Finucane Review', Sir Desmond de Silva QC, page 3, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/246867/0802.pdf
[39] Ibid

report as a 'sham' because they had no input into the investigation and continued to push for a public inquiry[40]. Prime Minister David Cameron refused to hold an inquiry because:

> *…if we look at the other inquiries… we see that some of them took five or six years or longer and cost tens of millions of pounds, and I do not believe that they got closer to the truth than de Silva has in his excellent and full report.*[41]

27. A judicial review of the decision was brought and the appeal dismissed by the Court of Appeal[42]. On 27 July 2017, the Supreme Court granted permission to appeal.

Battle of Orgreave

28. During the miners' strikes in 1984, the most violent clash between police and pickets occurred during the 'Battle of Orgreave', on 18 June 1984. A huge number of police officers, horses and riot gear and aggressive police tactics were seen as an offensive and planned police action to deter the strikes, while the police say they were defending themselves from rocks and bottles. Many were injured. There were also allegations that the BBC deliberately misrepresented footage so as to make it appear that the police were responding to the aggression of the pickets[43]. 95 miners were charged with various offences but their trials collapsed amid allegations that the police evidence was unreliable.

29. Many years later, in 2012, an IPCC investigation was commenced and reported in 2016 that there was *"evidence of excessive violence by police officers, a false narrative from police exaggerating violence by miners, perjury by officers giving evidence to prosecute the arrested men, and an apparent cover-up of that perjury by senior officers."* Calls for an inquiry escalated following the conclusion of the Hillsborough inquests. The same force was responsible for policing the football match in 1989 at which 96 people died and campaigners alleged that there followed a similar pattern of misinformation, impunity and "cover-up".

30. In October 2016, Home Secretary Amber Rudd rejected calls for an inquiry[44], citing the following reasons: there were no deaths or wrongful convictions; and, most importantly, given the length of time and the changes in the criminal justice system, there would be very few lessons for the policing system to learn from events that took place three decades before.

31. The Labour Party have promised that they will launch a public inquiry into what happened at Orgreave if they enter government.[45]

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[40] https://www.theguardian.com/uk/2012/dec/12/pat-finucane-family-report-sham
[41] 'Inquiries Act 2005: post-legislative scrutiny', para 97.
[42] *Geraldine Finucane v The Secretary of State for Northern Ireland* [2017] NICA 7
[43] https://www.theguardian.com/commentisfree/2015/jul/22/orgreave-truth-police-miners-strike
[44] https://www.theguardian.com/politics/2016/oct/31/government-rules-out-orgreave-inquiry
[45] http://www.bbc.co.uk/news/uk-england-south-yorkshire-41379097

Alexander Litvinenko[46]

32. In November 2006, Alexander Litvinenko died as a result of poisoning by radioactive polonium. A police investigation identified two suspects who would be prosecuted for murder but attempts to obtain their extradition from Russia were unsuccessful. An inquest into Mr Litvinenko's death was initially opened on 30 November 2006, adjourned pending the police investigation and resumed on 13 October 2011.

33. The Coroner decided that the issues within the scope of the inquest included the possible culpability of the Russian state and whether there were failures by the British state to prevent Litvinenko's death. However, as a result of successful PII applications in respect of material from the Government, the Coroner concluded that it would not be possible for him to conduct a full, fair and fearless investigation on those particular topics. However, he noted that a public inquiry under the 2005 Act would be able to hear evidence in closed session. As such, he ruled that those issues would no longer be included within the scope of the inquest and, on 4 June 2013, the Coroner wrote to the Lord Chancellor to request a statutory inquiry.

34. The Home Secretary (Theresa May MP) refused to order a statutory inquiry but acknowledged that there were factors pointing in opposite directions. As to those in favour of a public inquiry:

    - The Coroner had reviewed the evidence and was of the view that there was a *substantial* need for a statutory inquiry.
    - That a proper investigation could not be carried out by the Coroner as a result of the PII claim.
    - That section 19 and 20 of the Inquiries Act 2005 allowed evidence in an inquiry to be heard in closed session.
    - The Coroner indicated he would be willing to act as chairman of the proposed inquiry, to minimise delay and disruption.

