Neutral Citation Number: [2022] EWHC 2343 (Admin)

Case No: CO/3685/2021

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT

In the matter of an application under section 13 of Coroners Act 1988

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 15 September 2022

Before:

LORD JUSTICE HOLROYDE
MR JUSTICE GARNHAM

- -

Between:

LESLEY ANN DAVISON **Claimant**

- and -

HM SENIOR CORONER FOR HERTFORDSHIRE **Defendant**

HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST
Interested Party

- -
- -

Adam Straw KC (instructed by **Irwin Mitchell**) for the **Claimant**
Bridget Dolan KC (instructed by **Hertfordshire Local Authority**) for the **Defendant**
The Interested Party did not appear and was not represented
Hearing dates: 17 May 2022

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Approved Judgment

This judgment was handed down by the judge remotely by circulation to the parties' representatives by email and release to The National Archives. The date and time for hand-down will be deemed to be Thursday 15th September 2022 at 11am.

Lord Justice Holroyde and Mr Justice Garnham:

1. Megan Leanne Davison ("Megan") had the misfortune to suffer from Type 1 diabetes and diabulimia, a psychiatric disorder which involves the deliberate omission of insulin doses. Very sadly, she took her own life on 4 August 2017, aged just 27. At an inquest held on 28 March 2018, HM Senior Coroner for Hertfordshire ("the Coroner") concluded that Megan's death was suicide. He did not make a prevention of future deaths report ("PFD report"). By a claim issued on 11 October 2021, with the fiat of HM Attorney General, Megan's mother ("Mrs Davison") applied for an order under section 13 of the Coroners Act 1988 quashing the Coroner's conclusion and directing a fresh investigation be held. At the conclusion of the hearing we announced that the application would be granted and a fresh inquest directed. We refused an application by Mrs Davison for an order that the Coroner pay some of her costs. We indicated that we would give our reasons in writing at a later date. We now do so in this judgment of the court.

Summary of key facts:

2. From late August 2016 until her death, Megan was under the care of the Community Eating Disorder Service ("CEDS") at Hertfordshire Partnership University NHS Foundation Trust ("the Trust"). In September 2016 she took a potentially fatal overdose of insulin. She was subsequently detained under the Mental Health Act and admitted to an acute mental health unit. On two occasions in October 2016 she attended hospital suffering from diabetic ketoacidosis, a condition reflecting too low a level of insulin. In November 2016 she was admitted to an inpatient eating disorder service at a hospital. In January 2017 she left that hospital and took an overdose of insulin.

3. From March 2017 onwards, the treatment and management of Megan's eating disorder at CEDS was led by a psychological therapist, Ms Harris. In June 2017 Ms Harris, and other members of the CEDS team involved in Megan's care, were concerned that she might take her own life. On 8 June 2017 Megan was seen for the first time by Dr Sharma, a consultant psychiatrist at the Trust, who arranged a care plan. In mid-July Megan stopped taking her antidepressant medication and told one of her carers that there was no point living unless both her diabetes and her mental illness could be cured. Later that month she sent text messages to Ms Harris indicating that she wanted to end her life at Dignitas, but she was not able to do so.

4. On the morning of 4 August 2017 Megan sent a message to Ms Harris asking her to ensure that the emergency services, and not Megan's parents, would find her body. No immediate action was taken, but later that morning police officers went to Megan's home, where they found that she had hanged herself. She had left a note for her family.

The inquest:

5. Mrs Davison and her husband, and other members of Megan's family, attended the inquest. They were "interested persons" under section 47(2)(a) of the Coroners and Justice Act 2009. Mr and Mrs Davison had been sent, in advance of the inquest, a copy of the Hertfordshire Coroner Service Charter. That document set out standards of performance and customer care, but did not include any information about the way in which the Coroner would receive evidence. The interested persons did not know what witnesses were to be called until the inquest began.

6. In relation to Megan's care, the Coroner admitted into evidence part of a written statement by Ms Harris. He said that her statement was "very detailed and helpful" and indicated that he would read some portions of it together with the GP's history. Ms Harris therefore did not give oral evidence. Mrs Davison and her family did not know, and the Coroner did not tell them, of the right of an interested person to object to the admission of the written evidence.

