Inquest Law Update

21st February 2024

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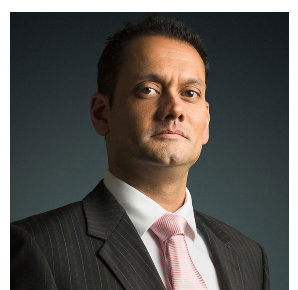
Speaker Biographies

Dr Georgia Richards is an Epidemiologist, Health Research Scientist, and Teaching Fellow at the University of Oxford where she teaches and coordinates modules on Evidence-Based Medicine and systematic reviews for the Medical School. She has a Doctor of Philosophy from the University of Oxford and a BSc in Biomedical Sciences with First Class Honours in Pharmacology from the University of Queensland, Australia. She has expertise in quantitative observational research, open science, and evidence synthesis, with her research focusing on patient safety, pharmacoepidemiology, and pharmaco-device-vigilance. In 2020, Dr Richards launched the Preventable Deaths Tracker, the first and only database of over a decade of published coroner reports in England and Wales.

Bridget Dolan KC leads our inquest law team and is the editor of the *Inquest Law Reports* and our *UK Inquest Law Blog*. She is regularly instructed in inquests and inquiries of the greatest complexity and sensitivity acting for bereaved families, individual interested persons and for public or corporate bodies. Her experience includes countless lengthy and high-profile 'Article 2 inquests' following deaths in prison, after police contact, in psychiatric detention and at the hands of terrorists. Bridget also frequently acts as Counsel to the Inquest or inquiry and sits as an Assistant Coroner herself in Sussex. Bridget is a specialist editor of Jervis on Coroners and has been assisting the Chief Coroner with the development of the forthcoming Bench Book for Coroners. She also delivers part of the Chief Coroner's Continuation Training for all coroners in England and Wales. A recent legal directory review has noted *"her consummate knowledge of the law, her tactical excellence and her exceptional humanity in dealing with people who are coming to terms with a difficult process, the outcome of which is critical to them."* (C&P)



Dijen Basu KC has decades of experience in inquests and inquiries where his training and experience as a doctor gives an edge where there are complex scientific and medical questions. He is also instructed in highly sensitive matters. Examples include deaths in custody, or following contact with the police, and unexpected deaths in hospital, both in the National Health Service and in the private sector. He recently acted on behalf of the Chief Constable of Warwickshire Constabulary (Debra Tedds) – National Police Chiefs' Council lead on Firearms Licensing in the Keyham Shooting Inquests. The Legal 500 describes him as '*approachable, very responsive, able to assimilate huge amounts of information into easily digestible advice. Very pleasant to work with.*'

Katie Gollop KC's inquest experience is broad and ranges from the most intense of one day hearings involving the death of a child, to a 42-day quasi-public inquiry involving the unlawful killing of 7 British nationals in Algeria by Al-Qaeda terrorists. She has extensive Article 2 experience and has acted in inquests into deaths in prison, Young Offender Institutions and secure units. Katie acts for families and for individual clinicians and institutions. Inquests are emotionally draining experiences for all concerned: there are never any winners and there is not always closure. Katie's aim is to make the process as calm, bearable and productive as possible. The Legal 500 suggests *"she leaves clients feeling they have had the very best advice."*

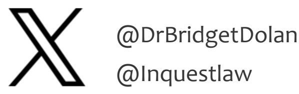
The current edition of Chambers & Partners describes **Paul Spencer** as a *"respected advocate who is particularly noted for his adroit handling of complex inquests."* He has a unique knowledge and experience of acting for NHS Foundation Trusts and Independent sector healthcare organisations in complex and high profile inquests. For over 15 years Paul advised and acted for the CQC, but since 2015, he has acted for Trusts, Care providers, GP and Dental practices who face regulatory enforcement action brought by the CQC. He has defended in all the leading CQC NHS prosecutions including Southern Health, East Kent, and Dudley as well as other independent sector organisations. Paul has a long history of working with the healthcare sector, prisons, secure services, schools, care, nursing and children's homes and has an in-depth insight into the statutory framework and policies and procedures of those organisations and how they function and how systems can occasionally fail.

Rachel Spearing's experience in coronial proceedings includes acting on behalf of Trusts, police, prisons, medical and nursing professionals. She has particular expertise of managing sensitive inquests or inquiries where there may be high profile issues, media interest or subsequent disciplinary or criminal/civil implications. She has experience of Article 2 and jury inquests. She draws on her civil, criminal and public law knowledge to advise and assist with a client focused outcome. Rachel has delivered training to coroners in England and Wales and is an author of the Inquest Law Reports. She currently sits as an Assistant Coroner in Hampshire.

Jamie Mathieson regularly receives instructions in complex inquests, helping clients achieve their goals within the unique parameters of a Coroner's inquest and often appearing alongside barristers of far higher levels of call. He accepts instructions to appear for all kinds of Interested Person, and has represented bereaved families, NHS Trusts, GP surgeries, individual clinicians and healthcare professionals, police forces, social care providers, charitable organisations, providers of supported accommodation, and local government. He regularly acts in Article 2 inquests and in cases involving arguable neglect. He also accepts instructions to act as Counsel to the Inquest, and can apply his experience and expertise from the Deepcut inquests to support all Coroners in the management of major inquests. Jamie is recommended by both The Legal 500 and Chambers & Partners as a leading junior in inquests and public inquiries. Recent editorial has noted that *'Jamie is very bright and has an excellent, reassuring manner with clients and witnesses.'*

Coronial Causation

Back to basics with the Blue Bus



Coronial Causation

Tainton v HMC Preston [2016] Inquest LR 207

- **Standard for causation:** on the balance of probabilities
- **Threshold of causation:** must have contributed more than minimally, negligibly or trivially
- **Causation Question:** Whether, on the balance of probabilities, the event or conduct in question contributed to the death in a more than trivial way

Causation & Neglect

Tainton v HMC Preston [2016] Inquest LR 207

- The conduct or event must make an actual and <u>material</u> contribution to the death of the deceased
- Not enough to show that a particular event or conduct deprived the deceased of an increased chance of life
- Not enough to show that made the death more likely than it would otherwise have been

Causation & Neglect

Khan v HMC West Herts [2008] Inquest LR 200

For neglect:

- Must be shown on BoP not only that care would otherwise have been given, but that it *would* have saved the deceased or prolonged life
- Not enough for <u>neglect</u> to show a lost opportunity to give care that *may* have made a difference

The balance of probabilities

On an overall assessment of the evidence, or on a preponderance of the evidence, the case for believing that the suggested event did happen is more compelling than the case for not reaching that belief

- It's a judicial balance

Statistical probability

Between all the events that might occur, what is statistically more likely to happen

“Some use statistics like a drunk uses lamp-posts…

…for support rather than illumination”

Law not statistics

Is it more probable than not that the statistically more likely event actually happened <u>here</u>?

Mesothelioma death

R (Wandsworth) v HMC Inner West London [2021] EWHC 801

1a bronchopneumonia

1b malignant mesothelioma

*"D died **from exposure to** asbestos whilst resident at 8 Eliot Court, **causing** malignant mesothelioma"*

Mesothelioma Missteps

- No work history of asbestos exposure
- Asbestos panels removed from flat in 2003
- No *evidence* deceased had ever actually been exposed to freely circulating asbestos dust there

Basis for causation

Pathologist said:

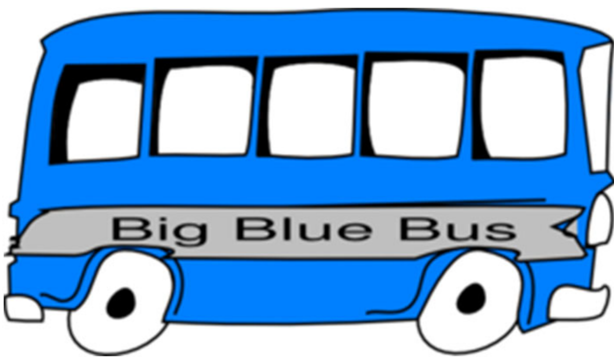
- An *"extremely strong association"* between mesothelioma and asbestos
- *"Often and usually"* long delay between asbestos exposure and illness
- History *"entirely consistent"* with the evidence that exposure *may* have occurred whilst living in the flat

Reasonable assumption?

So was "**reasonable to assume** exposure at the flat"

SERJEANTS' INN

The Blue Bus Proof Paradox



The Blue Bus Paradox

- A pedestrian was killed by a bus
- The only eye-witness is colour-blind

- Three quarters of the buses that travel along the street are owned by the Blue Bus company, all the rest are run by the Red Bus Co.

On the balance of probabilities, did a Blue Bus caused this death?

The Blue Bus Paradox

- What if 99% of the buses that travel along the street are owned by the Blue Bus company

Now on the balance of probabilities, did a Blue Bus caused this death?

Don't let statistics drive you

- 54% of active drivers in the UK are men
- Men are responsible for 73% of road traffic deaths

On the balance of probabilities, was the unobserved driver who caused a hit & run road death a man?

Is the driver statistically more likely to have been a man?

Question of law, not statistics

- Is it more probable than not that the statistically more likely event actually took place ?

The Blue Bus Paradox

- Tyre marks near victim in the road same as tyres on 100% Blue and 2% Red buses
- Hub cap found nearby is of same as on 100% Blue and 1% of the Red buses

On the balance of probabilities did a Blue Bus cause this death?

The Blue Bus paradox

- The statistical evidence is equally compatible with a narrative in which the bus that caused harm was blue or red
- Competing exculpatory narratives cannot properly be ignored when they are not ruled out by the statistical evidence
- **Legal proof involves something more than mere statistical likelihood**

Statistical likelihood of different medical explanations for an injury

A = 30%

B = 30%

C = 40%

Statistical likelihood of possible medical causes of death

A = 24%

B = 24%

C = 52%

Statistical likelihood of possible causes of death

X = 1%

Y = 1%

Z = 98%

Law not statistics

- Is it more probable than not that the thing that ***predictive*** statistics suggest will happen more often, is what did actually happen here, ***in the past***?

Statistics aren't enough

- Statistical evidence does not deal with the individual case, something more will be required before the court will be able to reach a conclusion, on the balance of probability

Lord Mance *Sienkiewicz v Greif* [2011] 2 AC 229

Assumptions v Evidence

R (Wandsworth) v HMC Inner West London

Pathologist said:

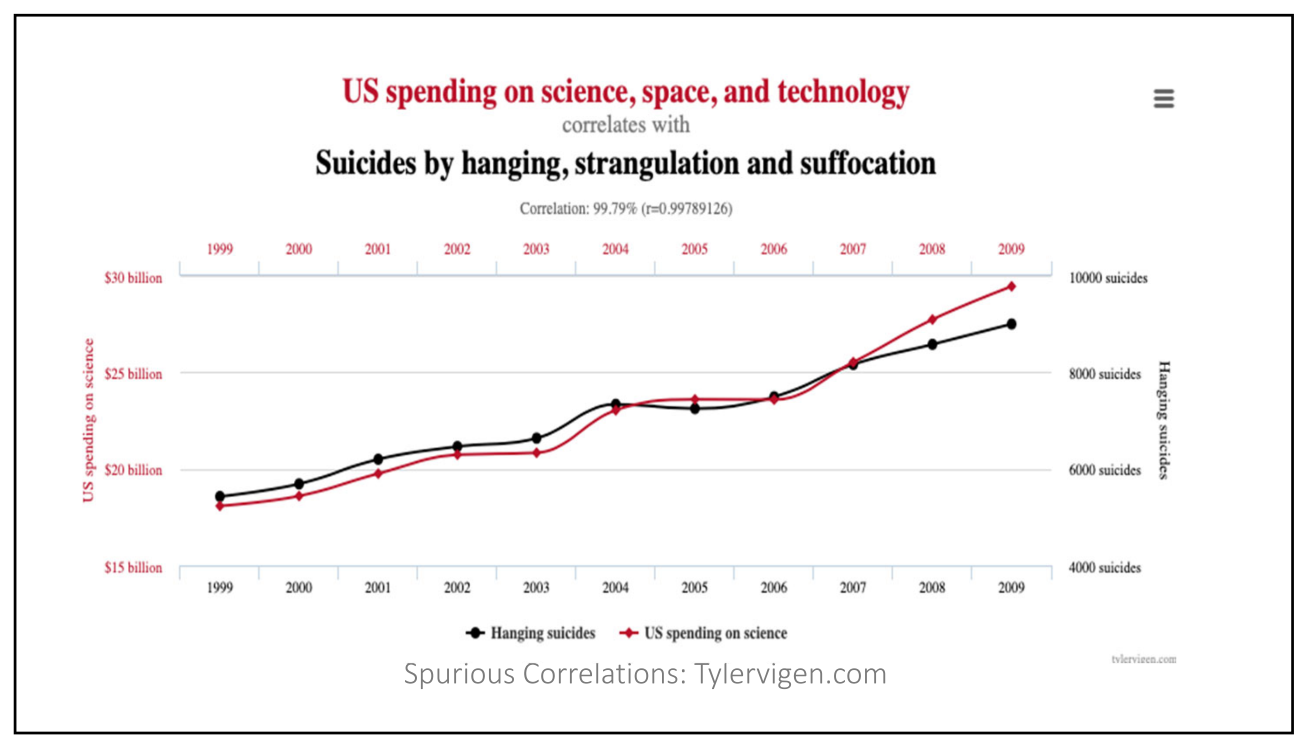
- He was '*entirely satisfied on the balance of probabilities*' that living in accommodation where asbestos exposure has occurred has led to this death'

Strayed far beyond the sphere of his medical expertise

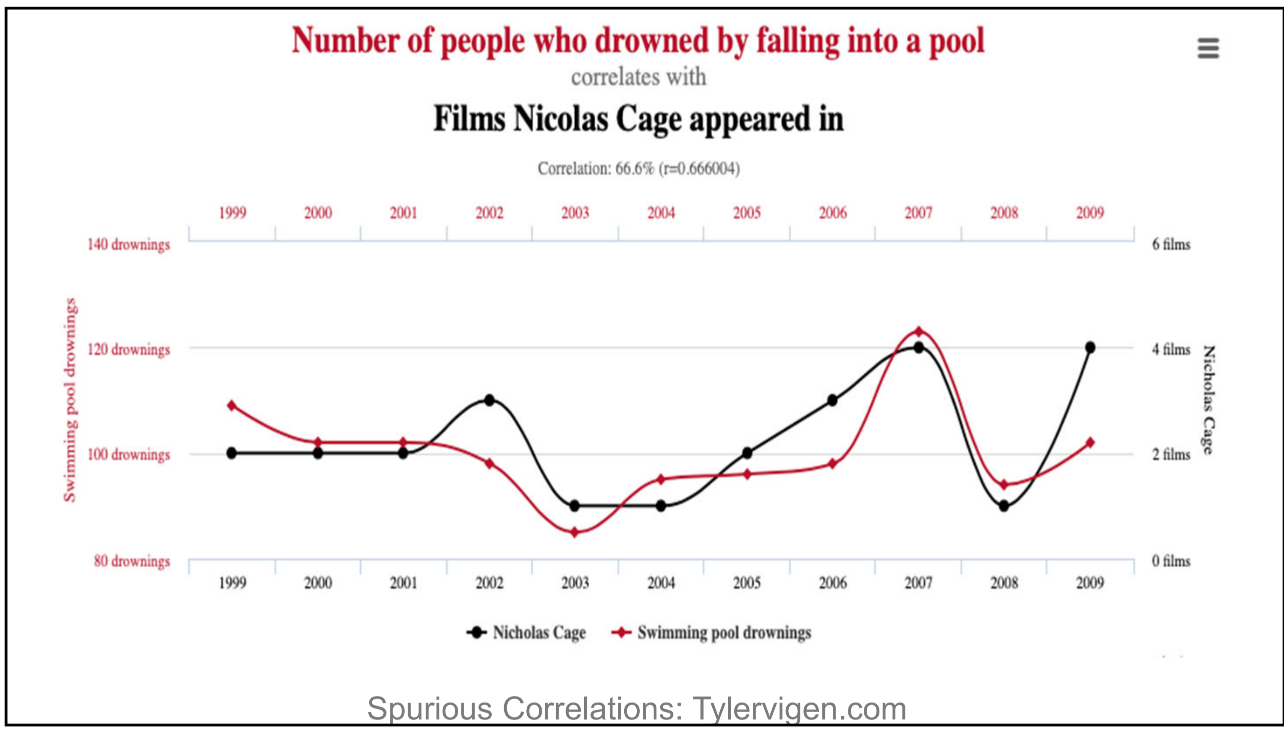
Not an opinion he should have been allowed to express

Correlation is not Causation

- Mesothelioma can arise without asbestos exposure
- Any exposure could have been other than at her flat
- Absence of evidence (of exposure elsewhere) is not evidence of absence



Spurious Correlations: Tylervigen.com



Spurious Correlations: Tylervigen.com

Correlation is not causation

- That someone lived in a place where asbestos was present is insufficient to establish that <u>this</u> mesothelioma was caused by <u>that</u> asbestos
- Was mesothelioma caused by asbestos on b.o.p?
- If so did that exposure on b.o.p occur at the flat ?
- Epidemiological statistics cannot prove causation without more – you need an **evidential** link

Civil law policy exception

Fairchild v Glenhaven Funeral Services Ltd [2003] 1 AC 32

- Can establish causation if show an employer had contributed to asbestos exposure, so materially raised the probability of contracting cancer
- Where on the facts the 'but for' test cannot be reasonably or fairly applied, the 'materially increased risk' of harm test may be used

Why this exception?

- it is *inherently unjust* to deny claimants a remedy in a civil claim where breach of duty to protect and
- no way of identifying, even on a balance of probabilities, the source of the fibre or fibres which initiated the disease

Not relevant in coroners courts

High Court's view

- Mistake was assuming exposure without any evidence of exposure

"Statistical association by itself is incapable of establishing a causal link"

- A causal link cannot properly be inferred without *some* evidence **specific** to the index case.

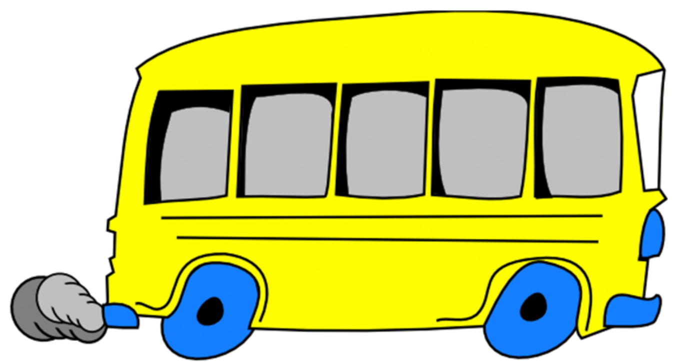
Causation needs evidence

- No evidence that the deceased had ever been exposed to freely circulating asbestos fibres of the kind associated with malignant mesothelioma, let alone that such exposure had taken place at any identifiable location

- The sole basis for linking the death to asbestos was thus the very strong – but not 100% – statistical correlation between exposure to asbestos fibres & mesothelioma

A different source of asbestos?

A different cause of mesothelioma?