35. Factors pointing in the opposite direction included:

    - An inquest will go a substantial way to addressing or allaying public concern about the incident.
    - Article 2 EHCR was not engaged, so the question is to be considered on a domestic rather than ECHR context. As such, the inquest could be conducted on the narrower basis of looking at the four statutory questions only.
    - An inquiry could sit in closed session but would only be able to reveal publicly that which the inquest could reveal publicly so it was of no significant advantage.

[46] This summary is based on the High Court judgment in *R (Marina Litvinenko) v SSHD and Others* [2014] EWHC 194 (Admin)

- The Government could consider the possibility of an independent review on the closed material separate to the conclusion of the inquest.
- An inquiry is costly of time, money and resources.
- Foreign countries would be able to grasp the integrity of an inquest led by an independent coroner rather than an inquiry under a chairman appointed by the Government.

36. Marina Litvinenko, the widow of Mr Litvinenko, challenged the Home Secretary's decision by way of judicial review. At the hearing, the Home Secretary accepted that article 2 *was* engaged (per *Menson*[47] – the duty which arises where someone is killed by a member of the public, not a state agent) but that it had been discharged. The Court allowed the challenge and quashed the decision. In his judgment, Lord Justice Richards held that:
    - The first reason, that the inquest will go a substantial way to addressing public concern was not a sustainable reason for not holding an inquiry. The Coroner had decided that the Russian state involvement issue was no longer within the scope of the inquest, so it was unsustainable that the issues would be substantially investigated.
    - It was accepted by the SSHD in the course of the JR that article 2 *was* engaged but the Court held that steps had been taken to fulfil the *Menson* duty in relation to Litvinenko's death. As such, an inquiry was not required to fulfil the state's article 2 obligations.
    - Given that the Coroner had initially determined that the Russian state involvement issue fell within scope, the fact that he was prevented from considering it due to the sensitive material meant that he was unable to fulfil the legislative purpose of the inquest. The SSHD erred in considering that this was a reason to refuse the request.
    - The inquiry could plainly provide some useful conclusions after hearing evidence in closed session, so this was a poor proposition on which to base a refusal.
    - While cost was a relevant consideration, it could not, alone, be a good reason to refuse an inquiry so the Court did not consider it further.
    - In respect of the foreign understanding of the independence, this was also not determinative.
37. The High Court could not mandate the establishment of an inquiry but it quashed the reasons provided by the Home Secretary for refusing one. On 22 July 2014, the Home Secretary announced a public inquiry under the Inquiries Act 2005.

Other factors

[47] *Menson v United Kingdom* [2003] 37 EHRR CD220

38. A number of other judicial reviews have provided further guidance on reasons that are acceptable for rejecting public inquiries. For example, a minister is entitled to have regard to the costs of an inquiry[48] and there is no presumption in favour of a fully open (as opposed to a private) inquiry but that the balancing of open versus closed inquiry are pre-eminently a matter for a minister[49].

39. In the context of a death, it is very likely that the extent to which the state has complied with its article 2 obligations will be a very important factor. These will no doubt be considered further in the *Finucane* appeal in the Supreme Court.

D. Inquests

40. Under the Coroners and Justice Act 2009, section 1 requires a Coroner to investigate a death if they have *"reasons to suspect that (a) the deceased died a violent or unnatural death, (b) the cause of death is unknown, or (c) the deceased died while in custody or otherwise in state detention."*

41. In most situations, the original opening of an inquest is uncontroversial. However, problems may arise in either of the two following circumstances: first, when the inquest is suspended, often pending criminal proceedings, there can be a dispute as to whether the inquest should be resumed; secondly, an inquest may be resumed if the original conclusion is quashed.

42. An inquest may be suspended, pursuant to section 11 of the 2009 Act: (a) where there are possible or actual criminal proceedings (Sch 1, para 1-2); (b) where there is to be a public inquiry (Sch 1, para 3), unless there is an exceptional reason; or (c) in any case where it appears appropriate (Sch 1, para 5). Thereafter, generally, an inquest can be resumed where the Coroner considers that there is sufficient reason for resuming it.