7. No evidence, written or oral, was given by any other member of the CEDS team.

8. The only oral evidence heard by the Coroner was given by the police officer who found Megan's body and by Dr Sharma. Dr Sharma stated that he was not a specialist in eating disorders or diabetes, and had not previously encountered diabulimia. He understood that the combination of Type 1 diabetes and diabulimia was "quite a rare condition". He also understood that there were no facilities to manage it and that the prognosis for those suffering from the disorder is poor. In answer to a question from a member of Megan's family as to whether Megan could have been treated in a different way if he had had a better understanding of diabulimia, Dr Sharma said that the CEDS team was in a better position than he was to manage Megan's condition.

9. The Coroner, as we have said, returned a conclusion of suicide. In explaining why he was sure that Megan had intended to end her life, he referred to diabulimia as "this terrible intractable eating disorder". He said it was important to outline the context, and he therefore recorded that Megan -

> "… had suffered for many years from type 1 diabetes and an eating disorder with bulimic patterns known as diabulimia."

10. The Coroner explained why he would not make a PFD report. Unfortunately, a part of the recording was inaudible, and there are clearly some words missing from the transcript. It records the Coroner as saying –

> "… it seems from the information that I provided that despite this being a rare condition, and one that is only starting to be understood, I do note – and it's from a BBC report – that a spokesman for NHS England, in fact the National Clinical Director for the Mental Health Team, told the BBC as recently towards September of last year that people are waking up to this condition [inaudible] involved in producing guidelines on eating disorders and debated a whole section on how you manage people who have got diabetes and an eating disorder. We are now disseminating that around the country. We have been asleep no doubt but we are waking up."

The new evidence:

11. In July 2020 Mrs Davison sought the fiat of HM Attorney General to enable her to make this application to the High Court. HM Attorney General obtained a report from Professor Khalida Ismail, who is Professor of Psychiatry and Medicine at King's College, London, an honorary consultant psychiatrist and a leading expert in diabetes and diabulimia. Prof. Ismail properly disclosed that she had had some limited previous contact with Megan, though Megan had not been under her care

12. For present purposes, it is sufficient for us to summarise as follows some key points in Prof. Ismail's detailed report:

    i) About 400,000 persons in the UK have Type 1 diabetes, and the incidence of the condition is increasing. Management of the condition includes the daily injection of insulin. Omission of insulin, whatever the reason, causes weight loss. It also activates ketosis, which can lead to ketoacidosis, with risk of death.

    ii) Diabulimia is a psychiatric condition which causes sufferers to omit some or all of their insulin because of a fear that taking the insulin will cause an increase in weight. The condition is also referred to as T1DE: Type 1 diabetes with disordered eating.

    iii) An estimated one-third of those with Type 1 diabetes omit some insulin for fear of weight gain. Diabulimia is therefore not a rare condition. Around 5-10% of those who omit some insulin are severe cases who would likely meet the criteria for diagnosis of an eating disorder. The more severe cases present most commonly with recurrent diabetic ketoacidosis. Those with severe diabulimia "are at very high risk of acute and chronic diabetes complications and premature mortality".

    iv) Healthcare professionals do not routinely screen for diabulimia or directly question patients as to whether they are omitting insulin.

    v) Diabulimia and clinical depression often co-occur. It is therefore appropriate to integrate medical and psychiatric treatment. However, there is still a lack of awareness that those with Type 1 diabetes who also have mental health problems find it more difficult to manage their diabetes; and the differing health systems involved in caring for someone with multiple morbidities can lack knowledge of, and confidence in, one another. There is no pathway of care for diabulimia.

    vi) The mortality rate for diabulimia is unacceptably high.

13. Prof. Ismail made a number of criticisms of the care which Megan had received, and expressed her opinion as to the potential value of a new inquest in increasing understanding of the nature and incidence of diabulimia, which could lead to more screening and assessment of patients and so reduce the number of deaths.

