Cox v HM Senior Coroner for the Area of Avon: How to Turn Around an Inquest – April 2017

Inquest – housing - homeless – mental health – police

The jury's perceptive conclusion at the end of this non-Article 2 fortnight's hearing shows how committed, imaginative lawyers can turn around a poorly planned, overly narrow inquest and avoid a miscarriage of justice. With the **superb support of Clarke Willmott** who funded and prepared an emergency JR application and in the teeth of institutional and judicial opposition, I was able to achieve all of the client's objectives: answers for Robert's children, reassurance that this would not happen again and public accountability of those responsible.

http://www.bristolpost.co.uk/news/bristol-news/999-call-handler-sacked-after-19490

http://www.bbc.co.uk/news/uk-england-bristol-39501158

The Facts

Robert Cox was a 24 year old father of two when, at 10pm on 9 August 2013, he was fatally stabbed by Derek Hancock outside the supported housing facility in Bristol where they both lived. The facility was commissioned by the City Council but run by Stonham/Home Group, a national provider of accommodation for vulnerable, homeless adults.

Robert was receiving treatment and looking forward to moving on. Hancock was an itinerant, undiagnosed, untreated schizophrenic. Despite that, Hancock was deemed suitable for step down accommodation where there was no evening or weekend support and the two men were housed together.

For months before the stabbing, Hancock made delusional, paranoid complaints of sexual harassment by male co-residents, including Robert, to Stonham staff and the police. The staff were not mental health professionals and risk assessed Hancock with no knowledge of his mental health history; they sought no advice about how to help or manage him. Five months before the stabbing and separately, a consultant psychologist diagnosed childhood autism which diagnosis did not account for the paranoid delusions. The consultant was employed by the NHS Trust for post-diagnostic services but working for a mental health charitable organisation outside the Trust when she made the diagnosis.

On the night of the stabbing, Hancock made repeated 999 calls complaining that Robert was harassing and threatening him. Police attended and spoke to Robert but did not identify him as the man complained of. Eventually Hancock said he would deal with matters himself. He took a knife and killed Robert.

The Adult Safeguarding Board commissioned a Serious Case Review with which Robert's family was entirely dissatisfied. They complained and the Board accepted the conclusions of a formal investigation which found that the SCR was deficient in methodology, evidence and analysis and that it lacked independence.

The Board published a misleading Summary of the SCR but kept the SCR and the complaint report out of the public domain.

The Crown accepted Hancock's plea of guilty to manslaughter on the ground of diminished responsibility: schizotypal disorder.

It followed that the inquest was *the only* public investigation into Robert's death.

The Inquest's Scope

Disappointingly, having refused to say that Article 2 applied, the Coroner also refused to set an appropriately wide scope. Her narrow scope focussed on the day itself and Stonham's risk assessment. It left out of account: suitability of accommodation where there was no 24 hour support, investigation of mental health provision and any investigation at all of multi-agency working and communication.

She refused to make either the Safeguarding Board or Bristol City Council Interested Persons.

The Coroner agreed to the family's application that she obtain PFD statements not only from IPs but also the City Council. These provided valuable material.

Disclosure

Prior to the inquest the Safeguarding Board accepted not only that its SCR was deficient but also that it was inaccurate where it stated that there was no 24 hour supported accommodation in Bristol at the time of Robert's death. Notwithstanding those matters, the Coroner relied on *The Worcestershire Case* and refused the family's application for disclosure of the full SCR and the underlying statements and agency reports.

Judicial Review

The family applied for JR of the Coroner's decisions on scope and disclosure and applied for an injunction (not granted) to stop the inquest proceeding. Throughout the 9 day inquest, the Coroner was aware that there were live JR proceedings.

Jury's Conclusions

The jury concluded that all of the factors the Coroner had refused to put in scope had contributed to Robert's death:

> "*Box 3*
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> *Robert was stabbed…by a fellow resident with significant ongoing mental health problems which were not recognised and fully understood. The Egerton Road Project was a supported housing scheme for vulnerable homeless people with mental health needs and where no staff were in attendance at nights or weekends.*
>
> *Box 4*
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> *Unlawful killing with the following contributing factors:*
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> 1. *A delay in diagnosis and treatment of delusional thinking.*
> 2. *A lack of standardised procedures in ensuring accurate recording and sharing of information between relevant services.*
> 3. *Interactions with police and call handlers along with an absence of on-site support are likely to have exacerbated the situation*."

Learning Points - How Was this Result Achieved?

The following measures were key:

1. Early focus on scope. If the Coroner will not make your inquest Article 2, turn your attention to scope and try to persuade the judge to broaden it out.

2. Use the PFD duty as a workaround. If the Coroner insists on a narrow scope and restricts disclosure, use the PFD duty to force her to obtain witness evidence that will assist you on causation. Then use those statements as the basis of an application for further disclosure.

3. Be tenacious. In this case we had no GP records and the Coroner said they could not be obtained. We ascertained she had contacted the wrong practice. When we gave her the right address, contact at 10am resulted in provision of records at lunchtime the same day and a (very helpful) GP report the next.

4. Written submissions. Do them for every application.

5. Where necessary, go nuclear and apply for JR. Even if your paper application is unsuccessful, the fact that the challenge is live will encourage the Coroner to give you greater latitude on questioning so that the evidence ruled out of scope is heard.