Resumption or fresh inquest

43. A decision not to resume an inquest is subject to judicial review. This paper does not seek to cover all the grounds on which a challenge by way of judicial review may be brought but may include some procedural irregularity or improper or unlawful decision on the part of the Coroner, for example, refusing to leave to the jury a verdict open to them on the evidence[50], or refusing to hear material expert evidence[51].

44. In *R (Douglas-Williams) v Inner London Coroner*, the Court was invited to quash the conclusions of an inquest on the basis that the Coroner had improperly directed the jury. While it was accepted that there had been an improper direction, the Court held that the same verdict would have been reached in any event. In his judgment, Lord Woolf MR approved earlier guidance which is instructive as to when the Court is likely to order a fresh inquest:

[48] *R v Secretary of State for Health, ex parte Crampton* (CA, 9 July 1993)
[49] *R (Persey) v Secretary of State for environment, Food and Rural Affairs* [2002] EWHC 371 (Admin)
[50] *R v Inner North London Coroner, ex p. Linnane (No.2)* (1990) 155 JP 343
[51] Ibid

> *The court is not to attend to mere informalities, nor to criticise minutely the summing up, or the nature of the evidence or of the procedure. But if the inquest has been so conducted, or the circumstances attending it are such, that there is a real risk that justice has not been done, and a real impairment of the security which right procedure provides that justice is done and is seen to be done, the court ought not to allow the inquisition to stand.*[52]

45. Aside from 'traditional' judicial review grounds, many challenges rely on the enhanced investigative obligations placed on the state by article 2. In *R (Silvera) v Senior Coroner for Oxfordshire and Ors*[53] an inquest was opened and suspended pending criminal investigation. A woman was killed by her daughter who had a history of mental illness and who had absconded from a psychiatric hospital. As a result of a guilty plea to manslaughter, there was no criminal trial in which the circumstances were examined. Two other investigations were undertaken by the relevant NHS Trust and by a social worker, both in private, albeit that the latter took into account the family's views. The Coroner refused to resume the inquest as the *"facts of the death have been adequately aired".* The Court held that article 2 was engaged and the Coroner had applied the wrong legal test. The police investigation and two subsequent NHS and local authority investigations were insufficient as they were not public investigations before an independent judicial tribunal, and a fresh inquest was ordered.

46. In *R (Amin) v Secretary of State for the Home Department*[54], a man was murdered by his cell-mate and a number of investigations took place. The prison service accepted responsibility for the death, the cellmate was convicted of murder, an internal inquiry was undertaken by the prison service, and a police investigation looked at whether the police service or its employees should be prosecuted. The Commission for Racial Equality investigated racial discrimination in the prison service referring specifically to this death. An inquest was opened but it was suspended pending the criminal investigation and never resumed. The Home Secretary refused the request from the family to hold a public inquiry. They then challenged – and the House of Lords accepted – that the state had not complied with its article 2 obligations in the absence of an independent public investigation. None of the investigations, individually or cumulatively, met the minimum standards required by the ECHR. Lord Bingham famously outlined the purposes of an article 2 compliant investigation (a description that is equally important in respect of article 2-compliant inquests and public inquiries):

> *The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and*

[52] *R (Douglas-Williams) v Inner London Coroner* [1999] 1 All ER 344
[53] [2017] EWHC 2499 (Admin)
[54] [2003] UKHL 51

that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others.

Attorney General's Fiat

47. This is the most appropriate method to establish an inquest where new facts or evidence have emerged which shed light on the death. The Attorney-General and subsequently the High Court must be satisfied that (a) a coroner has refused or neglected to hold an inquest, or (b) where an inquest has been held, whether *"it is necessary or desirable in the interests of justice"* that a fresh inquest is held[55].

48. Fresh evidence needs no elaboration save that this can include an expert report which contradicts earlier evidence[56] or an expert changing their opinion.