14. Having considered Prof. Ismail's report, the Attorney General authorised the making of this application.

The legal framework:

15. Section 13 of the Coroners Act 1988 ("s.13") provides:

> "**13 Order to hold investigation.**
>
> (1) This section applies where, on an application by or under the authority of the Attorney-General, the High Court is satisfied as respects a coroner ("the coroner concerned") either–

> (a) that he refuses or neglects to hold an inquest or an investigation which ought to be held; or
>
> (b) where an inquest or an investigation has been held by him, that (whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise) it is necessary or desirable in the interests of justice that an investigation (or as the case may be, another investigation) should be held.
>
> (2) The High Court may –
>
> (a) order an investigation under Part 1 of the Coroners and Justice Act 2009 to be held into the death either –
>
> (i) by the coroner concerned; or
>
> (ii) by a senior coroner, area coroner or assistant coroner in the same coroner area;
>
> (b) order the coroner concerned to pay such costs of and incidental to the application as to the court may appear just; and
>
> (c) where an inquest has been held, quash any investigation on, or determination or finding made at that inquest."

16. In *Sutovic v HM Coroner for Northern District of Greater London* [2006] EWHC 1095 (Admin) Moses LJ referred, at [54], to the "very broad terms" of s13(1)(b) and noted that the necessity or desirability of another inquest may arise by reason of one of the listed matters "or otherwise". He continued:

> "Notwithstanding the width of the statutory words, its exercise by courts shows that the factors of central importance are an assessment of the *possibility* (as opposed to the probability) of a different verdict, the number of shortcomings in the original inquest, and the need to investigate matters raised by new evidence which had not been investigated at the inquest … ."

17. The correct approach to s.13 was also considered in *Attorney General v HM Coroner for South Yorkshire (West)* [2012] EWHC 3773 (Admin) at [10]. Lord Judge CJ said:

> "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 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 of the evidence which tends to confirm the correctness of the verdict to be publicly revealed."

18. Section 5 of the Coroners and Justice Act 2009 provides:

> "**5 Matters to be ascertained**
>
> (1) The purpose of an investigation under this Part into a person's death is to ascertain –
>
> (a) who the deceased was;
>
> (b) how when and where the deceased came by his or her death;
>
> (c) the particulars (if any) required by the 1953 Act to be registered concerning the death.
>
> (2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.
>
> (3) Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than –
>
> (a) the questions mentioned in subsection (1)(a) and (b) (read with subsection (2) where applicable;
>
> (b) the particulars mentioned in subsection (1)(c).
>
> This is subject to paragraph 7 of Schedule 5."

19. Paragraph 7 of Schedule 5 to the 2009 Act provides -

> "(1) 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.
>
> (2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.
>
> (3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner."

20. Where a report has been made by a senior coroner pursuant to that paragraph, regulation 28(4)(a) of the Coroners (Investigations) Regulations 2013 requires the coroner to send a copy of the report to "every interested person who in the coroner's opinion should receive it".

21. So far as is material for present purposes, rule 23 of the Coroners (Inquests) Rules 2013 ("r.23") provides:

> "**23. Written evidence**
>
> (1) Written evidence as to who the deceased was and how, when and where the deceased came by his or her death is not admissible unless the coroner is satisfied that –
>
> (a) it is not possible for the maker of the written evidence to give evidence at the inquest hearing at all, or within a reasonable time;
>
> (b) there is a good and sufficient reason why the maker of the written evidence should not attend the inquest hearing;
>
> (c) there is a good and sufficient reason to believe that the maker of the written evidence will not attend the inquest hearing; or
>
> (d) the written evidence (including evidence in admission form) is unlikely to be disputed.
>
> (2) Before admitting such written evidence the coroner must announce at the inquest hearing –
>
> (a) what the nature of the written evidence to be admitted is;
>
> (b) the full name of the maker of the written evidence to be admitted in evidence;
>
> (c) that any interested person may object to the admission of any such written evidence; and

> (d) that any interested person is entitled to see a copy of any written evidence if he or she so wishes.
>
> …
>
> (4) a coroner may direct that all or parts only of any written evidence submitted under this rule may be read aloud at the inquest hearing."