Statistics alone not enough

- General statistical evidence of survivability is relevant and admissible BUT Being a figure in statistics does not prove causation without more

Stats are not enough alone

Wardlaw v. Farrar [2003] EWCA Civ 1719

‘While judges are of course entitled to place such weight on statistical evidence as is appropriate, they must not blind themselves to the effect of other evidence which might put a particular patient in a particular category, regardless of the general probabilities’

Statistics can assist

Re B (Minors) [2008] 3 WLR 1HL

‘The inherent probabilities are simply something to be taken into account, where relevant, in deciding where the truth lies’

Baroness Hale of Richmond

But are not the answer

Nulty Deceased v Milton Keynes Borough Council [2013] EWCA Civ 15

'Judging whether a case for believing that an event was caused in a particular way is stronger than the case for not so believing, is not a scientific process (although it may include evaluation of scientific evidence)…

… to express the probability of some event having happened in percentage terms is illusory'

'Preponderance of evidence' is not mathematical

Nulty Deceased v Milton Keynes Borough Council [2013] EWCA Civ 15

'Expressing the 'balance of probability' standard mathematically as '50+ % probability' may carry a danger of pseudo-mathematics'

Least unlikely is not the legal test

'Look at the whole picture, including what gaps there are in the evidence, whether individual factors relied upon are in themselves properly established, what factors may point away from the suggested explanation and what other explanation might fit the circumstances.'

Nulty Deceased v Milton Keynes Borough Council [2013] EWCA Civ 15

Stats are just too simplistic an answer

In 51% of cases in the past this happened this way, so I find that it did this time too….

In 99% of cases in the past this happened this way, so I find that it did this time too…

Practice Point

Preponderance of evidence
is the legal test

Stop saying that balance of probabilities means 'more than 50%'

Beware Experts

Smith v HMAC NW Wales [2020] Inquest LR 39

Expert: "This is an entirely treatable condition… in the vast majority of cases patients make a good recovery … over 99% do not go on to kill themselves"

"this death was predictable and preventable"

Look at individual circumstances

- Expert opinion was little more than a statistical assertion re the five-year mortality rates
- Close examination showed this view was supported by the statistics but no other evidential foundation
- The coroner "did a good job of exploring and taking into account all the evidence. The conclusion she reached was rational and securely based on the whole of her careful evidential enquiry."

Practice Point

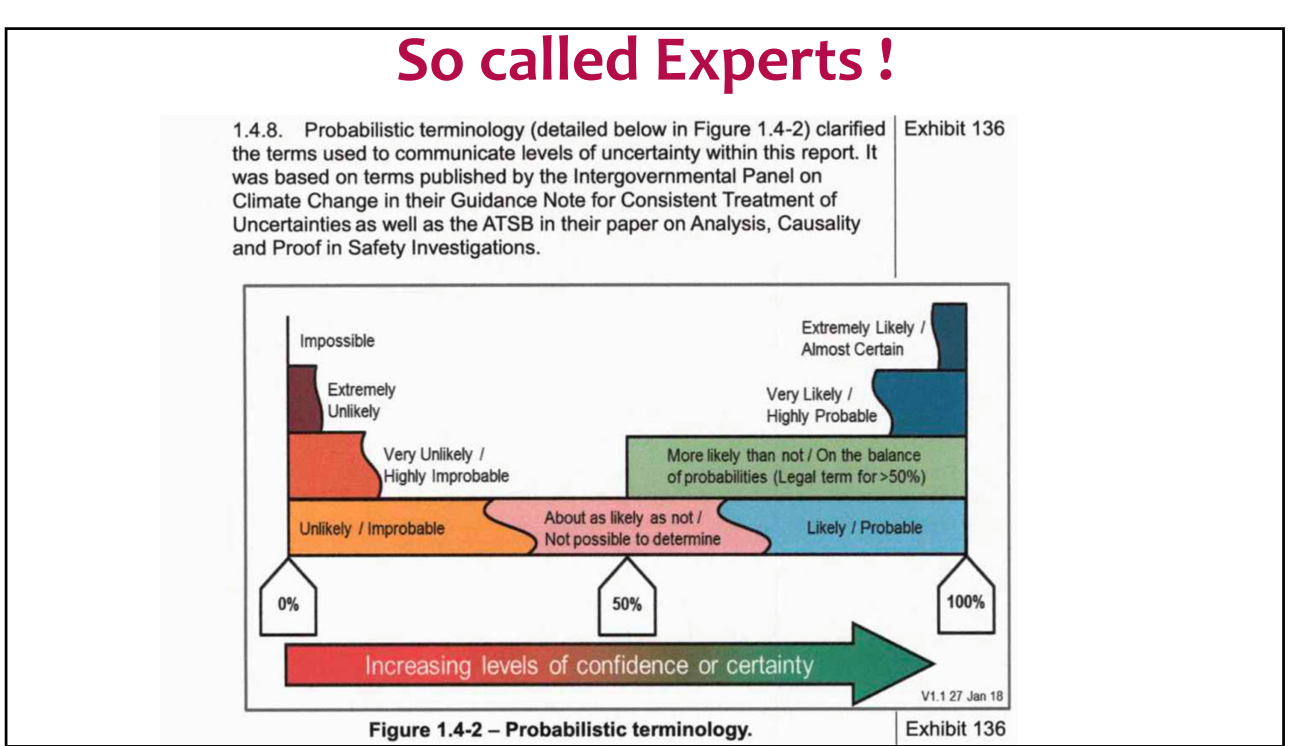
Don't rely on doctors to understand legal causation

So called Experts

"The mortality of acute behavioural disturbance is approximately 10% . This means that 90% of people with it do survive, and hence on this fact alone it means on the balance of probability he would have a 90% survival rate from the acute behavioural disturbance if he had not been restrained."

Expert report commissioned by Coroner

So called Experts !



1.4.8. Probabilistic terminology (detailed below in Figure 1.4-2) clarified the terms used to communicate levels of uncertainty within this report. It was based on terms published by the Intergovernmental Panel on Climate Change in their Guidance Note for Consistent Treatment of Uncertainties as well as the ATSB in their paper on Analysis, Causality and Proof in Safety Investigations.

Exhibit 136

Figure 1.4-2 – Probabilistic terminology.

Exhibit 136

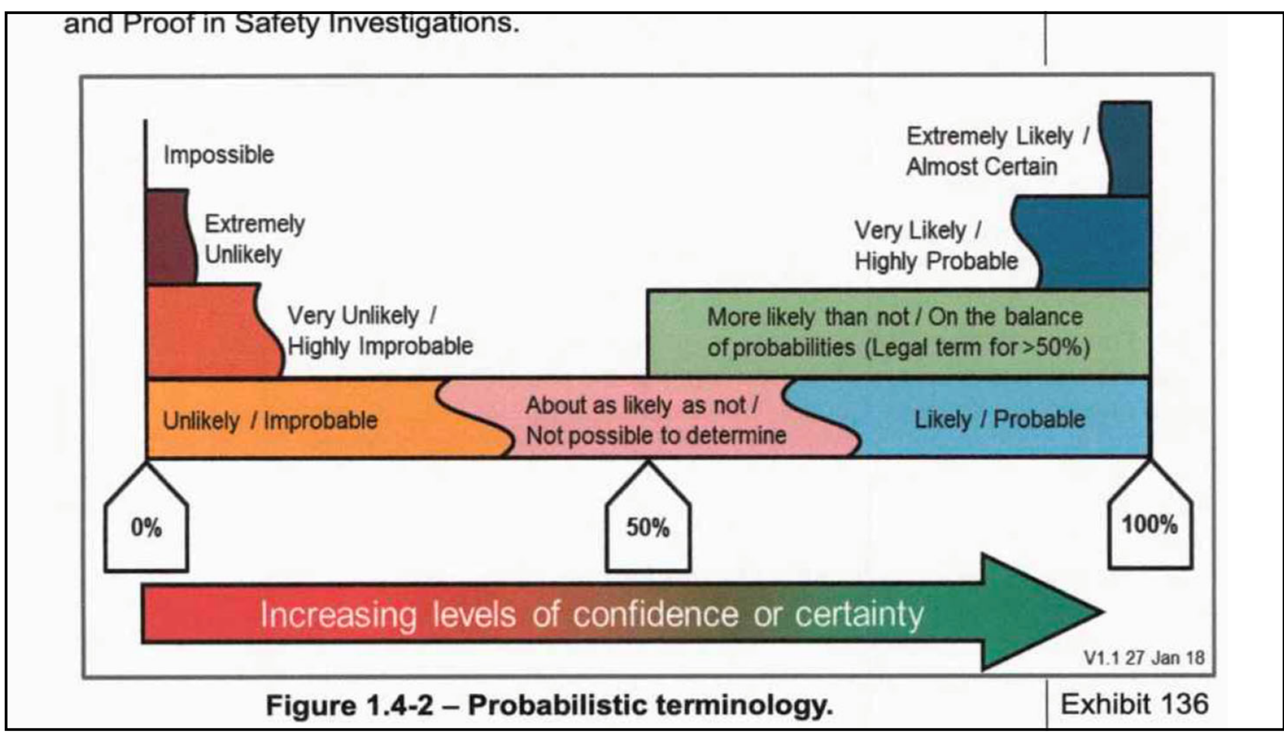


Figure 1.4-2 – Probabilistic terminology.

Individualised approach

***R (Chidlow) v HMC Blackpool* [2019] Inquest LR 93**

- Will be safe to leave causation to the jury if there is credible additional evidence of causation which, if accepted, *together with* the general statistical evidence could properly lead the jury to a finding on the balance of probabilities
- Expert had relied on: clinical experience; PM finding of no underlying disease; condition when police arrived **as well as** the statistics

Practice Points

- Issue is not how many of general population die or are saved, but could *this* life have been saved
- The expert clinical evidence can address that *alongside* statistics
- Ask expert about clinical experience and any relevant features specific to the deceased that would place *them* in survivor or fatality group

Practice Point

Just because an event is exceedingly rare for a particular person does not necessarily mean it is a surprising event to occur to someone

Contributing to suicide?

Jamie Mathieson

How can someone contribute to another's suicide?

- The traditional inquest issue: Failure to prevent suicide.
- Should an inquest be investigating 'the impact of past events on a person's mental health'?
  - Cessation of benefits.
  - Accusations of wrongdoing/investigation into conduct/job losses.
  - Bullying – at work/school.
  - 'Adverse life events'. Personal life? Family relationships?

‘Amid…’

Post

Fraser Nelson
@FraserNelson

“Amid” is a word beloved by fake news websites, to conflate correlation and causation. UK crime is also up “amid” spread of fidget spinners.

Donald J. Trump @realDonaldTrump · 20 Oct 2017
Just out report: "United Kingdom crime rises 13% annually amid spread of Radical Islamic terror." Not good, we must keep America safe!

12:19 pm · 20 Oct 2017

‘Amid…’

JOURNAL ARTICLE

Sociodemographic inequalities of suicide: a population-based cohort study of adults in England and Wales 2011–21

Isobel L Ward, Katie Finning, Daniel Ayoubkhani, Katie Hendry, Emma Sharland, Louis Appleby, Vahé Nafilyan

European Journal of Public Health, ckad233,
https://doi.org/10.1093/eurpub/ckad233
Published: 07 February 2024

SERJEANTS' INN

‘Amid…’

Conclusion

Our results show that suicide risk varies by sex and age. Among males, those aged 40–50 years, who are unemployed long term or have never worked, who are disabled or have a long-term health problem, or are single have the highest suicide rates. In women, we find a similar pattern, with the absolute rates being lower. Interestingly, the relative risk is greater for disabled people compared with non-disabled people for women, indicating that this group in particular should be targets of intervention. The current work provides novel population-level insights into the groups with the highest rates and factors which are independently associated with suicide.

SERJEANTS’ INN

Jodey Whiting

HM Assistant Coroner for Teeside and Hartlepool (2017)

- Jodey died from suicide; diagnosed EUPD; family say stress due to decision by DWP to stop benefits
- Coroner: *“As a Coroner, it’s not our position to question any decisions made by the Department of Work and Pensions. That’s just outside the remit of this court.”*
- Lasted 37 minutes.
- Box 3 – blank. Box 4 – “Suicide”

Dove [2021] – High Court

Judicial Review on basis of fresh evidence:

- Report from Independent Case Examiner - 'shocking' DWP failures
- Expert evidence linking withdrawal of benefits to state of mind

Dove [2021] – High Court

Divisional Court say no fresh inquest:

- PFD power does not make the Coroner *'the guardian of the public interest…the Coroner has no specialism in these matters and is not well-equipped to undertake such an enquiry.'*
- *'The causal link which (the expert) draws relates to Ms Whiting's state of mind and not her death…He did not rule out other stressors as causative of her suicidal state or suicide….It is likely to remain a matter of speculation as to whether or not the Department's decision caused Ms Whiting's suicide.*

Dove [2023] – Court of Appeal – causation

Divisional Court wrong to separate mental health from death:

> *'Her suicide was the end point to which her mental health problems brought her.'*

Dove [2023] – Court of Appeal – causation

Causation at an inquest = contributed more than trivially => the Coroner can consider the extent to which acts or omissions contributed to the deceased's mental health deterioration.

- The Coroner has a wide discretion to record the facts which contributed to the circumstances which may or may not have led to the death.
- Doing so may be part of investigating whether or not the deceased intended to take their own life.

Dove [2023] – Court of Appeal – discretion

- ‘It seems to me that it was well within the Coroner’s discretion to conclude that the Department’s failings lay **outside** the remit of the inquest…if a second inquest were to be ordered, it would be for the Coroner conducting that inquest to decide whether to admit the ICE report…’
- ‘Beyond acknowledging that fact, I doubt that the Coroner would wish to investigate the Department’s conduct further; the specifics of individual errors and breaches of policies of the Department would appear to me to lie beyond the scope of any Jamieson inquest.’

Was a fresh inquest required?

Significance to the family

- *‘The Coroner may or not make the findings which Jodey’s family seeks, but, either way, this is part of determining the ‘**substantial truth**’.*

Public interest

- *‘If Jodey’s death was connected with the abrupt cessation of benefits by the Department, the public has a legitimate interest in knowing that…the consequences of terminating benefit payments to (vulnerable people) should be examined in public, where it can be followed and reported on by others who might be interested in it.’*

SERJEANTS’ INN

Was a fresh inquest required?

Possibility of a PFD report

- *'If the Coroner concluded that the error had contributed in any way, direct or indirect to Jodey's death, that would be a serious matter to which the Department should be alerted, in order that remedial steps can be taken…'*

Ruth Perry

HM Senior Coroner for Berkshire (2023)

- No mental health history; contact with mental health support prior to death.
- Ofsted grading of the school is out of scope.
- Findings about 'rude and intimidating' behaviour by inspectors.
- *Jamieson* – no judgmental language in Box 3 / Box 4.
- Box 4: 'Suicide, contributed to by an Ofsted inspection…'

Where next?

- Decisions on scope remain at the Coroner's discretion and very hard to overturn on JR
- Failings by state bodies that contributed to the deceased's 'mental health deterioration' **may** be in scope, even in a *Jamieson* case
- Admitted failings probably will be in scope at an inquest where i) they go to the 'substantial truth' of what happened, ii) it is in the public interest to record them, and iii) there may be a PFD report

- But what if those failings *aren't* admitted?

Thank you

Presented by Jamie Mathieson

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Media Access to Materials Used in Inquests

Dijen Basu KC

Outline

- the open justice principle
- anonymity
- restrictions on recording and reporting
- reporting and access to documents by reference to the Chief Coroner's guidance

The open justice principle

"Sunlight is said to be the best of disinfectants; electric light the most efficient policeman."

Louis Brandeis (later an associate justice of the Supreme Court of the United States); "*What Publicity Can Do*"; *Harper's Weekly* 1913

He was writing about regulations to prevent financial crime, rather than courts

SERJEANTS' INN

Lord Denning's watchdog of justice

"… we must hold fast to the principle that every case must be heard and determined in open court. … The reason for this rule is the very salutary influence which publicity has for those who work in the light of it. The judge will be careful to see that the trial is fairly and properly conducted if he realises that any unfairness or impropriety on his part will be noted by those in court and may be reported in the press. He will be more anxious to give a correct decision if he knows that his reasons must justify themselves at the bar of public opinion."

SERJEANTS' INN

The open justice principle

- all inquest hearings should be **in public**
- court room **easily accessible** to the media and public
- all **witnesses identified** and can be seen
- **fair, accurate and contemporaneous media reporting** of inquest proceedings is to be encouraged

R v Felixstowe Justices Ex parte Leigh [1987] QB 582

SERJEANTS' INN

The open justice principle

- reporting only curtailed if **strictly necessary**
- any departure from open justice must be justified
- any person who might be affected by a proposed order is **entitled to know about it <u>and</u> to be heard**

SERJEANTS' INN

Closed hearings are rare

- coroner may only exclude **interested persons** from hearing where is an issue of **public interest immunity**
- coroner may only exclude the **public & media** (not interested persons) **from an inquest** in the interests of **national security** – r.11(4)
- May also exclude **public & media** from **pre hearing reviews** in the **interests of justice** - r.11(5)

Open justice in practice

- RRO / anonymity / screening **applications usually in public**
- Preferably considered **in advance of the inquest** – at a pre inquest review
- the **outcome** of any closed hearing should be announced in open court, with sufficient **reasons** given

Coroners' powers to restrict reporting

- a coroner has **no common law power** to restrict reporting of things said in open court – see ***Re AB (Application for reporting restrictions: Inquest)*** [2019] EWHC 1668 (QB), §24
- once something is said in open court it is likely to be **too late**
- but a coroner has common law powers to control their own proceedings
- seek **proactive** directions – prevention is better than cure

Coroners' power to order anonymity

- coroner's power to anonymise witnesses or others falls within their general case management powers
- coroner usually applies a common law test, making an 'excursion' if appropriate into the territory of Article 2 ECHR (see ***Re Officer L*** [2007] 1 WLR 2135 at §29).
- This involves a two-stage process, depending on whether or not **refusal of the orders would create or materially increase a risk to the life of the person**, such that the risk would be **real and immediate**

Coroners' power to order anonymity

- if **refusal of the orders <u>would</u> create or materially increase a risk to the life of the person**, such that the risk would be **real and immediate**, at least a degree of anonymity is likely to be granted
- if **<u>not</u>**, then the matter is governed by the common law principles, **balancing the factors for and against** the orders sought

Coroners' power to order anonymity

The factors to be balanced:-

- the subjective fears of the person, whatever their objective justification (see ***Re Officer L***, at §22)
- the consequences of granting / refusing the orders sought e.g. that the identification of a police officer who does specialist work would prevent her/him continuing in her/his current role and would deprive the force of a valuable resource (see ***R v Bedfordshire Coroner, Ex Parte Local Sunday Newspapers*** (2000) 164 JP 283).