49. The Court must also be satisfied that it is necessary and desirable in the interests of justice to hold a fresh inquest. Certain examples would include whether the fresh evidence would provide a 'real possibility' of a different verdict[57]; the fact that an individual died in prison would be a compelling factor[58]. The length of time from the original inquest is a reason not to resume an inquest. For example, in *Linnane*, the court held that a lapse of 21 months since the death rendered a second inquest inappropriate. However, in *N (A Child)*, a new inquest was ordered albeit that it was five years since the death[59].

50. In the *Hillsborough* application by the Attorney General, following the publication of the report by the Hillsborough Independent Panel, the Court ordered fresh inquests into the deaths of 96 individuals more than 20 years after they died (see further detail and analysis in Matthew Hill's paper). The Lord Chief Justice held:

> *The single question is whether the interests of justice make a further inquest either necessary or desirable. The interests of justice, as they arise in the coronial process, are undefined but, dealing with it broadly, it seems to us elementary that the emergence of fresh evidence which may reasonably lead to the conclusion that the substantial truth about how an individual met his death was not revealed at the first inquest, will normally make it both desirable and necessary in the interests of justice for a fresh inquest to be ordered. The decision is not based on problems with process, unless the process adopted at the original inquest has caused justice to be diverted or for the inquiry to be insufficient. What is more, it is not a pre-condition to an order for a further inquest that this court should anticipate that a different verdict to the one already reached will be returned. If a different verdict is likely, then the interests of justice will make it necessary for a fresh inquest to be ordered, but even when significant fresh evidence may serve to confirm the correctness of the earlier verdict, it may sometimes nevertheless be desirable for the full extent*

[55] Section 13(1)(b) Coroners Act 1988
[56] *Attorney General v Hampshire Coroner* (1990) 155 JP 190
[57] *R (Mulholland) v HM Coroner for St Pancras* [2003] EWHC 2612 (Admin)
[58] *R (Sutovic) v HM Coroner for North London* [2006] EWHC 1095 (Admin)
[59] *N (A child) v Coroner for the City of Liverpool* [2001] EWHC Admin 922.

of the evidence which tends to confirm the correctness of the verdict to be publicly revealed. Without minimising the importance of a proper inquest into every death, where a national disaster of the magnitude of the catastrophe which occurred at Hillsborough on 15 April 1989 has occurred, quite apart from the pressing entitlement of the families of the victims of the disaster to the public revelation of the facts, there is a distinct and separate imperative that the community as a whole should be satisfied that, even if belatedly, the truth should emerge.[60]

E. Conclusions

51. The judgment in the *Hillsborough* case refocuses our attention on the importance of the public interest and public concern in obtaining major inquests and inquiries into events.

52. Previous investigations – whether into deaths or major public scandals or disasters –may not undercut the calls for a public inquiry or a fresh inquest. Ministers often rely on this as a reason for rejecting calls for an inquiry but a previous investigation that is considered to be incomplete, partial or otherwise inadequate may actually increase the determination of campaigners and pressure on the government. It will often be insufficient for an investigation that does not involve the victims or families or one which takes place in private to satisfy the public concern about the events in question. In particular, where there is evidence of wrongdoing on the part of an institution, the public concerns around a 'cover-up' will rarely be allayed until there is a public inquiry. The example of the Orgreave Campaign is instructive. There has been no judicial review of the Secretary of State's decision, but neither has there been a general acceptance of it. The issue is now in the political rather than the legal real, but it is not necessarily concluded.

53. A failure by a regulatory or investigatory body will likely trigger calls for and lead to the announcement of a public inquiry. In these circumstances, the index event will be investigated but the public concern will really focus on the failure of the system to prevent or respond appropriately to perceived failures. It is telling that there was no public inquiry into the death of Mark Duggan, despite the public concern surrounding the riots. In the event that a regulatory body or coroner highlights a need for a public inquiry, it is likely that this will be a very compelling factor.

54. The cost of an inquiry or inquest is likely to be a relevant matter to consider when weighing the public interest but it is unlikely to ever be determinative in the courts (even if it is in the mind of ministers).