22. In *Mueller v Area Coroner for Manchester West* [2017] EWHC 3000 (Admin), Sir Brian Leveson P stated at [23] that one example of an "irregularity" within the meaning of s.13(1)(b) was a failure by a coroner to comply with the Rules. He referred to r.23 and said, at [31] –

> "Where, as in this case, a coroner sets out with the intention of dealing with the inquest by reading the statements, it is equally important to explain to all concerned, in advance, exactly what that will mean. The coroner should indicate which statements and documents are likely to be read or summarised at the public hearing, and which parts (if any) of the statements or documents are not to be read."

The grounds of the application:

23. In his written and oral submissions on behalf of Mrs Davison, Mr Straw KC raised nine issues:

i) Prof. Ismail's report is important new evidence, enabling the circumstances of Megan's death to be explored more fully than it was at the inquest. At a fresh inquest, the coroner would be invited also to call oral evidence from Ms Harris and other members of the CEDS team, so that both the care given to Megan, and the systemic issues raised by Prof. Ismail, could be explored.

ii) It is at least possible that a fresh inquest would lead to a PFD report, in particular because of the systemic issues raised by Prof. Ismail. That may be of public importance, because diabulimia is a highly dangerous but poorly understood disorder, with a high mortality rate and many preventable deaths.

iii) In the light of Prof. Ismail's report, it is at least possible that a fresh inquest may lead to the medical cause(s) of Megan's death being recorded in different terms.

iv) Prof. Ismail refers in her report to the substantial public interest in more being known about the dangers of diabulimia.

v) Mrs Davison and her family want a fresh investigation so that they can fully understand how Megan met her death, and so that lessons can be learned with a view to preventing others dying in similar circumstances.

vi) The Coroner failed to comply with r.23(2)(c). Had he done so, Mrs Davison and her family would have asked for Ms Harris to give oral evidence so that important questions could be raised with her. This was a significant error by the Coroner, and an "irregularity of proceedings" within s.13(1)(b).

vii) The Coroner concluded that nothing in the evidence made it likely that any act or omission by the mental health services had caused or contributed to Megan's death. That was not a conclusion which was open to him without having at least questioned Ms Harris and other members of the CEDS team. Nor should he have declined to make a PFD report on the basis of a BBC news website item, without having called evidence from an appropriate person within the NHS. In these respects, there was an "insufficiency of inquiry" within s13(1)(b).

viii) In the light of Prof. Ismail's report, it is at least possible that a fresh inquest may lead to a different and fuller narrative conclusion than was stated by the Coroner.

ix) A fresh investigation is necessary to comply with the duty under article 2 of the Convention to conduct an effective investigation into Megan's death.

24. The Coroner set out his views in December 2020, in a detailed written response to an inquiry by the Attorney General. He has taken a neutral stance in this application, but on his behalf Ms Dolan KC made the following points in her oral submissions:

i) The Coroner proceeded under s.5 of the 2009 Act, and was not under the duty to consider wider matters which would have arisen if he had conducted an article 2 inquiry. At the time of the inquest, there was no suggestion by anybody that article 2 was engaged.

ii) The Coroner accepts he was in error in failing to comply with r.23(2)(c), but it is for the court to determine whether it was a material error: it is submitted that an objection by an interested person would be a factor for the Coroner to consider, but would not necessarily compel him to receive oral evidence.

iii) It is submitted that the Coroner was not under a duty to take proactive steps to seek out additional evidence which might give rise to a duty to make a PFD report.

iv) It is for the court to decide whether a fresh inquest is necessary or desirable in the interests of justice, in circumstances where after the initial inquest an expert witness suggests there should have been a wider inquiry than was carried out.

v) It is submitted that nothing in Prof. Ismail's report gives rise to any realistic prospect of a finding that Megan's death was caused by neglect. Megan had capacity, and could not be detained under the Mental Health Act. She was therefore able to discharge herself from medical care.

25. The Trust has also adopted a neutral attitude, and has taken no active part in this application.

Submissions as to costs:

26. Mr Straw applied for an order that the Coroner pay Mrs Davison's costs from 17 September 2021, when the Coroner was sent a copy of Prof. Ismail's report, the written grounds of claim and a draft consent order, with a view to avoiding a hearing. The Coroner did not make any representations about the grounds, but required a hearing, for – it is submitted – no good reason.