Coroners' power to order anonymity

- the fundamental principle of open justice (***see Re LM (Reporting Restrictions: Coroner's Inquest)*** [2007] CP Rep 48 at §§26 – 40)
- giving names and personalities to witnesses is recognised to be an important aspect of openness in the justice system (see ***In re Guardian News and Media Ltd*** [2010] 2 AC 697 at §63)
- weigh any claimed Article 8 right against the free speech rights of media organisations under Article 10 (see ***R (T) v West Yorkshire (Western Area) Coroner*** [2018] 2 WLR 211 at §63)

SERJEANTS' INN

Coroners' consequential powers

S.11 of the Contempt of Court Act 1981 provides for an enforcement mechanism:-

"**In any case where a court (having power to do so) allows a name or other matter to be withheld from the public in proceedings before the court, the court may give such directions as appear to the court to be necessary for the purpose for which it was withheld.**"

Extends to the coroner making anonymity orders giving directions prohibiting the reporting of names and identifying details in connection with the inquests

SERJEANTS' INN

Sound and images

SERJEANTS' INN

Sound and images

- S.9 Contempt of Court Act 1981: using, or even bringing into court for use, – any sound recording device without leave is a contempt, as is publishing a recording of legal proceedings
- that applies to remote access to hearings
- S.41 CJA 1925: no taking or sketching of images of a person in court. Applies also to remote access

SERJEANTS' INN

Protecting a child witness

s.39(1) Children and Young Persons Act 1933

Prohibits reporting of:

- Name & address
- School or work
- Particulars that might identify the child
- Picture

Does not apply to:

- Minor child of the deceased - unless also a witness
- Deceased child who is the subject of the inquest
- After the child turns 18

Protecting a child non-witness

In addition to anonymity powers of the coroner

- Identity of a deceased or living child may be protected if Family Division of High Court imposed a RRO that remains in force at the inquest
- IP may seek an injunction from the High Court to restrict publication of details regarding a living child

Re LM (Reporting Restrictions Coroner's Inquest) [2007] Inquest LR 221

Victims of sexual assault

s.1 Sexual Offences (Amendment) Act 1992

- it is a criminal offence to publish details of the identity and other personal information that might identify any living person who is alleged to have been a victim of a sexual offence
- no order is necessary – in fact, the coroner cannot make an order disapplying this provision
- extendable beyond death on application to magistrates

The Order

Must:-

- be in precise terms
- explain its legal basis
- set out its precise scope
- clearly state its duration and when it will cease to have effect
- be put into writing as soon as practicable
- (if made *ex parte*) must give anyone affected (particularly the liberty to apply to vary or discharge the order at short notice in order to be heard

SERJEANTS' INN

Protecting sensitive material

Coroner can direct that irrelevant sensitive material is not mentioned in open court

- Need not give full / current name
- Need not give address in public
- Not reveal other identifying details
- May use back door to avoid cameras

Reporting and media access

- Chief Coroner's Guidance No. 25
- live text-based commentary – journalists & legal commentators vs members of the public
- recordings of proceedings: ***interested persons*** – as of right (subject to r.15), ***others*** – dealt with as below pursuant to r.27(2)
- there is a presumption in favour of providing access (see ***Observer and Guardian v UK*** [1992] 14 EHRR 153)
- that presumption may be displaced by "*some strong contrary argument*" or "*countervailing reasons*"

SERJEANTS' INN

Reporting and media access

- documents which have not been relied upon and adduced in evidence in court need not be disclosed
- recording proceedings dealt with in the same way
- redaction or (partial) withholding may be justified e.g. on grounds of national security, public interest immunity, legal privilege, the avoidance of prejudice to current or future criminal proceedings, the protection of sensitive or harmful personal information, Article 8 rights of witnesses or others

Reporting and media access

- withholding documents which have been read out in full (e.g. suicide note) or recordings that have been played in open court may be easier to justify with a countervailing reason
- the coroner will balance the Art 10 rights of the Press and the principle of open justice against the countervailing reason
- any derogation must be a proportionate means of achieving a legitimate aim
- draft skeleton arguments etc. with media access in mind

MEDIA ACCESS TO MATERIALS USED IN INQUESTS

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MEDIA ACCESS TO MATERIALS USED IN INQUESTS – DOCUMENTS, WITNESS STATEMENTS AND VIDEO EVIDENCE

Dijen Basu KC

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THE OPEN JUSTICE PRINCIPLE

Introduction

"Sunlight is said to be the best of disinfectants; electric light the most efficient policeman."

So wrote Louis Brandeis (a prominent lawyer and later an associate justice of the Supreme Court of the United States) in his 1913 Harper's Weekly article titled, "*What Publicity Can Do*".

He was actually talking about the way in which transparency could reduce financial crime, rather than about open justice, but the phrase is memorable.

The principle of open justice finds further expression in the right to freedom of expression contained in Article 10 of the (European) Convention for the Protection of Human Rights and Fundamental Freedoms 1950, but it is an ancient principle of the English common law. Not only must justice be done, but it must be seen to be done.

Save upon rare occasions when a court is entitled to sit in camera, it must sit in public – see ***R v Felixstowe Justices Ex parte Leigh*** [1987] QB 582 (Watkins LJ, Russell and Mann JJ)), in which Watkins LJ quoted approvingly from *The Road to Justice* (1955), by Lord Denning MR, at page 64:-

"A newspaper reporter is in every court. He sits through the dullest cases in the Court of Appeal and the most trivial cases before the magistrates. He says nothing but writes a lot. He notes all that goes on and makes a fair and accurate report of it. He supplies it

> for use either in the national press or in the local press according to the public interest it commands. He is, I verily believe, the watchdog of justice. If he is to do his work properly and effectively we must hold fast to the principle that every case must be heard and determined in open court. It must not take place behind locked doors. Every member of the public must be entitled to report in the public press all that he has seen and heard. The reason for this rule is the very salutary influence which publicity has for those who work in the light of it. The judge will be careful to see that the trial is fairly and properly conducted if he realises that any unfairness or impropriety on his part will be noted by those in court and may be reported in the press. He will be more anxious to give a correct decision if he knows that his reasons must justify themselves at the bar of public opinion."

The Information Age

In the modern world, potentially anybody anywhere in the world has instantaneous access to the written and spoken word, images and video from everyone and everywhere in the world. Everybody carries a high quality video camera, recording and broadcasting device in their pocket at all times.

All hearings can now be conducted in a hybrid fashion so that they can be watched from anywhere by a wide audience.

We are recorded everywhere, including in our most difficult – including our terminal – moments – during a serious incident, when calling the emergency services, and when dealing with the police.

Many hearings are broadcast – e.g. all those in the Supreme Court of the United Kingdom, many hearings before the Court of Appeal (both divisions) and some hearings where a sentencing judge delivers her or his sentencing remarks.

Inquests are uniquely personal and poignant public hearings which follow the tragic last hours or days of a person's life – a journey we are all destined to take – sometimes requiring the playing of recordings of emergency calls, CCTV footage, police body worn camera

footage or recordings made by ordinary citizens. They may involve the viewing of social media consumption by the deceased or publications by them.

Frequently, media organisations will wish to broadcast and/or publish on the internet the newsworthy recordings and documents.

The public have a strong interest in this material – both in the narrower, sometimes salacious, sense and in the broader sense of the supervision by the people of their justice system.

Countervailing interests

(i) Privacy rights

While intensely private material may be sensitively shown in inquests, that will not completely extinguish the privacy rights of third parties, family members or first responders.

(ii) Anonymity and reporting restrictions

Obviously, anonymity of witnesses (and others) and reporting restrictions (e.g. where there has been an allegation of a sexual offence having been committed against a person, whose identity then becomes protected) will complicate the provision of material to the Press.

(iii) Policing, intelligence and defence etc.

Similarly, there may be genuine policing concerns, e.g. police tactics, intelligence and sources, or defence interests which may be engaged by a media request for access to material used during an inquest. The more the authorities seek secrecy, the more the Press and public seek transparency. The regrettable mutual distrust this engenders is misplaced. It should be replaced by a mutual understanding of the legitimate concerns of the other. In an inquest, the coroner who must referee between the two.

(iv) Costs

Disclosure of material may be very costly, e.g. where a great deal of labour is required in order to ensure that the material disclosed does not violate the interests outlined above – e.g.

the pixelation of videos and the redaction of documents or audio recordings. Public authorities and other large organisations are often better served by devoting a sensible amount of resources in achieving satisfactory transparency.

(v) Time

Equally, disclosure may require considerable time – e.g. hearing time in, debating disclosure, and the time taken to provide material in an acceptable form.

If delay be the enemy of justice, it is no less the enemy of full and fair reporting.

ANONYMITY

The legal principles governing applications for anonymity are as follows:-

1. Orders anonymising witnesses or other persons within an inquest fall within the Coroner's general case management powers. There is no inconsistency between that power and requirements for inquests to be held in public (see ***R v HM Coroner for Newcastle upon Tyne, Ex Parte A*** (1998) 162 JP 387). They give effect to and balance relevant rights under the ECHR by exercising this power.

2. In deciding whether to make such orders, a coroner usually applies a common law test, making an 'excursion' if appropriate into the territory of Article 2 ECHR (see ***Re Officer L*** [2007] 1 WLR 2135 at §29). This involves a two-stage process:-

    (i) if the refusal of the orders would create or materially increase a risk to the life of the person, such that the risk would be ***real and immediate*** (see ***Osman v UK*** (1998) 29 EHRR 245), then the state – through the coroner – owes a positive duty under Article 2 to protect the witness by reasonable means. In those circumstances, as it was put in the ***Officer L*** case, the coroner "*would ordinarily have little difficulty in determining that it would be reasonable in all the circumstances to give the witness a degree of anonymity*"

A risk is "*real*" if it is substantial and significant, rather than remote and it is "*immediate*" if it is present and continuing (see ***Rabone v Pennine Care NHS Trust*** [2012] 2 AC 72 at §§37 – 40).

(ii) if the refusal of the orders would not create or materially increase a risk to the life of the person, such that the risk would be real and immediate, then the coroner should decide the matter as one governed by the ***common law*** principles, balancing the factors for and against the orders sought

3. When applying that common law test, the coroner must consider the ***subjective fears*** of the person concerned, whatever their degree of objective justification (see ***Re Officer L***, at §22). Risks of harm falling short of real and immediate risk of death (or of serious harm such as might engage article 3 rights) may be relevant to the balancing exercise (see ***Sunday Newspaper Ltd's Application (Judgment No. 2)*** (2012) NIQB at §17).

4. When striking the balance pursuant to the common law test, the coroner may consider all the consequences of granting and of refusing the orders sought. For example, in an application for anonymity by a police officer who does specialist work, a relevant factor may be that identification of the officer would prevent him/her continuing in her/his current role and would deprive the force of a valuable resource (see ***R v Bedfordshire Coroner, Ex Parte Local Sunday Newspapers*** **(2000)** 164 JP 283).

5. The common law test also requires the coroner to take proper account of the fundamental principle of open justice (see ***R (A) v Inner South London Coroner*** [2005] UKHRR 44 at §20). The principle of open justice requires that the administration of justice generally take place in the open, as a safeguard and to maintain public confidence (see ***Scott v Scott*** [1913] AC 417 at 437 – 439 and 476 – 478 and ***A-G v Leveller Magazine Ltd*** [1979] AC 440 at 449 – 450). The court recognises that giving names and personalities to witnesses is an important aspect of openness in the justice system (see ***In re Guardian News and Media Ltd*** [2010] 2 AC 697 at §63[1]). The

[1] *"What's in a name? 'A lot', the press would answer. This is because stories about particular individuals are simply much more attractive to readers than stories about unidentified people. It is just human nature. And this is why, of*

divisional court in ***R v Felixstowe Justices Ex p. Leigh*** [1987] QB 582 held that the names of the justices hearing a case of alleged gross indecency by six adults with, or in the presence of, a 12-month-old child, could not be withheld.

6. Where a witness seeks to justify anonymity by reference to his/her rights to private and family life under article 8 of the Convention, the court usually has to perform a balancing exercise which weighs those rights against the free speech rights of media organisations under Article 10 (see ***In re S (A Child)*** [2005] 1 AC 593 at §§16 – 17, ***In re Guardian News and Media*** and ***SSHD v AP (No. 2)*** [2010] 1 WLR 1652 at §7). This balancing exercise is "*highly fact-specific*" and "*must take into account the evaluation of the purpose of the principle of open justice as applied to the facts of the case and the potential value of the information in question in advancing that purpose, as against the harm the disclosure might cause the maintenance of an effective judicial process or to the legitimate interests of others*" (see ***R (T) v West Yorkshire (Western Area) Coroner*** [2018] 2 WLR 211 at §63).

7. It is important to bear in mind the nature of inquests and the fact that some of the considerations which apply to applications for special measures in criminal cases do not apply to inquests (e.g. the right of a defendant to confront his accuser, including by investigating the accuser's background) (see ***R v Davis*** [2008] 1 AC 1128 at §21).

8. In general terms, the open justice principle applies with full force to inquests (see ***Re LM (Reporting Restrictions: Coroner's Inquest)*** [2007] CP Rep 48 at §§26 – 40).

Where a coroner made an order for anonymity for particular individuals, it would greatly be weakened if they could be identified and named in some other way. Section 11 of the Contempt of Court Act 1981 provides for an enforcement mechanism:-

course, even when reporting major disasters, journalists usually look for a story about how particular individuals are affected. Writing stories which capture the attention of readers is a matter of reporting technique, and the European court holds that article 10 protects not only the substance of ideas and information but also the form in which they are conveyed"

"In any case where a court (having power to do so) allows a name or other matter to be withheld from the public in proceedings before the court, the court may give such directions as appear to the court to be necessary for the purpose for which it was withheld."

S.11 permits a coroner making anonymity orders to give directions prohibiting the reporting of their names and identifying details in connection with the inquests.

Remember that inquest hearings (including and any pre-inquest hearing) <u>must</u> be held in public unless it is necessary to exclude the public in the interests of national security and that the public may also be excluded from a pre-inquest review hearing if the coroner considers that it would be in the interests of justice to do so. There are very limited circumstances in which the coroner may exclude interested persons (especially the family) from a hearing. This may be necessary at a pre inquest review where a question of public interest immunity arises but the hearing would still have to be recorded (separately to avoid accidental disclosure). There is no closed material procedure and so the coroner (or the jury if she or he sits with one) cannot take material ruled PII into account, although it may be appropriate for the coroner to use their knowledge of the PII material to avoid a jury becoming inadvertently misled (per the approach of Hallett LJ in the 7th July 2005 bombings inquests).

If PII material[2] or material which cannot lawfully be disclosed (e.g. that derived from intercepted material) is relevant to the scope of the inquest, then that may mean that an inquest is impossible and that a public inquiry must instead fulfil the State's obligation to investigate the death.

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[2] that is, material which those holding it are under a duty to withhold from disclosure on the ground that the public interest in withholding the (e.g. defence or police or intelligence) material outweighs the public interest in open justice

RESTRICTIONS ON RECORDING ETC.

Sound

By s.9 of the Contempt of Court Act 1981, it is a contempt of court to use – or even to bring into court for use – any recording device for recording sound in court, except with the leave of the court. It is also a contempt of court to publish a recording of legal proceedings.

Images

It is an offence (punishable on summary conviction by a fine of up to £1,000) contrary to s.41 of the Criminal Justice Act 1925 to take or attempt to take, with a view to publication, any photograph, or make or attempt to make in any court any portrait or sketch of a person, being a judge, juror, witness or party to any proceedings before the court, or to publish any photograph, portrait or sketch so made.

Nothing prevents sketch artists from stepping outside the courtroom to make their sketches from memory.

While Press photographers may lie in wait for those entering the court precincts, photography of a person within "*the building or in the precincts of the building in which the court is held*" is prohibited.

Children

S. 39 of the Children and Young Persons Act 1933 empowers a court to direct that the name, address or school of a child concerned in proceeding (including as a witness), or any particulars calculated to lead to the identification of that child or picture of them, not be included in any publication.

By s.39(2), a breach of such a direction is punishable, on summary conviction, by a fine of up to level 5 on the standard scale.

Publications caught by the section include (in whatever form) anything which is addressed to the public at large or to any section of the public. Social media posts will usually be addressed to a section of the public and so be caught.

Alleged victims of sexual offences

S.1(1) of the Offences to which this Act applies., Sexual Offences (Amendment) Act 1992 provides for this automatic reporting restriction (which cannot be disapplied by a coroner but which can effectively be waived by the written consent of the alleged victim):-

> "Where an allegation has been made that [a sexual] offence has been committed against a person, no matter relating to that person shall during that person's lifetime be included in any publication if it is likely to lead members of the public to identify that person as the person against whom the offence is alleged to have been committed."

By s.1(2), a breach of this automatic restriction is punishable, on summary conviction, by a fine of up to level 5 on the standard scale.

S.3A empowers a magistrates' court to, for example, extend the restriction beyond the person's death, on the application e.g. of a close family member.

Offending publications have more recently included social media posts – the professional media being very conscious of this restriction.

Beware the witness who discloses sexual abuse or other sexual offences against her unexpectedly. If her identity were already publicly disclosed, this would not have the effect of somehow rendering her anonymous – the disclosure would have the effect of activating s.1(1) and prohibiting her being made identifiable as a survivor of such offences. In practice, that part of her testimony could not be published. In these circumstances, it may be appropriate to raise the matter immediately with the coroner so that everyone present can be reminded of the effect of s.1(1) of the 1992 Act.

Video and audio feeds and links

Coroners (like other courts and tribunals) may provide an audio or video link to proceedings (see s.85A of the Courts Act 2003) – and they do so not uncommonly even now that the coronavirus pandemic is long over. It must be in the interests of justice to do so and she or he must take into account the following factors (See Reg 4 of the Remote Observation and Recording (Courts and Tribunals) Regulations 2022):-

(a) the need for the administration of justice to be, as far as possible, open and transparent;

(b) the timing of any request or application to the court or tribunal to make a direction, and its impact on the business of the court or tribunal;

(c) the extent to which the technical, human and other resources necessary to facilitate effective remote observation are or can be made available;

(d) any limitation imposed by or under any enactment on the persons who are entitled to be present at the proceedings;

(e) any issues which might arise if persons who are outside the United Kingdom are among those watching or listening to the transmission;

(f) any impact which the making or withholding of such a direction, or the terms of the direction, might have upon—

(i) the content or quality of the evidence to be put before the court or tribunal;

(ii) public understanding of the law and the administration of justice;

(iii) the ability of the public, including the media, to observe and scrutinise the proceedings;

(iv) the safety and right to privacy of any person involved with the proceedings.

It will still be a contempt of court for any person to make, play to the public, distribute or publish an audio or video recording of the proceedings or to capture any still or moving images of the court room or those in it and the coroner will usually explain that to those attending or observing remotely. A warning may well be displayed in writing for those obtaining remote access.

CHIEF CORONER'S GUIDANCE NO.25 CORONERS AND THE MEDIA

Live text-based communications

The default position is that journalists and legal commentators will generally be permitted to provide live text-based commentary for the purposes of fair and accurate reporting at all hearings. Other members of the public must ask for permission.

Access to recordings of hearings required by r.26 of the Inquest Rules

(i) Requests by Interested persons

R.26 of the Coroners (Inquests) Rules 2013 requires the coroner to record all hearings, including PIRs. The default position is that interested persons will be entitled to a copy of the recording. The coroner may only refuse pursuant to the r.15 grounds. This may permit redaction of the recording to remove names which are the subject of a restriction.