55. Investigations which touch on matters of national security or other topics which involve public interest immunity applications can be the trigger for a public inquiry. This is the best method by which secret documents can be examined and some conclusions and information can be provided to the public. However, as the Finucane case shows, national security issues may make ministers less inclined to concede that a public inquiry should be undertaken.

[60] *HM Attorney-General v HM Coroner for South Yorkshire* [2012] EWHC 3783 (Admin)

56. Fundamentally, therefore, public inquiries and resumed inquests have been used in the past to deal with public dissatisfaction at the investigations and regulatory procedures which have preceded them. The inquiry into the *Contaminated Blood Scandal* is one such example. But the swift launching of the *Grenfell Tower Inquiry* shows a developing understanding that, however thorough, extensive and critical an investigation may be, the public concern or interest will often only be satisfied by a fully public investigation – whether in the form of an inquest or a public inquiry.

Deborah Coles

Executive Director of INQUEST

Deborah has worked for the charity since 1989. She leads INQUEST's strategic policy, legal and parliamentary work and has considerable expertise in working to prevent death and ill treatment in all forms of detention and for more effective accountable learning. She has been an independent expert adviser to numerous government committees and inquiries, is a regular media commentator, delivers conference papers nationally and internationally and is author of numerous articles and publications.

Deborah chairs meetings of lawyers representing bereaved families at the Grenfell Tower Inquiry. She coordinates “Inquest Law”, the journal of the Inquest Lawyers Group. She is also on the board of trustees of Clean Break and is a special adviser to Women in Prison.

INQUEST is the only charity providing expertise on state related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. INQUEST’S specialist casework includes death in police and prison custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question. This includes work around the Hillsborough football disaster and the Grenfell Tower fire.

The Honourable Mr Justice Garnham

Year of call: 1982

Year of silk: 2001

Sir Neil Garnham was called to the Bar in 1982 and took Silk in 2001. He was appointed an Assistant Recorder in 1999, a Recorder in 2000 and was sworn in as a High Court Judge in 2015. His practice at the bar focused on Public Law, clinical negligence and professional discipline. He acted in some of the most high profile public inquiries and inquests of the last 20 years; he acted as Counsel to the Inquiry in the Ladbroke Grove Rail Inquiry and the Climbie Inquiry, for the soldiers in the Baha Mousa and Al-Sweady public inquiries, he represented the Metropolitan Police Service in the Leveson Inquiry, acted on behalf of the Security Service in the 7/7 inquest and was counsel for the government in the Litvinenko inquest and public inquiry. He is now the Administrative Court liaison judge for Wales and the Midland and Western circuits.

The Honourable Mrs Justice Lambert

Year of call: 1988

Year of silk: 2009

Dame Christina Lambert was appointed as a Justice of the High Court on 11th January 2018 after 13 years at 1 Crown Office Row. She developed a specialist practice in Clinical Negligence and Professional Discipline, acting for both Claimants and Defendants. She frequently handled high value claims involving complex legal and/or medical issues. She has particular experience in claims for wrongful birth having been involved in many of the reported decisions in this field. Christina also has an established inquiries practice having been counsel to the Dame Janet Smith and Dame Linda Dobbs Reviews and leading counsel in the Hillsborough Inquiry.

Peter Skelton QC

Year of call: 1997

Year of silk: 2016

Peter.Skelton@1cor.com

Peter's practice encompasses public inquiries, inquests, human rights litigation, clinical negligence, judicial review, national security and personal injury litigation, with a particular emphasis on multi-party actions and claims arising in foreign jurisdictions. He acts for both claimants and defendants.

He is presently counsel to the inquests into the 1974 Birmingham bombings and the death of the Russian businessman Alexander Perepilichnyy. He also leading the accountability and reparations investigation in the Independent Inquiry into Child Sexual Abuse.

Over the last five years, Peter has been instructed by large numbers of claimants who allege that they were abused by Jimmy Savile and Max Clifford. He has also been acting for claimants in several other high-profile cases, including Ian Paterson (breast surgery) and Rob Jones (gynaecological surgery). Previously, he acted for the claimants in the Winterbourne View Litigation (institutional neglect and abuse exposed by Panorama), the Cornwall Partnership Trust Litigation, and the Nationwide Organ Group Litigation.