27. Ms Dolan opposed that application. She submitted that this application raises difficult issues, which it is for the court to resolve rather than for the Coroner to agree. The Coroner had taken a neutral stance and had not acted unreasonably.

28. We are grateful to both counsel for their submissions.

Analysis:

29. Having considered the transcript of the proceedings at the inquest, and the terms in which the Coroner delivered and explained his conclusion, it is in our view apparent that he proceeded on the basis that diabulimia is a rare condition. Prof. Ismail's report makes clear that it is, worryingly, a more widespread disorder than is commonly recognised. The report also indicates that there is a need for better coordination between different disciplines in the treatment of those suffering from both Type 1 diabetes and diabulimia; that there may be deficiencies in the general care of such persons; that warning signs and "red flags" were not acted upon in Megan's case; and that inadequate care may have contributed to Megan's decision to take her own life. Those features of the report have obvious implications for any consideration of the nature and standard of the care which Megan received, and of whether a PFD report is appropriate. Thus the new evidence not only adds important information but also casts a different light on the other evidence which was appropriate to be considered by the Coroner, and on the assessment of that evidence.

30. In those circumstances, we have no doubt that the discovery of new evidence makes it necessary or desirable in the interests of justice that a fresh investigation should be held.

31. Mr Straw's first ground therefore succeeds. Rather than decide this application solely on that basis, however, we think it right to record our conclusions about the other grounds, which to a significant extent overlap with one another.

32. On the basis that the first ground succeeds, we also accept – at least to some extent – a number of other grounds which would not have caused us to direct a fresh investigation if it had not been for the new evidence. First, in the light of the new evidence, it is possible that a fresh inquest would lead to a PFD report (ground 2), though the evidence considered by the Coroner was not such as to require him to make such a report. Nor was he required to seek out evidence to support the making of a report. His conclusion provided answers to the four questions which s.5 of the 2009 Act required him to consider. It will, of course, be a matter for the coroner who conducts the fresh investigation to decide whether, on all the evidence considered at that investigation, a PFD report should be made.

33. Secondly, Prof. Ismail's evidence shows a public interest in more being known about the dangers of diabulimia (ground 4).

34. Thirdly, the concerns and wishes of Megan's family carry an additional weight which they would not have had without the fresh evidence (ground 5).

35. Fourthly, it is accepted that the Coroner fell into error in failing to comply with r.23 (ground 6). We accept that, if Mrs Davison and her family had known of their right to object, they would have objected to the reading of certain extracts from Ms Harris' statement. If it had not been for the fresh evidence, we would not have regarded the

Coroner's error as having given rise to a risk that justice had not been done; but in the light of the new evidence, the family's wish to ask questions about Megan's care acquires greater weight, and their objection to reading parts of the evidence becomes much more persuasive. The error consequently becomes more important. If the Coroner had known of Prof. Ismail's evidence, we think he would have been likely to require oral evidence to be given by Ms Harris. In those circumstances, it is unnecessary to decide whether, as a matter of law, an objection by interested persons under r.23 operates in effect as a veto, or only as a relevant factor to be considered by a coroner.

36. Fifthly, the availability of new evidence may result in a different view being taken as to whether any act or omission in the care of Megan may have contributed to her death (ground 7). Again, of course, it will be for the coroner who conducts the fresh investigation to decide whether that is so.

37. Lastly, we accept that the new evidence makes it at least possible that a different, and more detailed, narrative conclusion will be recorded at the end of the fresh inquest (ground 8).

38. The medical cause of death noted in the Record of Inquest was "suspension". Even taking Prof. Ismail's report into account, we see no likelihood that the medical cause of Megan's death would be differently recorded after a fresh inquest. Ground 3 therefore fails.

39. As to ground 9, it will be for the coroner who conducts the fresh investigation to decide whether article 2 is engaged. We cannot, however, accept the submission that it was engaged on the basis of the evidence considered by the Coroner. He could properly find, on that evidence, that Megan had capacity and that, having been advised by the CEDS team not to discontinue her treatment, she was entitled to discharge herself from further care.