(ii) Requests by others

For others, including the media, recordings may be provided by the coroner pursuant to reg 27(2)) of the Coroners (Investigations) Regulations 2013 which provides:-

> "The coroner may provide any document or copy of any document to any person who in the opinion of the coroner is a proper person to have possession of it."

This provision – and media access generally – is dealt with below.

Requests by the media for documents, audio and video recordings

Reg 27(2) permits disclosure by the coroner, rather than requiring it. But the principle of open justice is a constitutional principle "*at the heart of our system of justice and vital to the rule of law*": per Toulson LJ in ***R (Guardian News and Media Ltd) v City of Westminster Magistrates' Court*** [2012] EWCA Civ 420, [2013] QB 618.

There is a presumption in favour of providing access (see ***Observer and Guardian v UK*** [1992] 14 EHRR 153) in order to enable the public to understand and scrutinise the justice system which may be displaced by "*some strong contrary argument*" or "*countervailing reasons*".

(i) Limitations on access

Only documents which have been relied upon and adduced in evidence in court need be disclosed. This does not include those documents not referred to in open court (e.g. witness statements which have not been read out or formally adopted or documents never referred to) and it means that the media will not be entitled to seek advance disclosure of documents that will inevitably be adduced in open court (although the coroner might provide such documents in an appropriate case for practical purposes with an express embargo until the document has been adduced).

Documents may be redacted or withheld in part for good reason, e.g. national security, public interest immunity, legal privilege, the avoidance of prejudice to current or future criminal proceedings, the protection of personal information (particularly in the case of a vulnerable person) which is sensitive or if disclosed could give rise to a risk of harm, the Article 8 rights of witnesses or others who may need to be protected from the glare of publicity.

If a document – such as a message, a threat or a suicide note – has been read out in open court, then this may help to shift the balance away from disclosure, given that those present in court were aware of the full contents of the document, but it is unlikely to be sufficient on its own. The Chief Coroner's Guidance suggests that there may be a good reason for refusing access to the contents of a suicide note, even though it has been referred to in court. The

same applies certain images or video / audio footage, even if they were seen or heard in open court. After all, members of the Press will have been able to see, watch or here the relevant material and so can describe it – without causing additional distress to family members of the deceased by having distressing personal material concerning their loved one – or affecting the dignity of their memory – being played and replayed publicly. The effect on the children of the deceased may be a powerful factor telling against disclosure.

The coroner may also refuse access if that would be disruptive to the court proceedings (although that might be limited to delaying access – or embargoing publication for a period) or if it would place a great burden on the court (***Guardian News and Media Ltd***).

(ii) The balancing exercise required

The coroner must balance the Article 10 rights of the Press and the principle of open justice against the countervailing interests in question – with any derogation having to be a proportionate means of achieving a legitimate aim.

She or he must hear those with an interest in the material in open court – they will include family members or others (including those who provided it to the coroner) who argue that the material should not be disclosed and members of the Press who argue for disclosure.

The coroner should then give reasons for their decision in public.

Lawyers for interested parties should be alive to the fact that the Press may wish to see their skeleton arguments and other submissions, and will do well to bring additional copies to court or provide electronic access to the coroner for her or his convenience. They should draft their submissions with media access in mind. One option if there is sensitive information of any sort which needs to be referred to therein, is to provide a sanitised version for disclosure or a summary of the arguments. That may help persuade the coroner to restrict disclosure to the sanitised version or summary and it may assuage the media demands. It will at least show what is said to be sensitive (e.g. a sanitised version with tracked changes).

CONCLUSIONS

Experience shows that adopting a collaborative and cooperative approach, so far as is possible, with the media pays dividends. Most journalists who cover courts are responsible and respectful of the processes and participants. The approach should be to be as open as possible with information in order to dispel suspicion.

The same applies, of course, to the approach to be taken with the coroner. Those representing interested persons who are the source of any controversial material often find it fruitful to offer to provide redacted copies of material – e.g. pixelated body worn video recordings – in order to provide a clear path of least resistance.

DIJEN BASU KC
18th February 2024

1

Deaths prevented (n=??)

All deaths recorded by the ONS in 2019
n=530,841

Preventable Deaths Tracker

Deaths referred to the coroner in 2019 (MOJ)
n=210,900
40% of all deaths

CCO publishes PFD & responses on website

Coroner sends PFD & responses to CCO

Inquests open in 2019 (MOJ)
n=30,000
6% of all deaths

Recipient/s respond to coroner within **56 days**

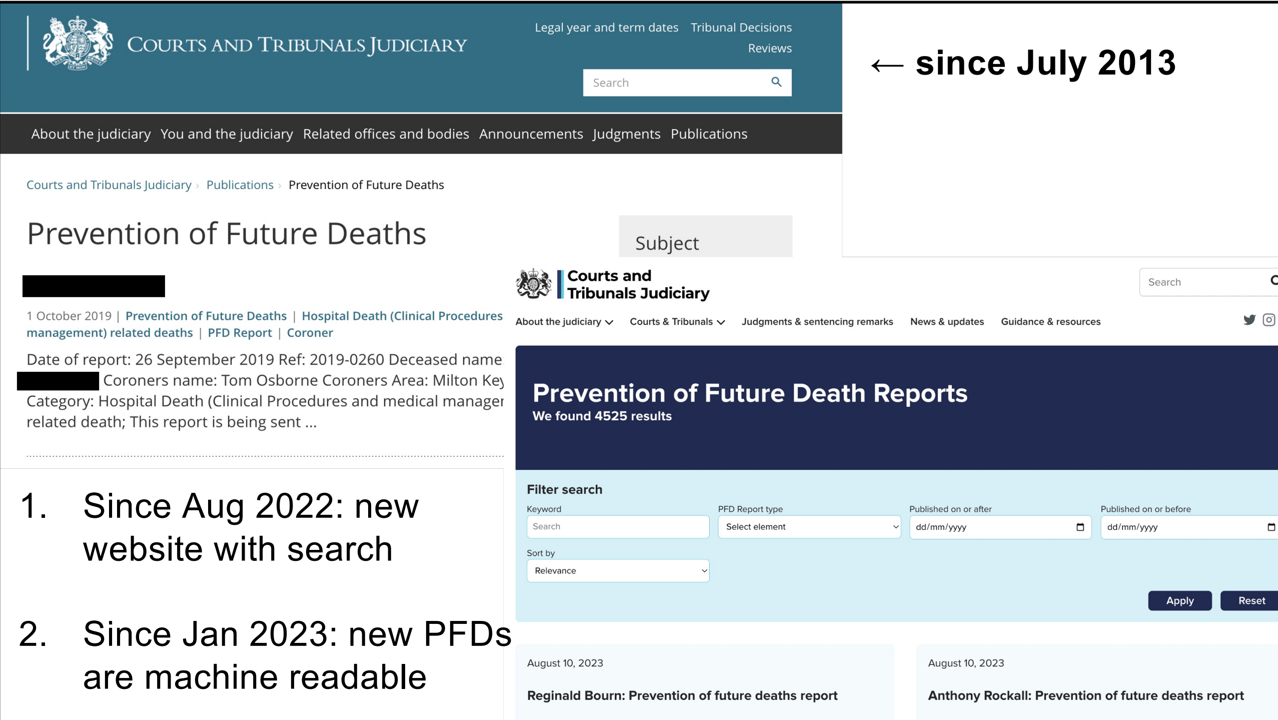
44%

PFDs

Coroner sends PFD to recipient/s **to take action**

n=528 in 2019
Mean of 460 per year
0.1% of all deaths
1.8% inquests open

2



3

The Preventable Deaths Tracker

1. An openly available **data-driven learning platform** that collects all published coroners' reports making them **useable** for research and analytics.

4

https://preventabledeathstracker.net/

Preventable Deaths Tracker About Research Database Support us

A platform to learn lessons following inquests

The **Preventable Deaths Tracker** is the first and only open database of all published coroner reports in England and Wales. It's a data-driven learning platform that includes over 4,800 reports and is updated weekly, providing real-time analytics and bespoke research investigations to prevent future deaths.

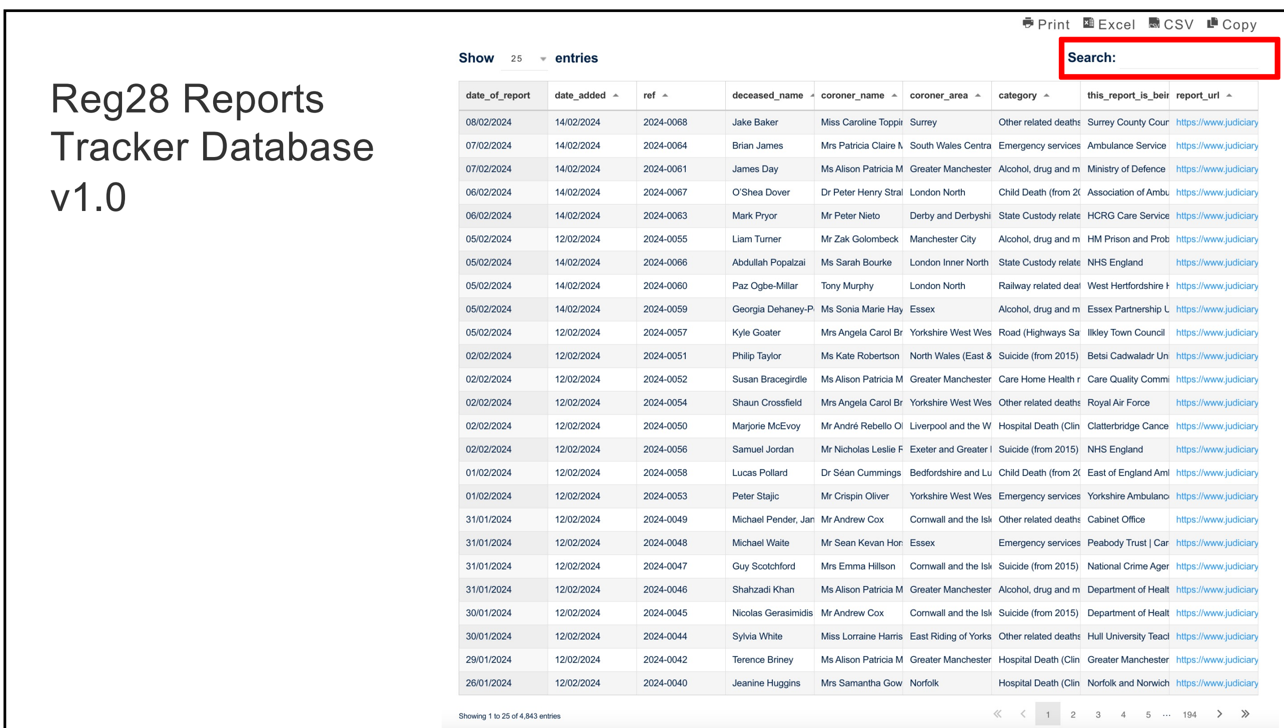
The mission of the **Preventable Deaths Tracker** is to make coronial data usable so that lessons can be learnt to improve public safety. Ultimately, we seek to save lives by reducing preventable deaths.

5

The Preventable Deaths Tracker

1. An openly available **data-driven learning platform** that collects all published coroners' reports making them **useable** for research and analytics.
2. The computer program cleans and processes **nearly 5,000 reports** and produces **real-time statistics** and a database that contains **over a decade of data**.

6



Reg28 Reports Tracker Database v1.0

Print Excel CSV Copy

Show 25 entries

Search:

date_of_report	date_added	ref	deceased_name	coroner_name	coroner_area	category	this_report_is_beir	report_url
08/02/2024	14/02/2024	2024-0068	Jake Baker	Miss Caroline Toppi	Surrey	Other related deaths	Surrey County Cour	https://www.judiciary
07/02/2024	14/02/2024	2024-0064	Brian James	Mrs Patricia Claire M	South Wales Centra	Emergency services	Ambulance Service	https://www.judiciary
07/02/2024	14/02/2024	2024-0061	James Day	Ms Alison Patricia M	Greater Manchester	Alcohol, drug and m	Ministry of Defence	https://www.judiciary
06/02/2024	14/02/2024	2024-0067	O'Shea Dover	Dr Peter Henry Stral	London North	Child Death (from 20	Association of Ambu	https://www.judiciary
06/02/2024	14/02/2024	2024-0063	Mark Pryor	Mr Peter Nieto	Derby and Derbyshi	State Custody relate	HCRG Care Service	https://www.judiciary
05/02/2024	12/02/2024	2024-0055	Liam Turner	Mr Zak Golombeck	Manchester City	Alcohol, drug and m	HM Prison and Prob	https://www.judiciary
05/02/2024	14/02/2024	2024-0066	Abdullah Popalzai	Ms Sarah Bourke	London Inner North	State Custody relate	NHS England	https://www.judiciary
05/02/2024	14/02/2024	2024-0060	Paz Ogbe-Millar	Tony Murphy	London North	Railway related deat	West Hertfordshire H	https://www.judiciary
05/02/2024	14/02/2024	2024-0059	Georgia Dehaney-P	Ms Sonia Marie Hay	Essex	Alcohol, drug and m	Essex Partnership U	https://www.judiciary
05/02/2024	12/02/2024	2024-0057	Kyle Goater	Mrs Angela Carol Br	Yorkshire West Wes	Road (Highways Sa	Ilkley Town Council	https://www.judiciary
02/02/2024	12/02/2024	2024-0051	Philip Taylor	Ms Kate Robertson	North Wales (East &	Suicide (from 2015)	Betsi Cadwaladr Uni	https://www.judiciary
02/02/2024	12/02/2024	2024-0052	Susan Bracegirdle	Ms Alison Patricia M	Greater Manchester	Care Home Health r	Care Quality Commi	https://www.judiciary
02/02/2024	12/02/2024	2024-0054	Shaun Crossfield	Mrs Angela Carol Br	Yorkshire West Wes	Other related deaths	Royal Air Force	https://www.judiciary
02/02/2024	12/02/2024	2024-0050	Marjorie McEvoy	Mr André Rebello Ol	Liverpool and the W	Hospital Death (Clin	Clatterbridge Cance	https://www.judiciary
02/02/2024	12/02/2024	2024-0056	Samuel Jordan	Mr Nicholas Leslie F	Exeter and Greater I	Suicide (from 2015)	NHS England	https://www.judiciary
01/02/2024	12/02/2024	2024-0058	Lucas Pollard	Dr Séan Cummings	Bedfordshire and Lu	Child Death (from 20	East of England Aml	https://www.judiciary
01/02/2024	12/02/2024	2024-0053	Peter Stajic	Mr Crispin Oliver	Yorkshire West Wes	Emergency services	Yorkshire Ambulanc	https://www.judiciary
31/01/2024	12/02/2024	2024-0049	Michael Pender, Jan	Mr Andrew Cox	Cornwall and the Isl	Other related deaths	Cabinet Office	https://www.judiciary
31/01/2024	12/02/2024	2024-0048	Michael Waite	Mr Sean Kevan Hor	Essex	Emergency services	Peabody Trust | Car	https://www.judiciary
31/01/2024	12/02/2024	2024-0047	Guy Scotchford	Mrs Emma Hillson	Cornwall and the Isl	Suicide (from 2015)	National Crime Ager	https://www.judiciary
31/01/2024	12/02/2024	2024-0046	Shahzadi Khan	Ms Alison Patricia M	Greater Manchester	Alcohol, drug and m	Department of Healt	https://www.judiciary
30/01/2024	12/02/2024	2024-0045	Nicolas Gerasimidis	Mr Andrew Cox	Cornwall and the Isl	Suicide (from 2015)	Department of Healt	https://www.judiciary
30/01/2024	12/02/2024	2024-0044	Sylvia White	Miss Lorraine Harris	East Riding of Yorks	Other related deaths	Hull University Teacl	https://www.judiciary
29/01/2024	12/02/2024	2024-0042	Terence Briney	Ms Alison Patricia M	Greater Manchester	Hospital Death (Clin	Greater Manchester	https://www.judiciary
26/01/2024	12/02/2024	2024-0040	Jeanine Huggins	Mrs Samantha Gow	Norfolk	Hospital Death (Clin	Norfolk and Norwich	https://www.judiciary

Showing 1 to 25 of 4,843 entries

1 2 3 4 5 … 194

7

The Preventable Deaths Tracker

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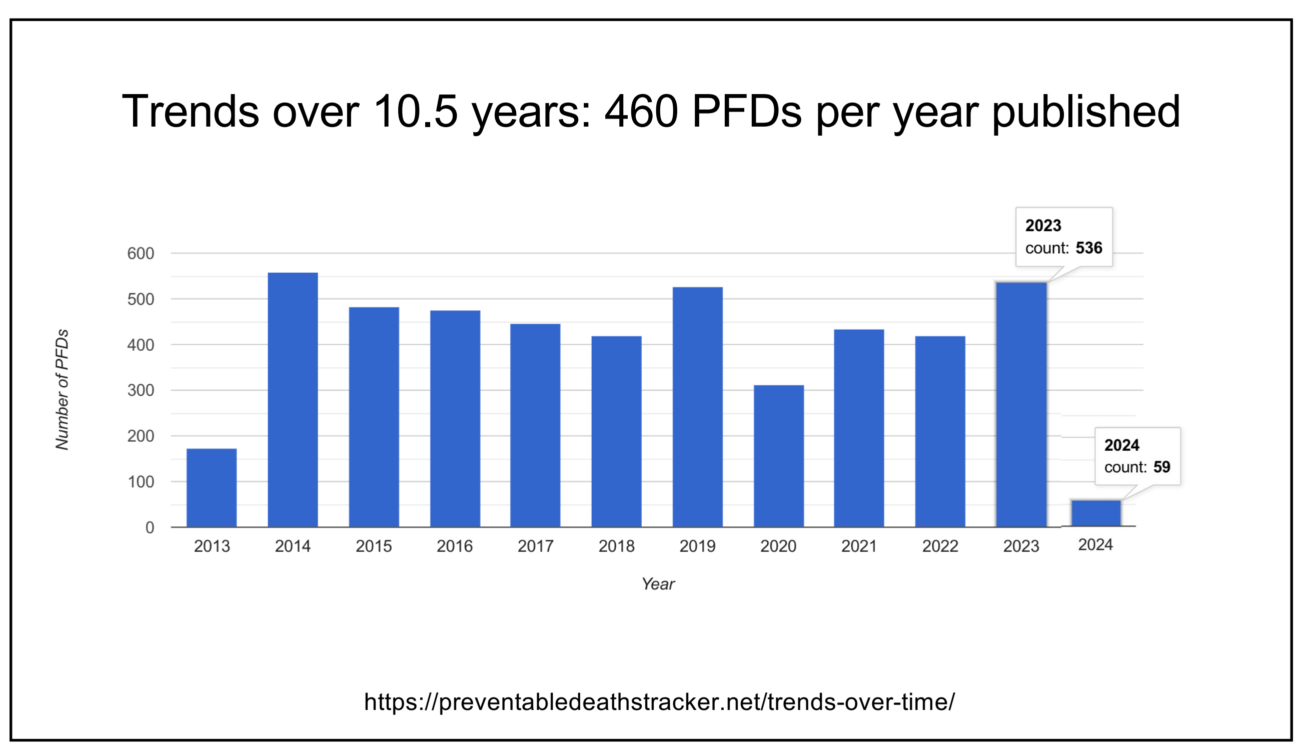