On the defendant side, Peter is counsel for the Metropolitan Police Service in a multi-party action arising from allegations of inappropriate sexual liaisons by undercover police officers. He is acting for the Foreign and Commonwealth Office in the Kenyan Emergency Group Litigation, which involves allegations of mistreatment by the Colonial Government of Kenya in the 1950s. He is also representing an international mining corporation in a multi-party human rights claim arising from allegations of police brutality in Sierra Leone.

Appointments:

Attorney General's A Panel of Counsel (2014-2016)
Special Advocate (2009)
Attorney General's B Panel of Counsel (2009)
Attorney General's C Panel of Counsel (2004)

Memberships:

PIBA
PNBA

Publications:

Contributing author of The Inquest Casebook Neil Garnham QC and Caroline Cross, Hart Publishing, 2016.

Contributing author of Public Inquiries Jason Beer QC, Oxford University Press, 2011, Second Edition forthcoming.

Awards:

Harmsworth Scholarship from Middle Temple to the Inns of Court School of Law (1996)
Economic & Social Research Council Scholarship to the University of Cambridge (1995)
Harmsworth Scholarship from Middle Temple to the College of Law (1994)
Academic Scholarship to the University of California (1992)

Directories:

Recommended as leading silk by Chambers & Partners and in the Legal 500.

"A confident advocate and good communicator." (Legal 500 2018)

"He comes up with novel ideas, provides a realistic and sensible evaluation of cases and deals with difficult clients well. He just navigates the course through." "Great on his feet, thinks quickly, sharp as a razor and very articulate." (Chambers & Partners 2017)

"Simply excellent." (Legal 500 2016)

Matthew Hill

Year of call: 2009

Matthew.Hill@1cor.com

Matthew Hill is a barrister at One Crown Office Row who specialises in inquiries and inquests, as well as public law, medical law and professional discipline.

He has acted as first junior counsel in the Hillsborough Inquests and in the renewed inquests into the Birmingham Pub Bombings. He is currently instructed as lead junior counsel to the inquiry in the Infected Blood Inquiry and the Independent Inquiry into Child Sexual Abuse. He is counsel to one of the interested parties in the Westminster Bridge Inquests. He previously worked on the Detainee Inquiry and the Al-Sweady Public Inquiry. He represents families, institutions and medical professionals at inquests, and he is a member of the Attorney General's Panel of Counsel.

Before coming to the Bar, Matthew was instructed as the historical research consultant to the Bloody Sunday Inquiry, working first with Counsel to the Inquiry and later with Lord Saville and the Tribunal. He studied and taught modern history at Oxford University, and was a Visiting Fellow at the Australian National University.

"An absolute class act with a remarkably sharp brain and standing beyond his year of call." (Legal 500 2018)

Emma-Louise Fenelon

Year of call: 2015

emma.fenelon@1cor.com

Emma accepts instructions in all areas of Chambers' work and is developing a broad practice in particular in Clinical Negligence, Personal Injury, Professional Discipline, Inquests, Public Inquiries, Public Law and Human Rights. She has a First Class Honours degree from Trinity College Dublin and a Masters in Law from Harvard Law School.

Emma joined Chambers as a tenant in September 2016 following successful completion of her pupillage. Since then Emma has been instructed for a key Core Participant in the Undercover Policing Inquiry and is currently instructed by Slater & Gordon on three modules of IICSA (the Independent Inquiry into Child Sexual Abuse) . She has also developed a practice in criminal prosecution, regularly appearing in the Magistrate's Court, has appeared in the Information Tribunal and has been instructed in a range of county court matters, including credit hire, holiday disputes, costs, case management and bankruptcy.

Emma also spent two years as a Parliamentary Aide to Lord Lester of Herne Hill QC, in particular assisting his work as a member of the Joint Committee on Human Rights, and in human rights analysis of draft legislation.