40. In *R (Morahan) v West London Assistant Coroner* [2021] QB 1205 the High Court considered, amongst other cases, the binding authority of the decision of the Court of Appeal in *R (Maguire) v Blackpool and Fylde Coroner* [2021] QB 409. Popplewell LJ, at [67], emphasised the need, when considering whether the operational duty under article 2 has been engaged, to consider the link between the nature of the control exercised by the state and the risk of harm to the person concerned. He continued –

> "Where, however, there is no link between the control and the type of harm, to impose an operational duty to protect against that risk would be to divorce the duty from its underlying justification as one linked to state responsibility. It would also undermine the requirement identified in *Osman* 29 EHRR 245 that the positive obligations inherent in article 2 should not be interpreted so as to impose a disproportionate burden on a state's authorities."

41. On the evidence considered by the Coroner, those who had been caring for Megan were obliged to respect her autonomy, and had no control over her conduct in the community. On that evidence, they were not, at the time of her death, under an operational duty to

protect her against the risk of suicide. In those circumstances, there was no basis for the Coroner to regard the investigative duty under article 2 as being engaged.

42. We are therefore satisfied that the Coroner's conclusion must be quashed and a fresh investigation ordered. In all the circumstances, and meaning no disrespect to the Coroner, we think it appropriate for the new investigation to be conducted by a different coroner.

43. Turning to the issue of costs, the terms of s.13(2)(b) give this court a discretion to make such order as appears just. The correct approach to the exercise of that discretion was considered by the Court of Appeal in *R (Davies) v Birmingham Deputy Coroner* [2004] EWCA Civ 207, [2004] 1 WLR 2739. Brooke LJ carried out a detailed review of previous case law, and concluded at [47] that –

> "… (1) the established practice of the courts was to make no order for costs against an inferior court or tribunal which did not appear before it except when there was a flagrant instance of improper behaviour or when the inferior court or tribunal unreasonably declined or neglected to sign a consent order disposing of the proceedings; (2) the established practice of the courts was to treat an inferior court or tribunal which resisted an application actively by way of argument in such a way that it made itself an active party to the litigation, as if it was such a party, so that in the normal course of things costs would follow the event; (3) if, however, an inferior court or tribunal appeared in the proceedings in order to assist the court neutrally on questions of jurisdiction, procedure, specialist case law and such like, the established practice of the courts was to treat it as a neutral party, so that it would not make an order for costs in its favour or an order for costs against it whatever the outcome of the application; (4) there are, however, a number of important considerations which might tend to make the courts exercise their discretion in a different way today in cases in category (3) above, so that a successful applicant … who has to finance his own litigation without external funding, may be fairly compensated out of a source of public funds and not be put to irrecoverable expense in asserting his rights after a coroner, or other inferior tribunal, has gone wrong in law, and where there is no other very obvious candidate available to pay his costs."

44. Applying that approach to the present case, we accept Ms Dolan's submissions. Unlike the case of *Hopkins and Ryan v HM Coroner for Swansea, Neath and Port Talbot* [2018] EWHC 1604 (Admin), on which Mr Straw relies, it cannot be said here that the only course the Coroner could reasonably have adopted was to sign the proposed consent order. The grounds of claim are based primarily on the availability of new evidence, not on a challenge to the Coroner's decision on the evidence which he considered. In the circumstances of this case, although we have found in Mrs Davison's favour, it was reasonable for the Coroner to adopt a neutral stance, leaving it to the court to determine whether the grounds of claim should succeed. Ms Dolan has played a neutral and helpful role in making her submissions, and it cannot be said that through her participation the Coroner has made himself an active party in the proceedings.

45. We recognise of course the financial burden on Mrs Davison of funding her own costs in circumstances where no public funding is available; but as against that, we think it important not to deter coroners, in a proper case, from taking a neutral stance, assisting the court and awaiting the court's decision.

Conclusion:

46. It was for those reasons that we quashed the Coroner's conclusion, directed a fresh investigation by a different coroner, and refused Mrs Davison's application for costs.