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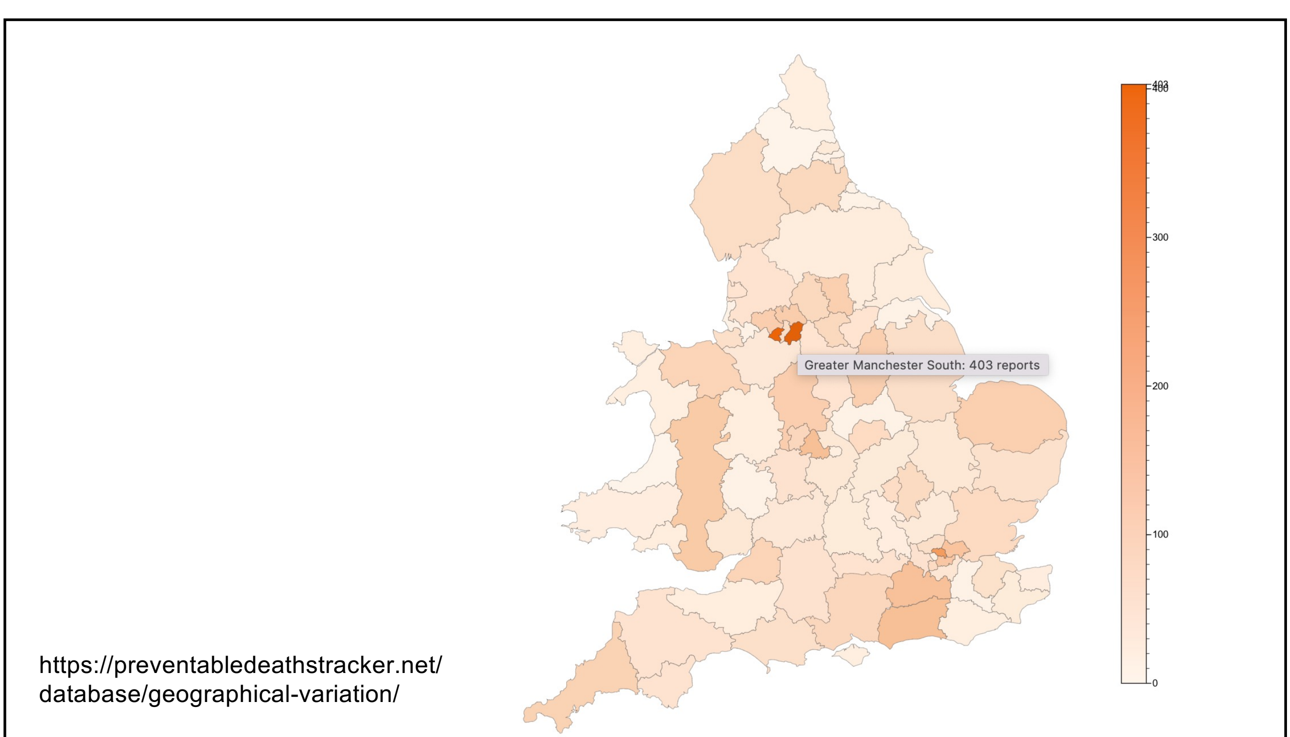

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11

RESEARCH

Deaths from cardiovascular disease involving anticoagulants: a systematic synthesis of coroners' case reports

Ali Anis[1], Carl Heneghan[2,3], Jeffrey K Aronson[2], Nicholas J DeVito[4], Georgia C Richards[2,3]*

12

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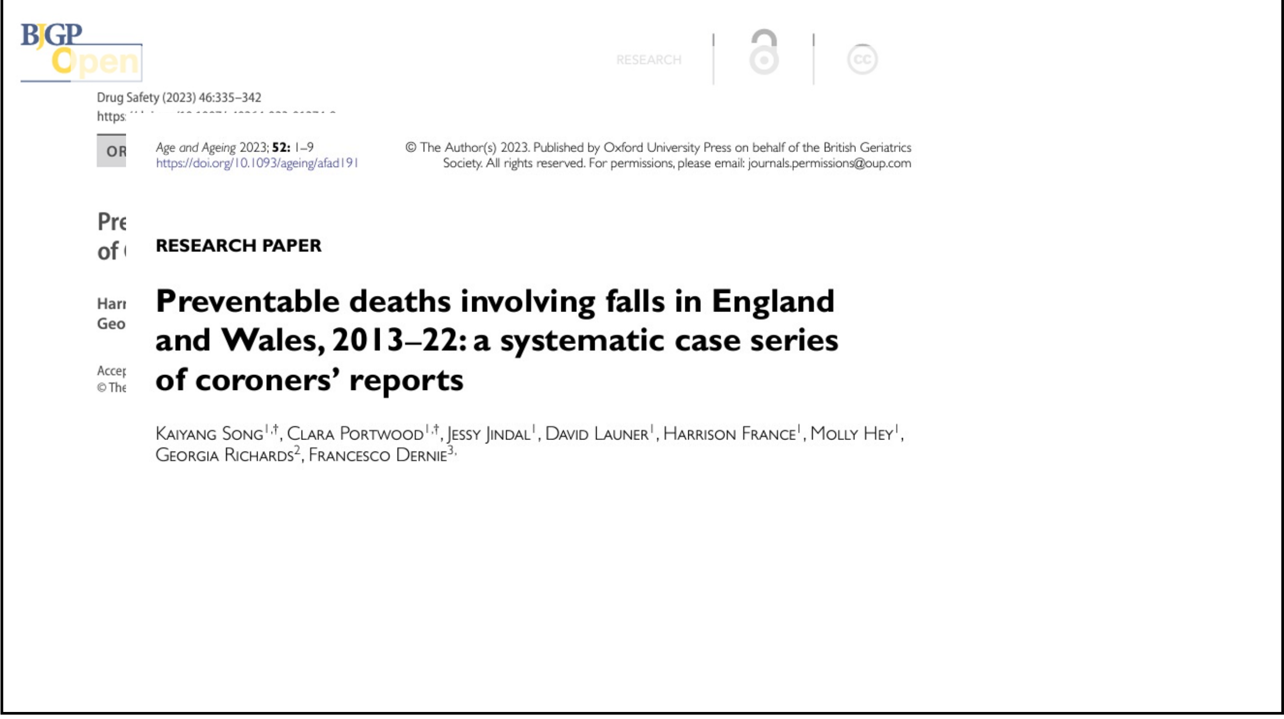

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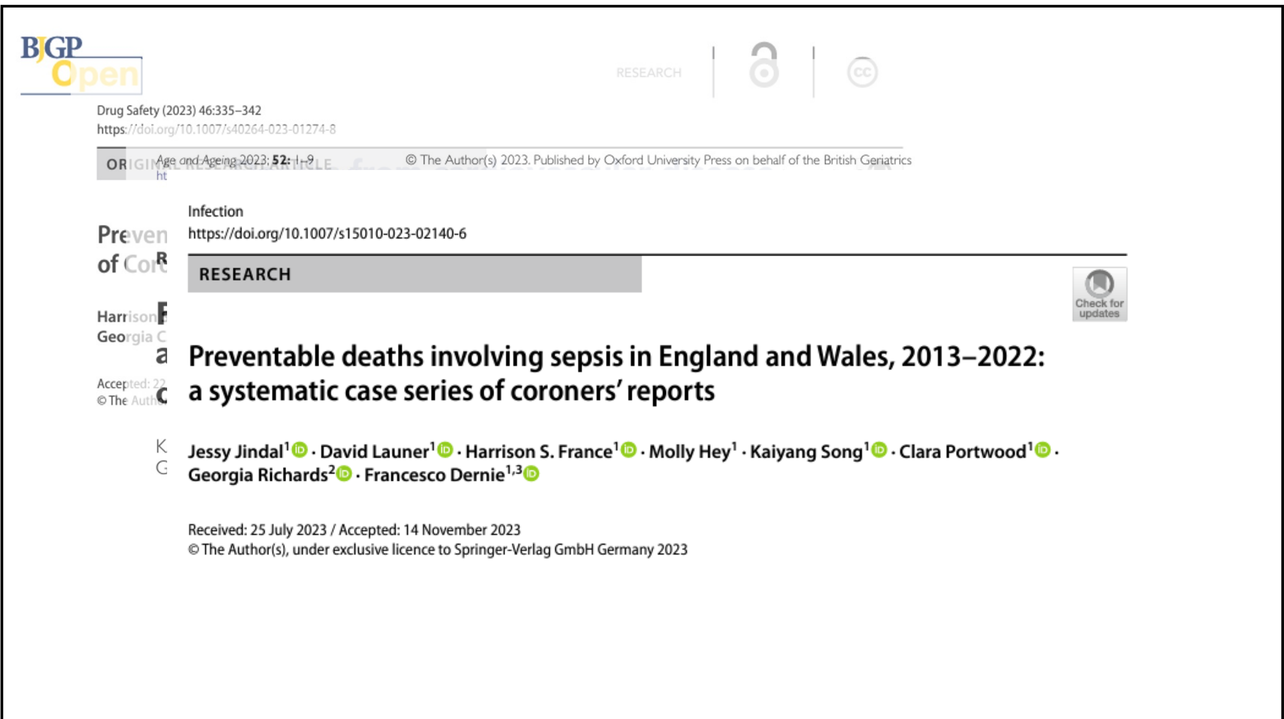

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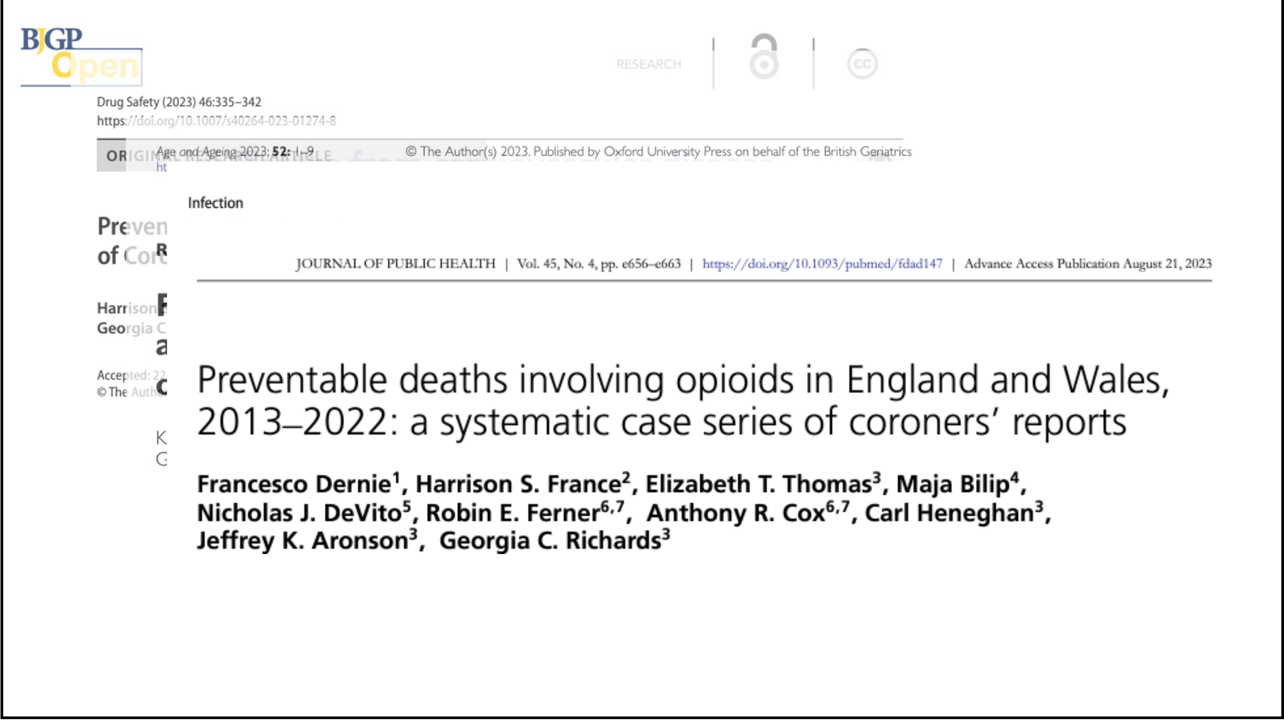

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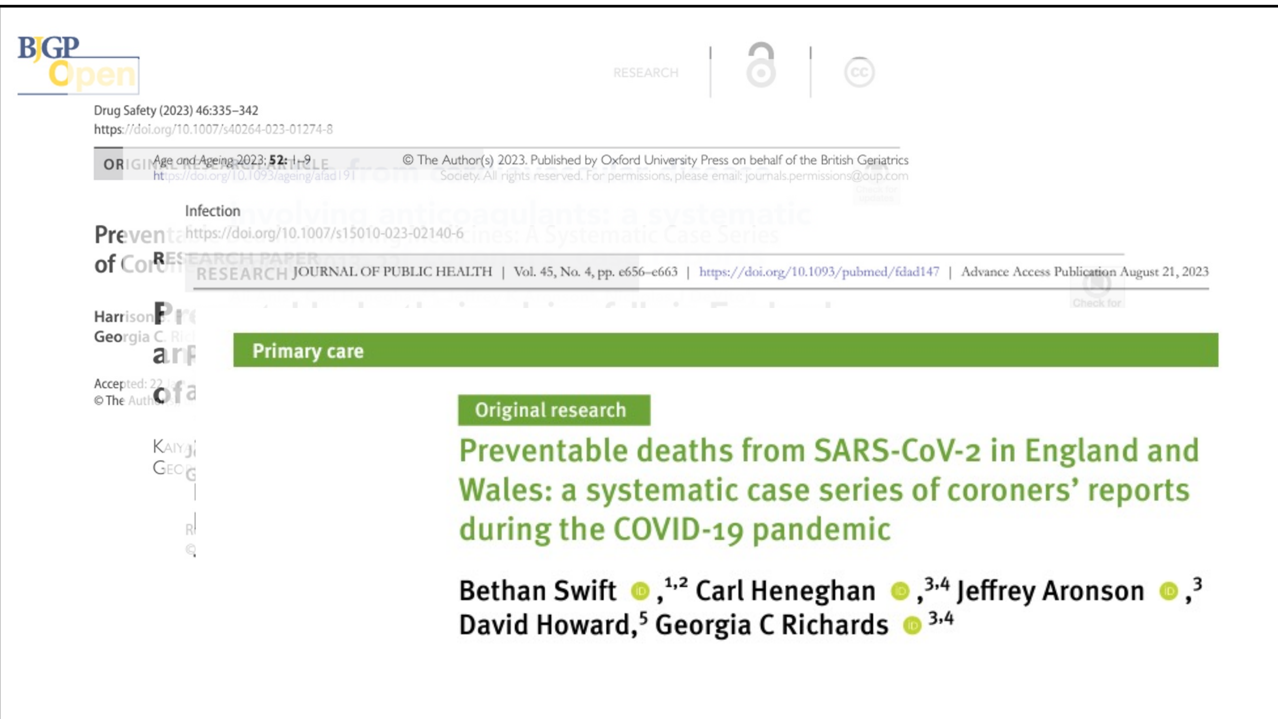

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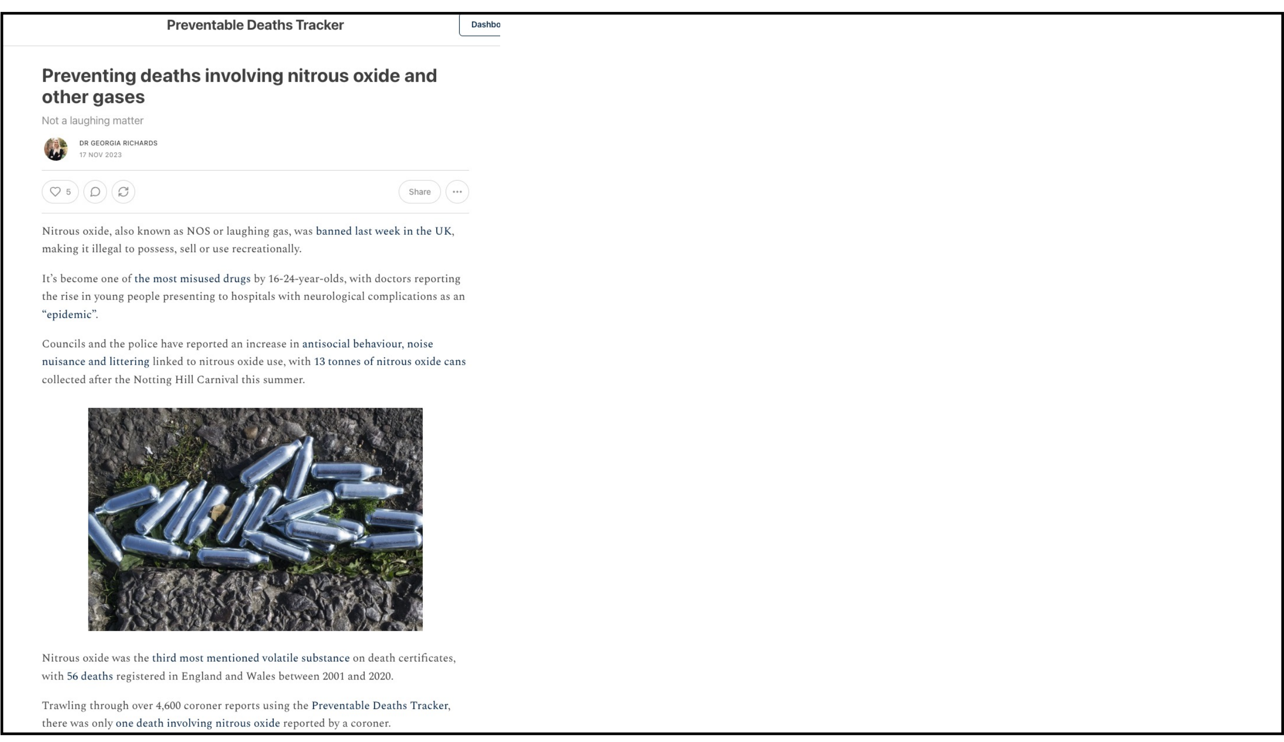

Preventable Deaths Tracker

Preventing deaths involving nitrous oxide and other gases

Not a laughing matter

DR GEORGIA RICHARDS
17 NOV 2023

Nitrous oxide, also known as NOS or laughing gas, was banned last week in the UK, making it illegal to possess, sell or use recreationally.