She gained further experience as a legal trainee at the European Court of Human Rights, Strasbourg (UK Division), as an intern on the case involving Radovan Karadzic at the International Criminal Tribunal for the Former Yugoslavia in the Hague and working for the Innocence Project while studying at Washington and Lee University, Virginia.

Memberships:

HRLA, Vice-Chair
ALBA
PIBA
BHRC
Liberty

Qualifications

LL.B, Trinity College Dublin (2010)
LL.M, Harvard Law School, Massachusetts (2011)
Bar Professional Training Course, BPP, London (2014)

Prizes and Awards

Lady Templeman Award, Middle Temple (2015)
Jules Thorn Scholarship and Blackstone Exhibition Award, Middle Temple (2012)
Satter Harvard Law School Human Rights Fellowship (2011)
John F. Kennedy Award for post-graduate study, National University of Ireland (2010)
Julian Prize for 2nd place overall in degree results, Trinity College Dublin (2010)
First Class Honours Book Prize for 3rd year exam results, Trinity College Dublin (2009)
Scholar, Trinity College Dublin (2008)
Entrance Exhibition Award, Trinity College Dublin (2005)

Gideon Barth

Year of call: 2015

Gideon.Barth@1cor.com

Gideon is developing a busy practice spanning all areas of Chambers' work including clinical negligence and personal injury, public and human rights law, equality law, inquests and public inquiries.

Following successful completion of his pupillage at 1COR, Gideon has been regularly instructed in clinical negligence and personal injury claims by both claimants and defendants. In addition to a wealth of medical work, Gideon is instructed in claims arising from accidents at work, road traffic injuries and inquests for claimants and defendants.

Gideon is also developing a varied public law practice. He is currently instructed by HMRC in an appeal in relation to authorisation under the WOWGR legislative scheme. He is also currently instructed by Coroner in the Birmingham Pub Bombings Inquest. Gideon is building on the public law experience he gained during pupillage, in which he worked on judicial review claims in respect of deaths in custody, immigration and article 8 challenges. He has since worked on unlawful detention claims and claims against the police and is keen to expand his immigration law practice.

Gideon has a growing interest in equality law work. He has appeared for a bus company in a claim for disability discrimination and acted for a mother and child in the Special Educational Needs and Disability (SEND) Tribunal.

While the bedrock of his practice is civil litigation, Gideon has also developed a criminal law practice, regularly prosecuting in the Magistrates' Court and also appearing in the Crown Court.

Before coming to the Bar, Gideon obtained a First Class degree from Cambridge University where he read History, before achieving a distinction on the GDL.

Memberships:

ALBA
ILPA
PIBA

Qualifications:

BPTC (Outstanding), City University, London (2015)
GDL (Distinction), City University, London (2014)
BA (Hons) History (First Class), St Catharine's College, Cambridge (2013)

Publications:

Blanket doping bans and human rights. Does a blanket ban on Russian athletes competing at Rio 2016 contravene human rights law?' [2016] Global Sports Law and Taxation Reports, with Richard Booth QC.

'Judicial Interpretation or Judicial Vandalism? Section 3 of the Human Rights Act 1998' [2016] Judicial Review 99, with Adam Wagner.

Gideon is a contributor to 1COR's UK Human Right's Blog.

Awards:

Inner Temple Advocacy Prize Semi-Finalist (2015)
Major Scholarship BPTC, Inner Temple (2015)
Exhibition Award GDL, Inner Temple (2014)
Ivo Forde History Prize (2013)

Inquests & Public Inquiries & Group Actions are 1COR are instructed in:

- Birmingham Inquests (1974)
- Inquest into the death of Alexander Perepilichnyy
- Westminster Bridge Inquests
- London Bridge & Borough Market Inquests
- Inquests into the deaths of former patients of Mr Paul Miller
- Shoreham Air Crash Inquests & Investigation
- Grenfell Tower Inquiry
- Undercover Policing Inquiry
- Independent Inquiry into Child Sexual Abuse
- The Infected Blood Inquiry
- The Litvinenko Inquest & Inquiry
- Kenyan Group Litigation
- Paterson Group Litigation
- Leeds Children's Homes Group Litigation
- Medomey Detention Centre Group Litigation
- Caldey Island Litigation
- Sophocleous v Foreign and Commonwealth Office

The Inquest Book

The Law of Coroners and Inquests Edited by Caroline Cross and Neil Garnham, with contributions from barristers at 1 Crown Office Row (Hart Publishing, 2016)

The 1COR Bundle

The 1COR Bundle is the annual newsletter of 1 Crown Office Row which features case analysis from all of 1COR's cases across the year in each of our practice areas. The current edition, The 1COR Bundle 2017 – 2018 is currently available, please email to receive your copy.

