Ruling in respect of Regulation 28 reports

Introduction

1. Mr Weatherby on behalf of 22 of the families submitted that after the jury have delivered their conclusions I should make three 'prevent future deaths' reports. They are, first, to the South Yorkshire Police and Crime Commissioner and the Home Secretary regarding the conduct of the current Chief Constable of South Yorkshire Police ("SYP") during the inquests; second, to the Secretary of State for Health regarding the conduct of the current Chief Executive of Yorkshire Ambulance Service ("YAS") during these proceedings and, third, to the Police and Crime Commissioner and the Home Secretary regarding the lack of policy regarding the use and retention of police pocket notebooks. As an alternative, it is submitted I should write a "letter of concern" to the Police and Crime Commissioner and the Home Secretary in relation to the recording of police accounts and the retention of police officers' pocket notebooks.

2. All the families support the submissions.

The legal framework

3. I do not understand there to be any real difference of view either as to the statutory framework or its meaning.

4. Under the heading, "*Action to prevent other* deaths," paragraph 7(1) of Schedule 5 of the Coroners and Justice Act 2009 ("CJA") provides:

> *"Where –*
>
> *(a) a senior coroner has been conducting an investigation under this Part into a person's death,*
>
> *(b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and*
>
> *(c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,*

the coroner must report the matter to a person who the coroner believes may have power to take such action."

5. Paragraphs 7(2) and (3) provide for the recipient of a report to reply in writing and both the report and its reply to go to the Chief Coroner.

6. Part 7 of the Coroners (Investigations) Regulations 2013 contains further provisions for the making of PFD Reports. Regulation 28 provides:

> *"(1) This regulation applies where a coroner is under a duty under paragraph 7(1) of Schedule 5 to make a report to prevent other deaths.*
>
> *(2) In this regulation, a reference to 'a report' means a report to prevent other deaths made by the coroner.*
>
> *(3) A report may not be made until the coroner has considered all the documents, evidence and information that in the opinion of the coroner are relevant to the investigation."*

7. Regulation 28(4) further stipulates that such a report be sent to the Chief Coroner and others (which by regulation 28(5) he may supply to others).

8. Before July 2013, the power to make such reports was contained in rule 43(1) of the Coroners Rules 1984. That provision was in similar terms to paragraph 7(1). However, it provided that the coroner "*may*," not "*must*," report the matter in the circumstances set out.

9. In short, if anything revealed by the Inquests gives rise to such a concern as is referred to in paragraph 7(1)(b), and I am of the opinion action should be taken "*to prevent the occurrence or continuation of such circumstances or to eliminate or reduce the risk of death created by such circumstances*," I am required to report the matter. Whether I am of that opinion involves a discretionary judgment: see *R (Cairns) v HM Deputy Coroner for Inner West London* [2011] EWHC 2890 (Admin) at paragraph 74.

10. As paragraphs 2 and 5 of the Chief Coroner's non-mandatory Guidance Number 5 state:

> "2. *These reports are important. Coroners have a duty not just to decide how somebody came by their death but also, where appropriate, to report about that death with a view to preventing future deaths. A bereaved family wants to be able to say: 'His death was tragic and terrible, but at least it shouldn't happen to somebody else.'...*
>
> *5. Broadly speaking reports should be intended to improve public health, welfare and safety. They should not be unduly general in their content; sweeping generalisations should be avoided. They should be brief, focused, meaningful and, wherever possible, designed to have practical effect.*"

11. Paragraph 10 of the Guidance, among other things, states that the duty may arise at any stage of the investigation. There is a relatively low threshold. It is a concern of a risk to life caused by present or future circumstances in respect of which in the coroner's opinion action should be taken to prevent a recurrence or reduce the risk of death.

12. Paragraph 17 rightly points out that paragraph 7 of Schedule 5 does not restrict the report to the matters which caused the particular deaths. As Mr Hough said, it requires that the material in the particular investigation has highlighted systemic risks or failures which may recur or continue, with potentially fatal consequences: (see too *R (Francis) v HM Coroner for Inner South London* [2013] EWCA Civ 313 at paragraphs 7 to 8).

13. In the result, as Mr Hough put it:

    (a) A coroner should make a report if (but only if) satisfied of two propositions: (i) that there is a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and (ii) that in his/her opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances. In making a judgment on these issues (especially the second), the coroner is exercising a judicial discretion.

    (b) The coroner must form his/her judgment based on the information revealed by the coronial investigation.

(c) It is not necessary for the coroner to conclude that the particular death under investigation was caused by the circumstances or risks which may be the subject of the report. However, it is necessary for the coroner to find that systemic risks or failures have been highlighted by the material in the particular investigation.

(d) It is perfectly proper for a coroner to say that a risk or issue has apparently been addressed, or that on the available material he/she cannot be satisfied that preventive action need be taken. In making a decision, the coroner is entitled to take account of the passage of time and changes of circumstances since the deaths.