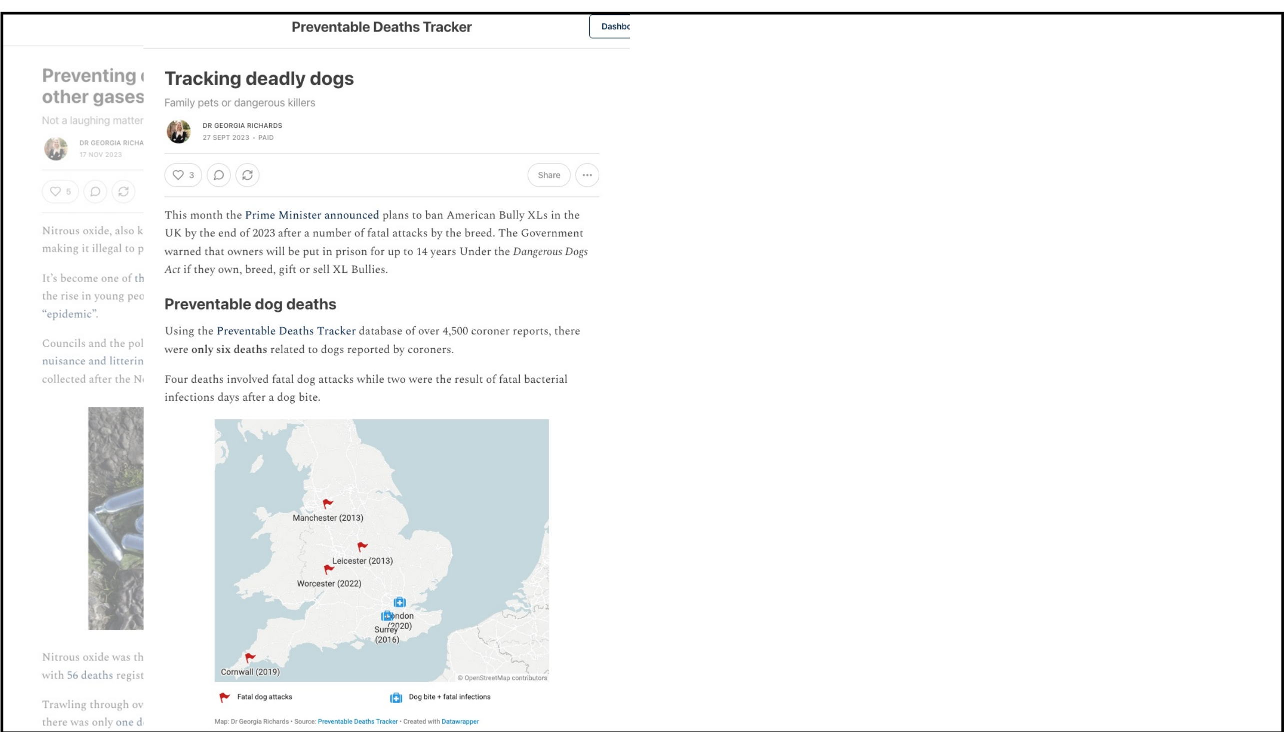
It's become one of the most misused drugs by 16-24-year-olds, with doctors reporting the rise in young people presenting to hospitals with neurological complications as an "epidemic".

Councils and the police have reported an increase in antisocial behaviour, noise nuisance and littering linked to nitrous oxide use, with 13 tonnes of nitrous oxide cans collected after the Notting Hill Carnival this summer.

Nitrous oxide was the third most mentioned volatile substance on death certificates, with 56 deaths registered in England and Wales between 2001 and 2020.

Trawling through over 4,600 coroner reports using the Preventable Deaths Tracker, there was only one death involving nitrous oxide reported by a coroner.

18



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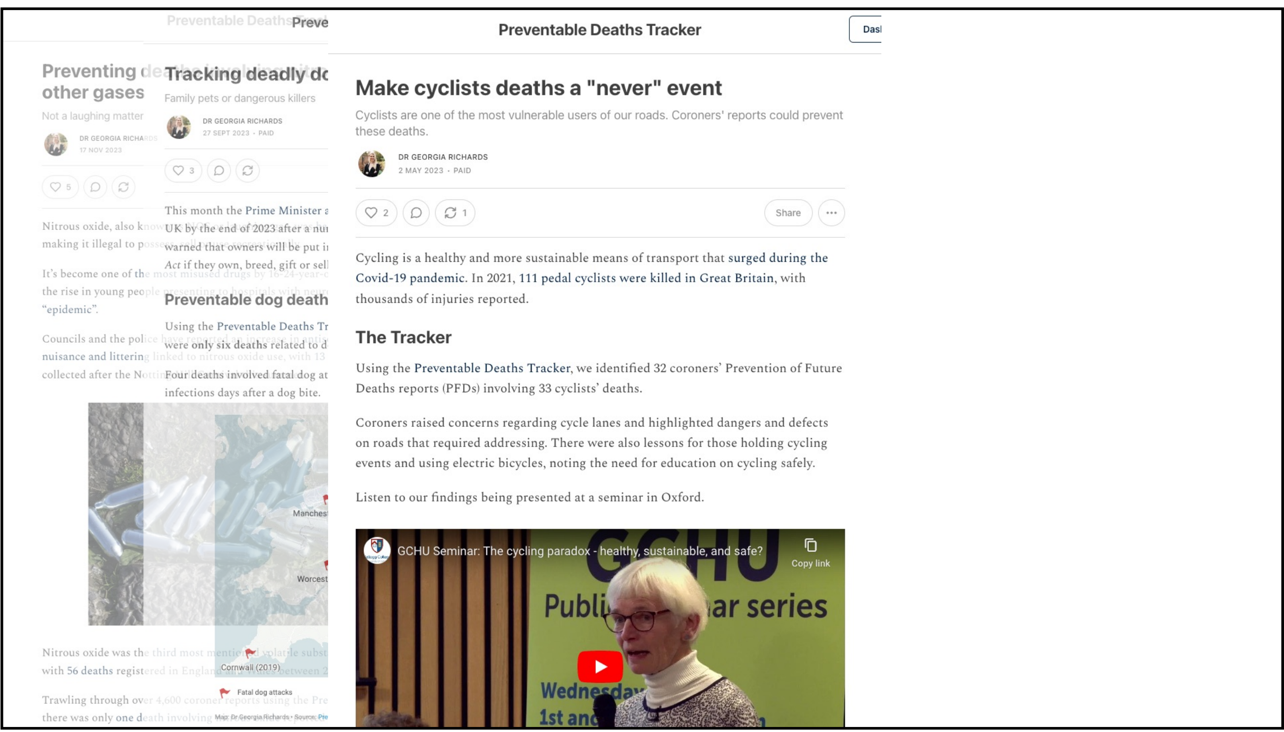

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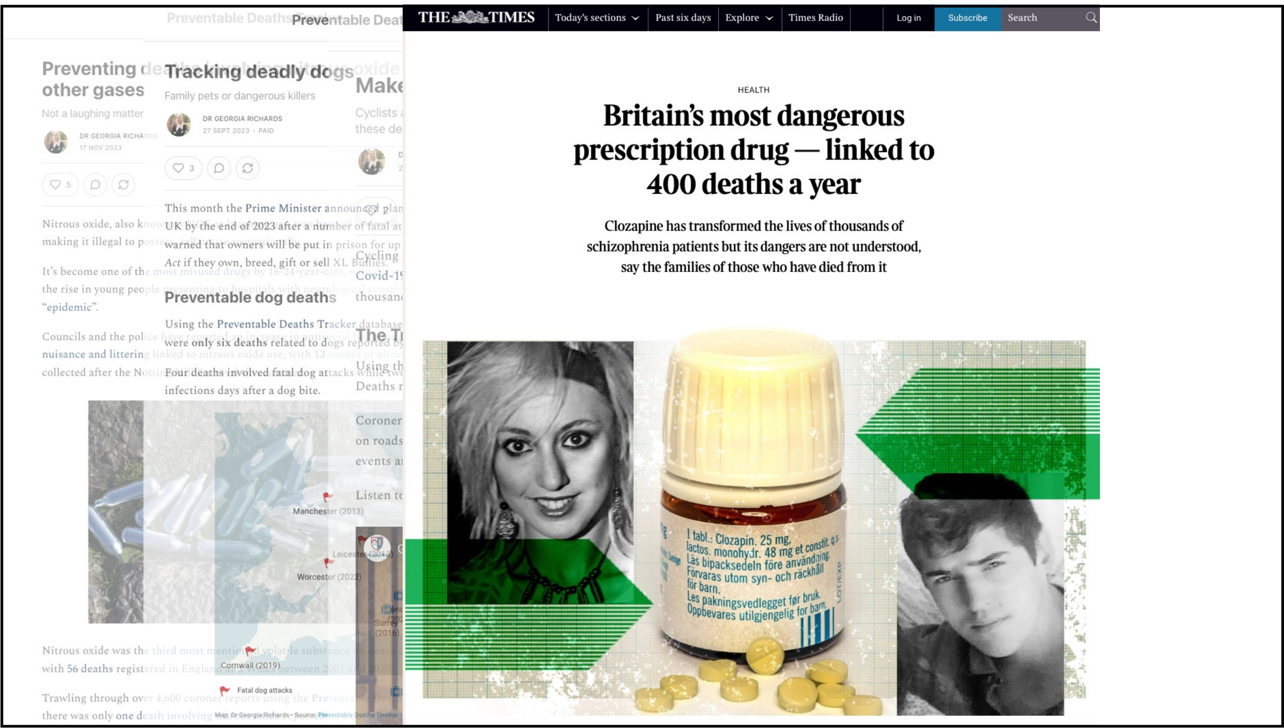

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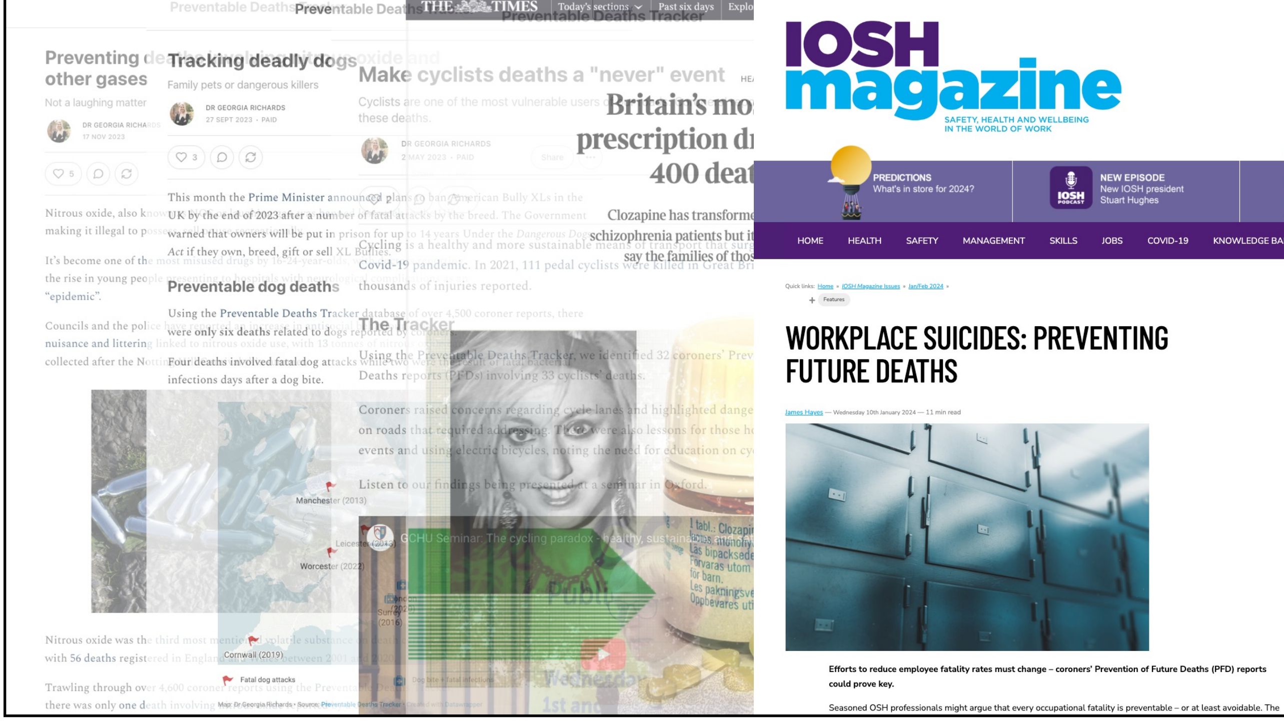

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5. The Tracker is being used to audit and apply the **publication policy** of Reg 28/29

23

Ensuring PFDs and their responses are sent to the Chief Coroner - PDF Tracker

Dear Coroners of England and Wales,

Schedule 5 Paragraph 7 of the Coroners and Justice Act 2009 outlines the duty of coroners to make Prevention of Future Deaths Reports (PFDs). It states:

7 (1) Where —

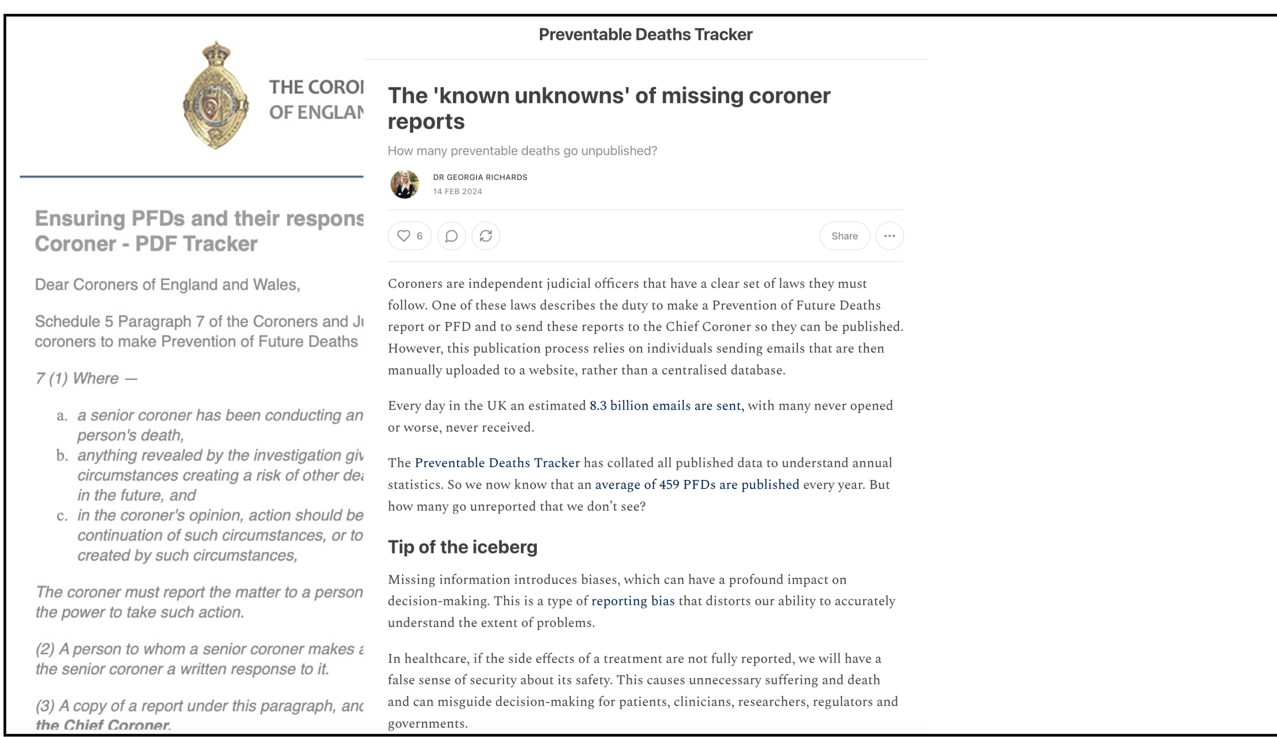
a. *a senior coroner has been conducting an investigation under this Part into a person's death,*
b. *anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and*
c. *in the coroner's opinion, 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 the 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.***

24



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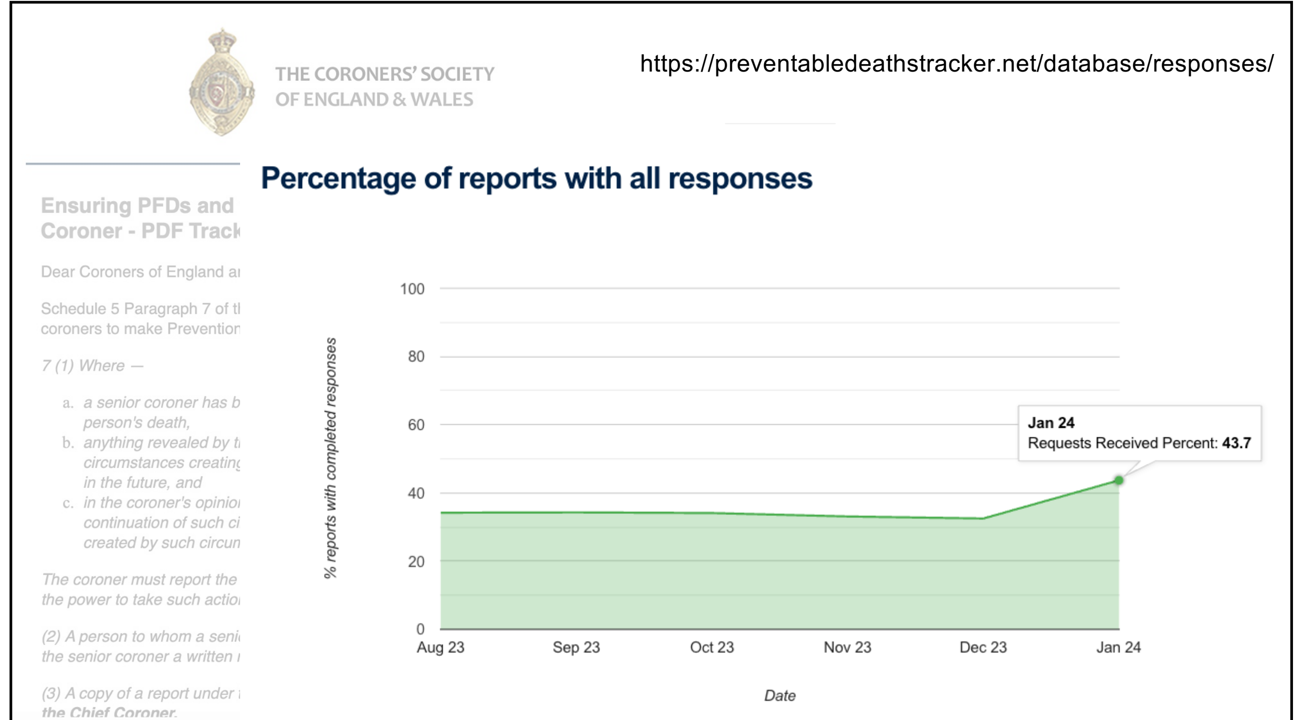