The UK Human Rights Blog

Up to date analysis and discussion on Human Rights Law in the UK from the specialists at One Crown Office Row.

Since its launch in March 2010, **The UK Human Rights Blog** has evolved into one of the most widely read online resources for people wanting to keep abreast of Human Rights Law.

Each week sees new posts and updates on the most high profile cases with comments and features written by our Human Rights and Public Law specialists. Please subscribe for regular updates.

"1 Crown Office Row's Human Rights Update is one of the most significant free legal resources to appear on the web." **Delia Venables, Internet Newsletter for Lawyers**

Law Pod UK

1 Crown Office Row have recently launched a new regular podcast, **Law Pod UK**, with presenter Rosalind English, to discuss developments across all aspects of Civil and Public Law in the UK.

It comes from the creators of the UK Human Rights Blog and is produced by the barristers at 1 Crown Office Row and Whistledown Productions, and each week features interviews with our QCs and barristers. Please visit iTunes and search Law Pod UK to download and listen.

Twitter & Linkedin

Please connect with our Twitter account at @1CrownOfficeRow for regular updates from our barristers and 1COR news. Please connect with our 1 Crown Office Row Linkedin Page for articles and updates.

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QCs

Robert Seabrook QC	1964	QC 1983	**John Whitting QC**	1991	QC 2011
Stephen Miller QC	1971	QC 1990	**David Evans QC**	1988	QC 2012
Guy Mansfield QC	1972	QC 1994	**Richard Booth QC**	1993	QC 2013
Philip Havers QC	1974	QC 1995	**Marina Wheeler QC**	1987	QC 2016
Elizabeth-Anne Gumbel QC	1974	QC 1999	**Henry Witcomb QC**	1989	QC 2016
Paul Rees QC	1980	QC 2000	**Owain Thomas QC**	1995	QC 2016
Margaret Bowron QC	1978	QC 2001	**Jeremy Hyam QC**	1995	QC 2016
David Balcombe QC	1980	QC 2002	**Clodagh Bradley QC**	1996	QC 2016
David Hart QC	1982	QC 2003	**Peter Skelton QC**	1997	QC 2016
Martin Forde QC	1984	QC 2006	**Oliver Sanders QC**	1995	QC 2017
William Edis QC	1985	QC 2008	**Shaheen Rahman QC**	1996	QC 2017
Angus McCullough QC	1990	QC 2010	**Sarah Lambert QC**	1994	QC 2018
			Sarabijt Singh QC	2001	QC 2018

Juniors

John Gimlette	1986	**Caroline Cross**	2006
Andrew Kennedy	1989	**Matthew Donmall**	2006
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Giles Colin	1994	**Amelia Walker**	2007
Sydney Chawatama	1994	**Isabel McArdle**	2008
Justin Levinson	1994	**Matthew Hill**	2009
Neil Sheldon	1998	**Alasdair Henderson**	2009
Richard Smith	1999	**Claire McGregor**	2009
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Matthew Barnes	2000	**Paul Reynolds**	2010
Iain O'Donnell	2000	**Lois Williams**	2012
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Rachel Marcus	2005	**Emma-Louise Fenelon**	2015
Leanne Woods	2005	**Gideon Barth**	2015
Pritesh Rathod	2006	**Jo Moore**	2015
		Jonathan Metzer	2016

Chambers of **Philip Havers QC**

Chambers Director
Andrew Meyler

Senior Clerk
Matthew Phipps

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Andrew Tull
John Mclaren
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