(e) Before deciding whether to make a report, the coroner should consider whether it would be directed to improving public health, welfare or safety and whether it would be focussed, practical and within the statutory remit.

The families' submissions

14. Mr Weatherby submitted that the jurisdiction for making a report was a permissive one, by which I took him to mean the court has a wide discretion to make a report, the use of the word "concern" does not suggest a high threshold, the statutory change from a power to duty underlines the importance of such reports and that, all things being equal, the coroner should lean towards making a report

15. The specific argument advanced was unusual. Put very shortly, it came to this. Both SYP and YAS have previously and in some detail admitted responsibility for their roles in the disaster. SYP has further admitted the role and responsibility of senior officers in a cover-up after the disaster. Each did so following publication of the Hillsborough Independent Panel Report. Those fulsome apologies can still be seen on their respective websites. As Mr Weatherby put it in his written submissions:

> "Despite their public stance, both organisations have sought to minimise their responsibility through their conduct in these inquests, to the extent that the jury is unaware of any acceptance of responsibility or fault. This institutional defensiveness risks subverting the process and raises a clear inference that these two organisations are preoccupied with their own position rather than engaged in a learning process which could lead them to adopt processes which would prevent future major incident deaths."

16. Mr Mansfield submitted it was worse than mere defensiveness. It amounted to a culture of denial: a reversion to the approach criticised by the Lord Chief Justice when quashing the original inquests.

17. Mr Weatherby was highly critical of the stance taken by each organisation during the course of the Inquests. He cited detailed evidence in respect of each which was said to show how they sought to minimise their responsibility, and, as he would put it, misleadingly go behind their previous admissions.

18. As to the police notebooks, Mr Weatherby submitted that:

> "A persistent problem with police evidence as to what happened at Hillsborough has been the reliability of first accounts. Disclosure and research has indicated a lack of clear policy relating to the making and retention of first accounts."

19. He submitted that a report on the issue of first accounts and pocket notebooks was entirely merited. Such a report would be influential and everyone would gain from it.

My view

20. In my view, there is a fundamental, logical flaw in Mr Weatherby's and Mr Mansfield's argument.

21. First, even assuming the two organisations have conducted themselves as described, it does not follow that gives rise to a concern that there is a risk of future deaths such as those which occurred at Hillsborough. If they did act in a manner inconsistent with their previous admissions, it does not logically lead to the conclusion that there exists the risk of future deaths. Such conduct would not demonstrate that either organisation was incapable of learning safety lessons for the future. It would say nothing about their capability to do so.

22. Second, no evidence has been adduced during the course of the inquests that their conduct of these proceedings reflects such an inability now to learn safety lessons from what happened in 1989. I know nothing about the approach in 2016 of either organisation to issues of safety in the context of mass sporting events. It was not appropriate during the course of these Inquests to adduce such evidence.

23. Third, a report on the basis suggested could not be "*...clear, brief, focused, meaningful and...designed to have practical effect*," as is suggested in paragraph 5 of the Chief Coroner's Guidance. It would be likely to be quite the opposite. As I observed in argument, it is difficult to discern what practical, beneficial action I could properly conclude would need to be taken, based on Mr Weatherby's argument.

24. Moreover, such evidence as I have heard suggests very considerable changes have taken place since the Disaster in 1989. Lord Justice Taylor's report led to considerable changes. Some of the expert and other evidence we heard suggested (entirely unsurprisingly given that some 27 years have passed) substantial changes in both police and ambulance procedures.

25. In short, even assuming the facts as advanced by Mr Weatherby and Mr Mansfield, I am of the clear view conditions (b) and (c) of paragraph 7(1) to Schedule 5 are not met. That being so, the power (let alone any duty) to make a report does not arise.

26. Equally, a report (or a letter of concern) in respect of police notebooks or evidence gathering is not warranted.

27. While I accept that the duty to make a report may be triggered as a result of something revealed in relation to processes or procedures post death, there again seems to me a fundamental problem with the submissions made. It does not follow that the evidence we heard regarding the way evidence was gathered and pocket books kept for this major incident in 1989 has any implications at all for the safety of fans at football matches (or anyone else) in 2016. There is another problem. There is no evidence of how notebooks and evidence would now be used or retained, or how evidence would now be gathered. The IPCC, in their helpful submissions, have indicated how different is current statutory background and practice to that 27 years ago. What they say underlines how inadequate is the evidence base I presently have to seek to suggest any guidance in any form in this complex area. The IPCC submissions suggest that ACPO and the College of Policing have these matters under active consideration.

28. Some examples of inquests, which have resulted in reports raising concerns about police practice, are referred to in the submissions. They are very different to this case. Those concerns related to current police practice about which there was evidence in the course of the inquest. They did not relate to police practice some 27 years before in a context where there is no evidence about present practice.

29. In all the circumstances, I see no sensible basis either for making a report or for writing a letter of concern.

30. It is unnecessary to say any more about the facts.

John Goldring
12 April 2016