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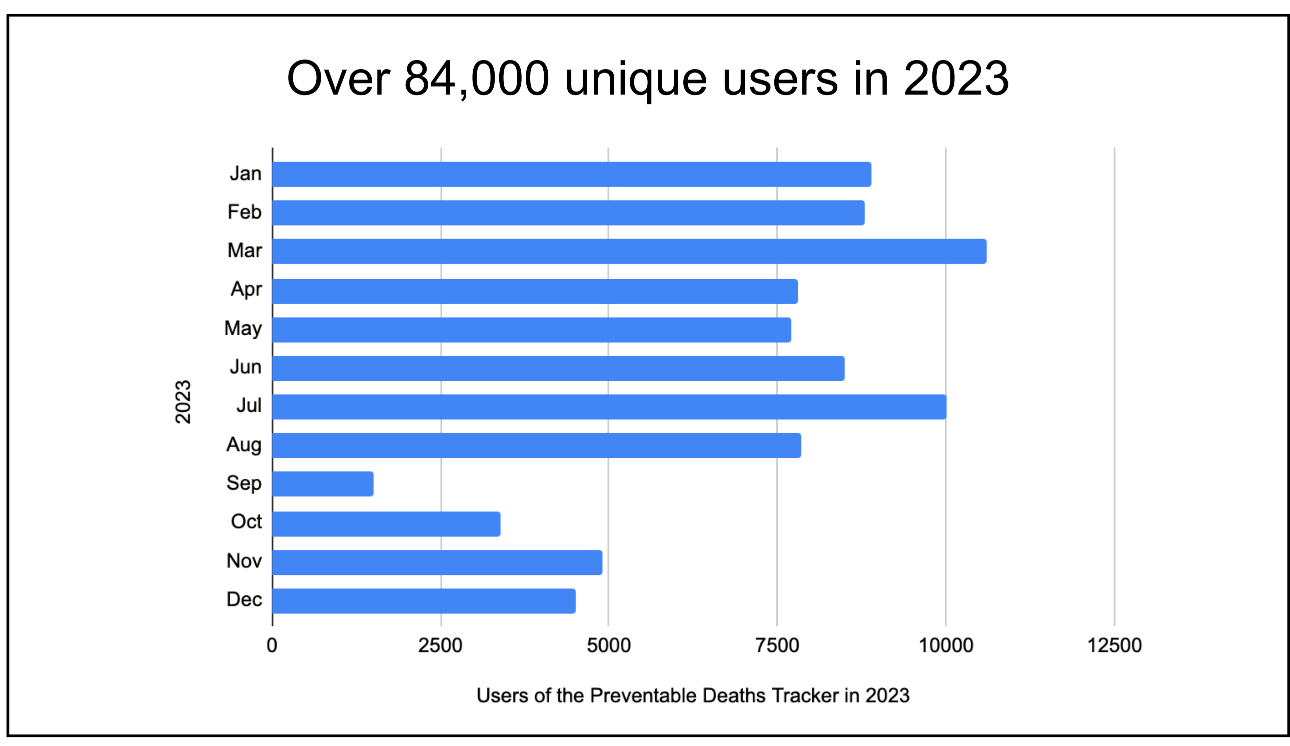
6. The Tracker is being used to **educate** the next generation of doctors

27



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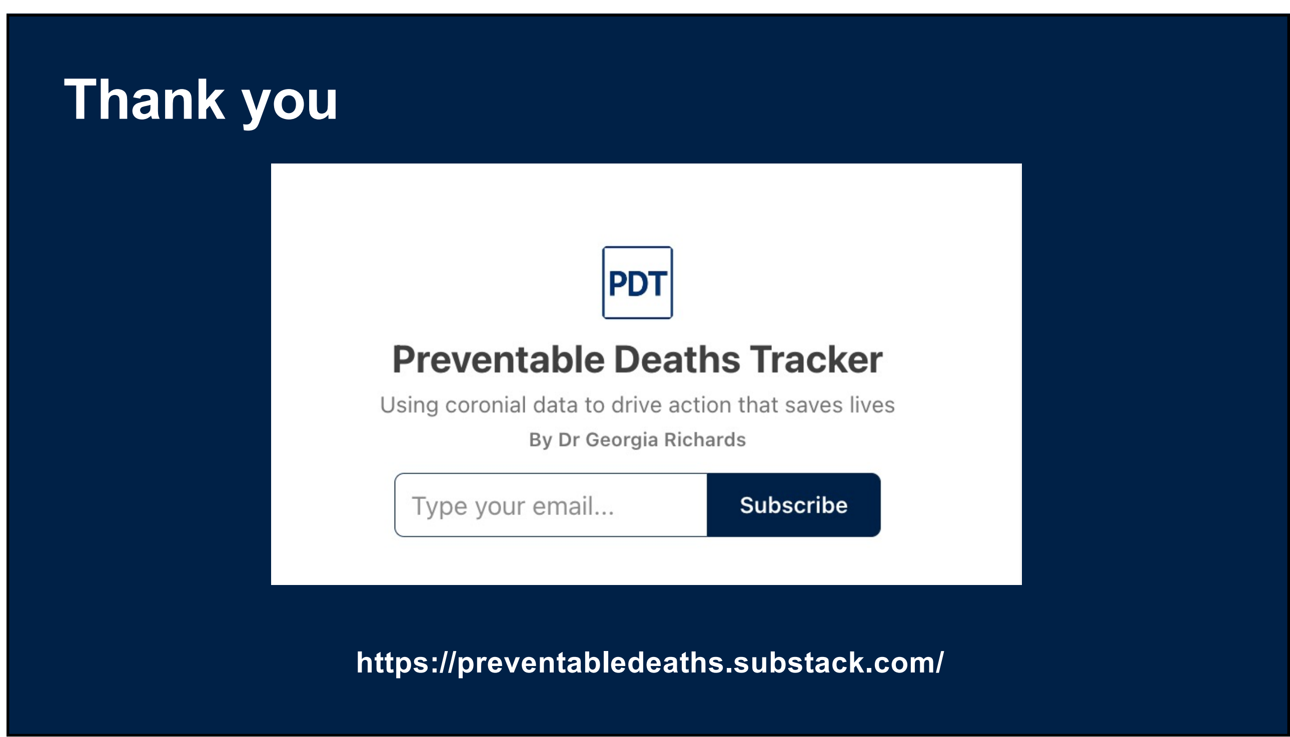


29

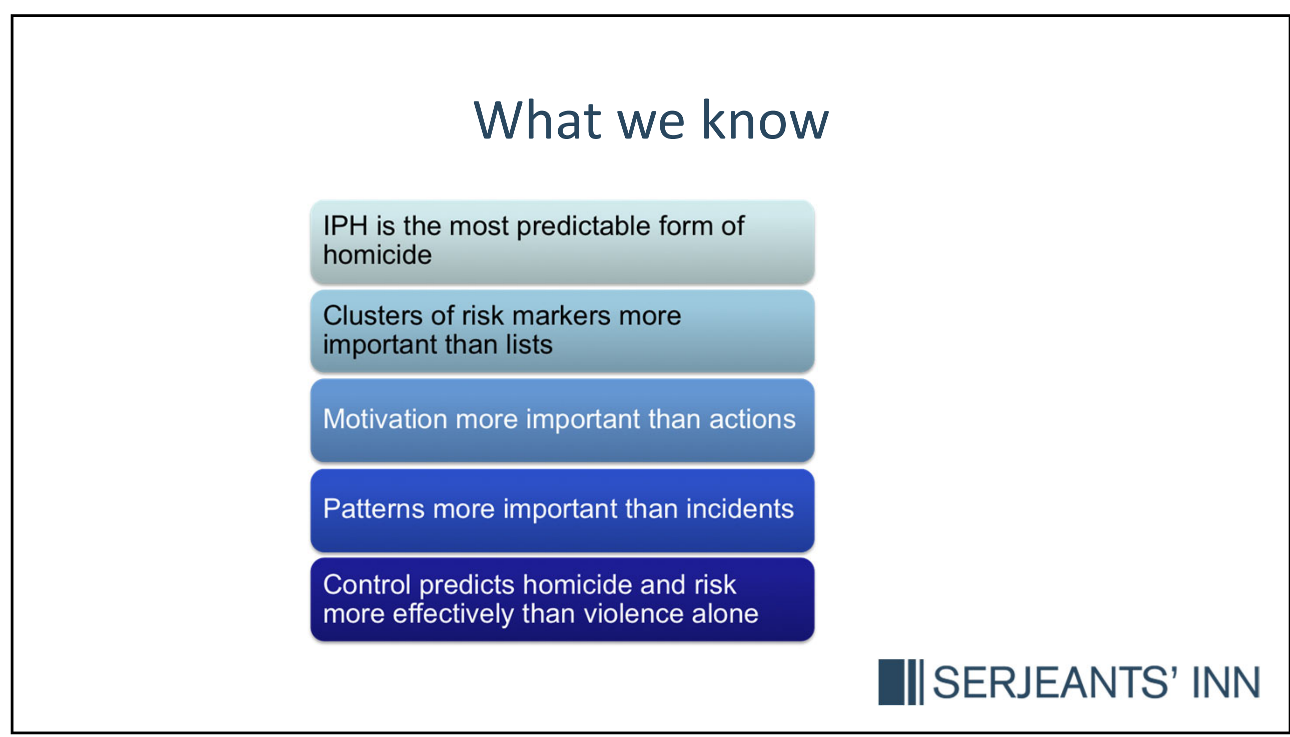
Intimate Partner Homicide Timeline

Rachel Spearing

Dangerous relationships and how they end in murder.

- "Why won't she get in the ambulance"
- "We must facilitate contact in furtherance of the rights of the child"
- "There are allegations and counter-allegations made to Police, there is insufficient evidence for a reasoned decision to be taken"
- "Trust records noted that husband became aggressive with staff when they sought to separate him from his wife for treatment"
- "It was not apparent to housing staff that they were in an intimate relationship, but flags were raised when DWP reported a joint benefits application"

Peer Review Process
Psychology, Sociology and Law
Home Office and NPCC DHR.
Domestic Abuse Act 2021
Reviewed by academic experts
Reviewed by professionals
Reviewed by victims
Reviewed by families bereaved through homicide
SERJEANTS' INN


What we know
IPH is the most predictable form of homicide
Clusters of risk markers more important than lists
Motivation more important than actions
Patterns more important than incidents
Control predicts homicide and risk more effectively than violence alone
SERJEANTS' INN

Application

Art 2 - Operational decision-making

Coronial Investigations

DHR: Domestic Violence, Crime & Victims Acts 2011

- Chief officers of police for police areas in England and Wales;
- Local Authorities;
- Strategic Health Authorities established under [section 13 of the National Health Service Act 2006];
- Primary Care Trusts (ICBs); Providers of probation services;
- Local Health Boards and NHS trusts

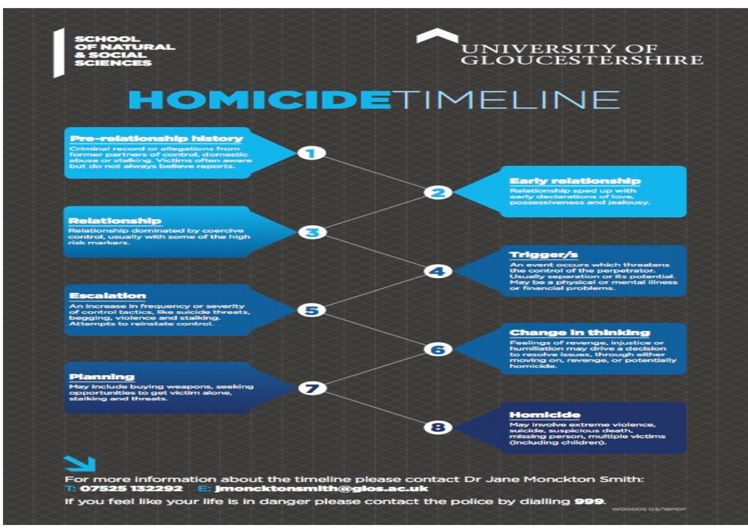
Aid in threat and risk assessment

Track escalation to inform court orders and safety planning

Support construction of a forensic narrative in homicide investigations

Support evidence collection in investigation of cases of coercive control

The Eight Stages of the Timeline



The Eight Stages Timeline to Homicide

Video available here

Refences to Professor Monkton-Smiths Research

- Adams, D. (2007). *Why do they kill? Men who murder their intimate partners.* Nashville: Vanderbilt University Press.
- Brennan, D. (2016). *Femicide Census.* Retrieved March 30, 2018, from http://www.northwales-pcc.gov.uk/Document-Library/Advice/Femicide-Census-Report-2016.pdf
- Dobash, R.E., & Dobash, R.P. (2015). *When Men Murder Women (interpersonal violence).* Oxford: Oxford University Press.
- Johnson, M. (2008). A *Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence.* Boston: Northeastern University Press
- Luckenbill, D. F. (1977). Criminal Homicide as a Situational Transaction. *Social Problems, 25,* (2), 176-186.
- Monckton Smith, J. (2019) The Homicide Timeline: Using Foucauldian Analysis to Track an Eight Stage Relationship Progression to Homicide *Violence Against Women* https://doi.org/10.1177/1077801219863876.
- Monckton Smith, J., Williams, A., & Mullane, F. (2014). *Domestic Abuse, Homicide and Gender: strategies for policy and practice.* Hampshire: Palgrave Macmillan
- Monckton Smith, J., Szymanska, K. & Haile, S., (2017). Exploring the relationship between stalking and homicide. *Suzy Lamplugh Trust*. Retrieved March 30, 2018 from http://eprints.glos.ac.uk/4553/
- Mullen, P.E. (2004). The autogenic (self generated) massacre. *Behavioural Science and Law. 22*, (3), 311-23.
- Schlesinger, L.B. (2002). Stalking, Homicide, and Catathymic Process: A Case Study. *International Journal of Offender Therapy and Comparative Criminology, 46*, (1), 64-74.
- Stark, E. (2009), *Coercive Control: How men entrap women in personal life.* Oxford: Oxford University Press
- UNODC (2013). Global Study on Homicide. *United Nations Office on Drugs and Crime.* Retrieved March 30, 2018 from https://www.unodc.org/documents/gsh/pdfs/GLOBAL_HOMICIDE_Report_ExSum.pdf

Thank you

Presented by Rachel Spearing
Serjeants' Inn Chambers
rspearing@serjeantsinn.com
020 7427 5000
www.serjeantsinn.com

Trusted When It's Critical
Clients choose us to steer them through crucial cases, often involving important legal, ethical and social issues.

The role of the Healthcare Regulator in Coroner's proceedings

Paul Spencer

The Care Quality Commission ("the CQC")

- **The CQC is the Registration authority and Regulator of**:

- NHS and Independent sector hospitals
- Mental health services and secure hospitals
- Care & Nursing homes
- Prison and Youth offender healthcare departments/wings
- GP and Dental practices
- Domiciliary care services

The CQC's role

- To protect and promote the health, safety and welfare of people who use health & social care services (s.3-4 Health & Social Care Act 2008)
- Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 requires regulated services to provide *safe care and treatment*
- It can inspect services where there are concerns and publish critical Inspection reports on the back of inspections
- Serve a section 29 Warning Notice on any service it considers is failing to comply with the 2014 Regulations

The CQC's role (cont.)

- Registered services must notify the CQC where there has been an unexpected death or a death which occurred whilst regulated activity was being carried out (The CQC (Registration)Regulations 2009)
- From 1 April 2015 the CQC took over criminal investigations and the prosecution role of the HSE, for healthcare harm events
- The CQC is prosecuting approx. 75 cases a year (but not wilful neglect or ill-treatment under sections 20-25 Criminal Justice & Courts Act 2015)
- It can cancel the Registration of registered services
- Attach conditions on the registration certificate to prevent regulation functions being undertaken

Memorandum of Understanding between the Coroner's Society of England & Wales and CQC

- To promote and continue effective working relationships between Coroners and the CQC
- The Coroner can request assistance from the CQC
- Independently of the Court, the CQC can be gathering its own evidence and where it does may share that with Coroners
- Where the CQC is considering a criminal investigation, it must consult and continue to update the Coroner
- However, CQC has up to 3 years to initiate a criminal prosecution (section 90 HSCA 2008) and historically, the regulator has been applying for a summons between 2.5 and nearly 3 years of the incident

What takes precedence – the substantive coronial hearing or a prosecution?

- Where the Police/CPS are considering a prosecution, Coroners will invariably await the outcome of the criminal investigation
- The picture is mixed where the CQC is considering a criminal investigation. Why?
- the CQC is slow to act
- the CQC frequently postpones its decision on whether to initiate a criminal investigation until after the conclusion of the Inquest. Oddly, or possibly for funding reasons, the CQC rarely attends Inquests where they may be considering criminal proceedings.
- In many instances, Coroners list the substantive Inquest ahead of any CQC decision and they are right to do so

Is the healthcare provider ‘out of the woods’ once the Inquest has concluded?

- Many healthcare IP’s consider matters to be at an end once the Inquest/any Reg 28 issues have been addressed
- They overlook, or may be unaware, that the Coroner may continue to liaise (but not direct) with the CQC following the conclusion of the Inquest
- The CQC can be spurred into action, by Coroners and/or bereaved families
- Such action may result in the CQC serving a PACE Notice (two plus years after a death) on the healthcare provider. Typically, the CQC do not interview under caution in the way the police do, but serve written PACE Notice Q’s
- Frequently the CQC PACE Notice will ask Q’s based on critical coronial findings/Reg 28 concerns raised

How important is the coronial process in CQC prosecutions?

Significant

- The PACE Notice will contain many CQC Q’s which start: “the Coroner found that …. What do you say?”
- Regulation 22 (4) of the 2014 Regulations contains a reverse burden of proof and it is for the healthcare provider to show that it “took all reasonable steps and exercised all due diligence ..”
- That is a high bar for healthcare providers to meet and may explain why most of those organisations who are summonsed plead Guilty
- CQC prosecutions are summary only and for large organisations fines can and do exceed £1m

Thank you

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Neutral Citation Number: [2021] EWHC 801 (Admin)

Case No: CO/494/2020

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

Royal Courts of Justice,
Strand, London, WC2A 2LL

Date: 31/03/2021

Before:

LORD JUSTICE POPPLEWELL
MR JUSTICE CAVANAGH
and
HIS HONOUR JUDGE TEAGUE QC,
CHIEF CORONER OF ENGLAND AND WALES

- - - - - - - - - - - - - - - - - - - -

Between:

THE QUEEN on the application of
WANDSWORTH BOROUGH COUNCIL

Claimant

- and -

HER MAJESTY'S SENIOR CORONER
FOR INNER WEST LONDON

Defendant

- - - - - - - - - - - - - - - - - - - -
- - - - - - - - - - - - - - - - - - - -

Peter Skelton QC (instructed by **South London Legal Partnership**) for the **Claimant**

The Defendant did not participate in proceedings

Hearing date : 17 March 2021

- - - - - - - - - - - - - - - - - - - -

Approved Judgment

Covid-19 Protocol: This judgment was handed down remotely by circulation to the parties' representatives by email, release to BAILII and publication on the Courts and Tribunals Judiciary website. The date and time for hand-down is deemed to be 4 p.m. on Wednesday, 31 March 2021.

His Honour Judge Teague QC, Chief Coroner of England and Wales:

Introduction

1. On 27 August 2018, Mrs Linda Johns died of bronchopneumonia at St George's Hospital in Tooting. She had previously lived for many years at a council-owned property, 8 Eliot Court, which was known to have contained asbestos during the early years of her tenancy. A consultant pathologist, Dr A. Coumbe, carried out a post-mortem examination which disclosed that the bronchopneumonia that led to Mrs Johns' death had resulted from malignant mesothelioma, a form of cancer that affects the lining of the lungs.

2. The senior coroner for Inner West London ("the coroner") held an inquest at which, having found that Mrs Johns had been exposed to asbestos while resident as the claimant's tenant at 8 Eliot Court, and that such exposure had led to and caused the mesothelioma from which she died, she recorded a short narrative conclusion that Mrs Johns had died from "exposure to asbestos whilst resident at 8 Eliot Court, causing malignant mesothelioma".

3. The claimant council, as the owner and landlord of 8 Eliot Court, now challenges the coroner's conclusion that the mesothelioma from which Mrs Johns died had resulted from exposure to asbestos at that address or, indeed, at all. The claimant seeks an order quashing the coroner's findings and conclusion and substituting a conclusion that Mrs Johns died of malignant mesothelioma, omitting any reference to asbestos. In summary, therefore, the issue to which this case gives rise is whether the coroner was entitled to conclude that it was probable, as opposed to merely possible, that Mrs Johns developed the mesothelioma that caused and led to her death as a result of exposure to asbestos while living in the council's property at 8 Eliot Court.

4. The coroner has adopted a neutral position and has not actively participated in these proceedings.

The facts

5. Mrs Johns was born on 25 May 1967. She was 51 years old when she died. She has a daughter, Kerri Matthews, who was born on 8 January 1984. From June 1989 until her death in 2018, Mrs Johns was a tenant of the claimant authority. In July 1996, she and her daughter moved into a flat at 8 Eliot Court.

6. As with many buildings of the time, asbestos had been used in the construction of the flats. In August 1984, twelve years before Mrs Johns took up residence at 8 Eliot Court, a firm of public analysts had detected a form of asbestos known as amosite inside the flat, specifically in an entrance hall cupboard, a heater cupboard duct, corner ducts in the two bedrooms and a kitchen wall partition.

7. Towards the end of 2003, the council instructed contractors to remove asbestos boards from 8 Eliot Court and, in addition, to replace the existing radiators with a new central heating system. At the request of the contractors, Mrs Johns and her daughter agreed

to vacate the flat while the asbestos was removed. During that operation, an item of equipment malfunctioned, staining and damaging some of Mrs Johns' possessions.

8. There is no dispute as to what happened. In summary, the work, which was expected to take a total of three or four days, began on 17 October 2003 with the removal of asbestos. The contractors entered the flat that morning to remove boards from the meter cupboard, the riser between the lounge and kitchen, some boarding over the toilet and four boards in the bedrooms. In view of the likely presence of asbestos in the boards, the contractors asked Mrs Johns to vacate the property while they carried out that task, and she and her daughter did so. In the course of the work on 17 October, a vacuum cleaner operated by the contractors "exploded", to use their expression, soaking the carpet, sofa, coffee table and video unit, as well as a mobile telephone, with a water-based polymeric substance.

9. In a witness statement dated 12 August 2019, Mrs Johns' daughter Kerri Matthews described the scene that faced them when they returned to the flat at the end of the day:

> "My recollection is that we came home together. We opened the door. I had my own key... We walked in. Our green sofa had this talcum powder stuff on it. There was a hoover-looking vacuum thing that was sitting there… I have no precise memory of my mother clearing up the mess, but she must have done… It did not look like there was any damage to the machine – it looked intact. It looked as if something had happened whereby what it was meant to do was to vacuum dust up but what it had in fact done is blown it out… There were bits of what looked like talcum powder. It was white. It was not distributed evenly. There was a patch on the sofa – it was not the entire sofa that was covered. The majority of the dust fell within a radius of about 1 metre of the hoover but there were bits of dust scattered around the room."

10. Mrs Johns was understandably angry when she discovered the damage to her possessions. The contractors did their best to clean the carpet, without success, and agreed to bear the cost of having the carpet and sofa covers professionally cleaned and repairing her damaged mobile telephone.

11. Three days later, on 20 October, plumbers attended 8 Eliot Court in order to remove the old radiators and install the new central heating system. This time, Mrs Johns was present. Again, some boards were removed from the cylinder cupboard, but it is not clear whether those particular boards were thought to contain asbestos.

12. On 3 November, Mrs Johns wrote to the claimant's housing department seeking compensation for the damage caused to her possessions. On 4 March 2004, following some further correspondence and negotiations, the contractors agreed to settle her claim by paying a modest sum in damages.

13. Thereafter, Mrs Johns continued to reside at 8 Eliot Court until 5 June 2017, when she moved to a new address. Twelve months later, on 29 June 2018, she attended her family doctor's surgery complaining of pain in her lower back. Her symptoms deteriorated rapidly. In July, she was admitted to St George's Hospital where her clinicians diagnosed a metastatic adenocarcinoma. Mrs Johns was too unwell for chemotherapy but received palliative care until her death in hospital on 27 August

2018. Upon being told by her family that Mrs Johns had lived for many years at a council-owned property which had once contained asbestos, the hospital reported her death to the coroner.

14. The consultant pathologist, Dr A. Coumbe, who conducted the post-mortem examination for the coroner, reported that the cause of death was bronchopneumonia resulting from malignant mesothelioma.

15. The coroner opened and adjourned the inquest on 5 September 2018. On 20 August 2019, she held a pre-inquest review hearing pursuant to rule 6 of the Coroners (Inquests) Rules 2013. At that hearing, no doubt having regard to her statutory obligation to conduct the investigation "as soon as practicable" (Coroners and Justice Act 2009, section 1), the coroner decided to receive oral evidence from the pathologist, Dr Coumbe. She appears to have done so with the concurrence of the interested persons, who agreed that it would not then be necessary for Dr Coumbe to re-attend the inquest proper. Even so, it was an irregular way of proceeding, if only because it did not comply with the guidance on pre-inquest reviews, which states that no evidence should be called at a pre-inquest review and no witness should be asked or required to attend: *Chief Coroner's Guidance No. 22*, 18 January 2016, §16.

16. Although the hearing on 20 August was recorded, the recording later turned out to be irretrievable for technical reasons. The coroner, however, took her own note of Dr Coumbe's evidence.

17. The transcript of the inquest hearing proper, which took place on 5 November, shows that Kerri Matthews was personally present and was represented by counsel, as indeed was the claimant. Having adduced from her coroner's officer the usual formal evidence of identification and the time and place of death, the coroner admitted a number of documents in evidence pursuant to rule 23 of the Coroners (Inquests) Rules 2013, namely Dr Coumbe's post-mortem report, a short report from Mrs Johns' family doctor summarising her medical history, a report from Professor Emma Baker dated 17 April 2019 describing the diagnosis and treatment of Mrs Johns' final illness in hospital, a letter from HM Revenue and Customs confirming that Mrs Johns had no history of paid employment (from which it followed that her mesothelioma could not have had an industrial origin), a witness statement from Kerri Matthews prepared by solicitors for the purpose of civil proceedings against the council, and a small bundle of correspondence and other documents concerning the work carried out on behalf of the council in 2003 at 8 Eliot Court and the resulting damage to Mrs Johns' possessions.

18. The small bundle to which I have just referred included the public analysts' report certifying the presence of asbestos in 8 Eliot Court in August 1984, Mrs Johns' letter of complaint to the claimant council dated 3 November 2003 relating to the damage caused to her belongings, and subsequent correspondence from the contractors culminating in an offer of compensation that Mrs Johns appears to have accepted. Also included in the bundle of correspondence are two undated narrative reports from the contractors confirming that on 17 October 2003, an item of their equipment had malfunctioned in the manner I have already described.

19. Having referred to the relevant portions of those documents, the coroner summarised her note of the oral evidence that Dr Coumbe had given at the earlier hearing. In the course of his post-mortem examination of the body of Mrs Johns, Dr Coumbe had found a large bloodstained effusion in the left pleural cavity. Tumour was present encasing the pleural surface of the lung and the inner lining of the chest wall on the left side. There was pleurisy of both lung linings and bronchi, and the airways were inflamed. Initial samples suggested possible malignant adenocarcinoma and further samples confirmed the presence of a malignant epithelioid tumour of the chest wall and lung.

20. Dr Coumbe confirmed the cause of death to be (1a) bronchopneumonia and (1b) malignant mesothelioma. His evidence was that there is an "extremely strong association" between asbestos dust exposure and malignant mesothelioma. He explained that there is "often and usually" a long delay between asbestos exposure and the development of malignant mesothelioma, adding that this was (and I quote directly from the coroner's summary of her note) "entirely consistent with the evidence as presented to him that may have occurred whilst [Mrs Johns] was living in the flat". He went on to express the view that "it was reasonable to assume" that exposure to asbestos while Mrs Johns was living at 8 Eliot Court had led to and caused the malignant mesothelioma from which she later died.

21. In relation to the polymeric substance that had damaged some of Mrs Johns' furniture and belongings, Dr Coumbe told the coroner that there were "no particular health concerns associated with exposure to polymeric coating" and no concern that such material could cause cancer. He said that there is no association between exposure to polymeric coating and malignant mesothelioma, adding that what he called "the polymeric dust explosion from the vacuum cleaner" would not be associated with Mrs Johns' death and would not have caused or contributed to it in any way. However, he went on to say that he was "entirely satisfied on the balance of probabilities that living in accommodation where asbestos exposure has occurred has led to and caused this death", a comment which strayed far beyond the sphere of his medical expertise.

22. At the end of the evidence, but before summing up her findings and conclusion, the coroner indicated to those present that she was "likely to find that Linda died as a result of malignant mesothelioma due to exposure to asbestos in her flat" and also to record a short narrative conclusion to the same effect. Counsel for the interested persons declined an opportunity to address her on the law.

23. The claimant's failure to raise the question of sufficiency of evidence at the inquest, while regrettable, is not without precedent in such proceedings. A similar situation arose in *R (S) v Inner West London Coroner* [2001] EWHC 105 (Admin), in which a claimant, having acquiesced in the coroner's decision not to leave neglect to a jury, was nonetheless permitted to challenge that decision before this court. The court pointed out (at §13 of its judgment) that because of the inquisitorial nature of the proceedings, it was for the coroner to decide whether there was evidence fit to be left to the jury. The same principle applies here. In inquisitorial proceedings, the views and submissions of interested persons are not determinative. The conduct of an inquest is the coroner's responsibility. Accordingly, the claimant's failure to challenge the coroner's provisional findings and conclusion at the time does not preclude it from doing so in this court.

24. In the absence of objection from anyone present, the coroner went on to direct herself correctly on the applicable legal principles and, in particular, reminded herself that she should make factual findings on the balance of probabilities.

25. The coroner then announced her findings and conclusion as to the cause of Mrs Johns' death in these terms:

> "I am entirely satisfied that the cause of her death is that as presented by the pathologist, of 1a bronchopneumonia and 1b malignant mesothelioma and this is completely supported by all the medical evidence in this case from the GP and from the professor who explained that Linda had presented in July with shoulder tip pain, was diagnosed and died within weeks of her diagnosis. The court is entirely satisfied that the only reasonable place that Linda can have been exposed to asbestos was whilst she was resident in Flat 8 of Eliot Court. I am satisfied that she was not exposed to asbestos during the course of her employment having considered the exhibit from the Department of Work and Pensions in relation to her employment. I am satisfied that asbestos was present in the flat based upon the exhibit C2 [*i.e.* the analyst's certificate of August 1984] which confirmed the presence of asbestos fibres (*sic*) at number 8 Eliot Court. I note that these panels were removed in October of 2003 and I make a logical inference that this removal will have also raised dust within the flat, but when the exposure occurred, I cannot say whether it was during the removal of the asbestos or whether it was just during Linda living [in] that flat. But I am entirely satisfied on the balance of probabilities that the source of asbestos to which she was exposed was at 8 Eliot Court. After consideration of the evidence of Dr Coumbe, I am also entirely satisfied that malignant mesothelioma virtually never arises without exposure to asbestos and therefore Linda's malignant mesothelioma was caused by exposure to asbestos and that this occurred whilst she was resident at number 8 Eliot Court and that this exposure to asbestos has led to and caused her death by causing her to develop malignant mesothelioma. This is therefore a natural death and I will make findings and determinations upon the record of inquest that properly reflect this."

The legal framework

26. Subject to an exception that does not apply to the present case, the purpose of a coroner's inquest is to ascertain the four matters specified in section 5(1) of the Coroners and Justice Act 2009, namely who the deceased was and how, when and where the deceased came by his or her death. The sole exception is where a wider investigation into the circumstances of the death is necessary in order to avoid a breach of any Convention rights: section 5(2).

27. Section 10(2) of the Act specifically prohibits the coroner from determining any question of criminal liability on the part of a named person or any question of civil liability. Equally, it is not the function of an inquest to provide a forum for attempts to gather evidence for pending or future criminal or civil proceedings: *R v HM Coroner for Greater London, ex parte Thomas* [1993] QB 610.

28. A coroner's investigation must be sufficient to achieve its statutory purpose. In the well-known words of Sir Thomas Bingham MR in *R v HM Coroner for North Humberside and Scunthorpe, ex parte Jamieson* [1995] Q.B. 1:

    "It is the duty of the coroner as the public official responsible for the conduct of inquests, whether he is sitting with a jury or without, to ensure that the relevant facts are fully, fairly and fearlessly investigated… He fails in his duty if his investigation is superficial, slipshod or perfunctory. But the responsibility is his. He must set the bounds of the inquiry. He must rule on the procedure to be followed. His decisions, like those of any other judicial officer, must be respected unless and until they are varied or overruled".

29. At the same time, the coroner is unlikely to possess the time or resources necessary to undertake an exhaustive forensic inquiry of the kind that may be necessary in adversarial litigation, and is not expected to do so. "It is not necessary to look into every possible issue": *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin), at §82, *per* Sir Brian Leveson P. The coroner must seek out and record as many of the facts concerning the death as the public interest requires: *Frost v HM Coroner for West Yorkshire (Eastern District)* [2019] EWHC 1100 (Admin), at §29.

30. The level of certainty, or "degree of conclusivity" (*pe*r Lady Arden) required of factual findings or conclusions in a coroner's inquest is the same as the standard of proof in civil adversarial proceedings, namely the balance of probabilities: *R (Maughan) v HM Senior Coroner for Oxfordshire* [2020] UKSC 46.

31. In jury inquests, the coroner must determine which conclusions or findings to leave to the jury by reference to what has become known as the 'Galbraith plus' test: *R v Galbraith* [1981] 1 W.L.R. 1039; *R (Secretary of State for Justice) v HM Deputy Coroner for the Eastern District of West Yorkshire* [2012] EWHC 1634 (Admin). That test has two components:
    (i) whether there is evidence upon which the jury properly directed can properly reach the particular conclusion or finding; and
    (ii) whether it would be safe for the jury to reach the conclusion or finding.

    In many cases, where there is evidence upon which a jury properly directed could properly reach a particular conclusion or finding, then it is likely to follow that the jury could reach it safely: *R (Chidlow) v HM Senior Coroner for Blackpool and Fylde* [2019] EWHC 581 (Admin). Where, as in the present case, there is no jury, the coroner will naturally consider the safety of any conclusion or finding he or she proposes to make as well as the sufficiency of the evidence available to support it, but need not expressly articulate a self-direction on both limbs of the 'Galbraith plus' test.

32. For causation of death to be established, the threshold to be reached is that the event or conduct said to have caused the death must have more than minimally, negligibly or trivially contributed to it. That question is to be determined on the balance of probabilities. Combining the threshold for causation and the standard to which it must be established, "the question is whether, on the balance of probabilities, the conduct in question more than minimally, negligibly or trivially contributed to death": *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin), at §41.

33. In civil proceedings, where it may not be necessary to establish that a particular exposure to asbestos was responsible for causing mesothelioma, a different test applies. In such cases, liability "falls on anyone who has materially increased the risk of the victim contracting the disease": *Fairchild v Glenhaven Funeral Services Ltd and Others* [2003] 1 AC 32. However, that principle has no application in coronial investigations, where it is clear that the relevant event "must make an actual and material contribution to the death of the deceased": *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin), at §62.

The claimant's submissions

34. The claimant does not dispute that there exists a strong and well-established association between malignant mesothelioma and exposure to asbestos dust or fibres or that the evidence available to the coroner was consistent with Mrs Johns having been exposed to asbestos many years before her death, possibly while living at 8 Eliot Court. However, the claimant argues that the totality of the evidence was not sufficient to justify a conclusion on the balance of probabilities that Mrs Johns had developed malignant mesothelioma as a result of exposure to asbestos at 8 Eliot Court.

35. In support of its submission that the coroner's findings and conclusion were not justified by the evidence and were therefore unreasonable, the claimant advances six specific propositions:
    - (i) as a matter of generality, living in a property that contains asbestos does not constitute exposure to asbestos;
    - (ii) there was no positive evidence that Mrs Johns had ever been exposed to freely circulating asbestos fibres at any time during her tenancy at 8 Eliot Court;
    - (iii) although malignant mesothelioma is often caused by exposure to asbestos, there are other possible causes which the evidence did not adequately exclude or address;
    - (iv) even if Mrs Johns had developed malignant mesothelioma as a result of such exposure, it could have occurred elsewhere than at 8 Eliot Court;
    - (v) the coroner was wrong to rely upon Dr Coumbe's evidence that it was "reasonable to assume" that exposure to asbestos at 8 Eliot Court had caused Mrs Johns's malignant mesothelioma, because that was not a matter on which Dr Coumbe was qualified or entitled to express an opinion; and
    - (vi) the coroner failed to apply the 'Galbraith plus' test by asking herself, first, whether there was sufficient evidence upon which to conclude that Mrs Johns developed malignant mesothelioma as a result of exposure to asbestos at 8 Eliot Court and, second, whether such a finding or conclusion was safe.

36. The claimant further submits that there was an insufficiency of inquiry by the coroner in failing to conduct an adequate exploration of potential explanations for Mrs Johns'

malignant mesothelioma other than that she had developed it as a result of exposure to asbestos at 8 Eliot Court.

Discussion and conclusions

37. Until its use was prohibited in the closing years of the last century, asbestos was a popular and commonplace building material, much valued for its cheapness and its insulating and fire-retardant properties. While harmless as long as it is left untouched, asbestos is capable of releasing injurious fibres when disturbed. These freely circulating fibres can lodge in the lungs of those who inhale them and, in some cases, may lead after a latency interval of many years to the development of malignant mesothelioma.

38. That Mrs Johns died from bronchopneumonia resulting from malignant mesothelioma is not in question. There is equally no doubt that asbestos had been present in her flat at 8 Eliot Court throughout the period between 1989 and 2003. The questions that arise are, first, whether there was evidence upon which the coroner could properly find, on the balance of probabilities, that the mesothelioma from which Mrs Johns died had resulted from exposure to asbestos fibres and, if so, whether there was evidence upon which the coroner could properly find, on the balance of probabilities, that such exposure had taken place while Mrs Johns was living at 8 Eliot Court.

39. As to the first question, it cannot safely be assumed that malignant mesothelioma is invariably caused by exposure to asbestos fibres. Although the statistical association between the two is, in Dr Coumbe's words, "extremely strong", it is by no means absolute. By itself, therefore, it is incapable of establishing a causal link in any particular case. To say, as the coroner did, that "malignant mesothelioma virtually never arises without exposure to asbestos and therefore Linda's malignant mesothelioma was caused by exposure to asbestos" is, with respect, to confuse statistical probability with the balance of probabilities. A causal link cannot properly be inferred without some evidence specific to the index case.

40. The public analyst's certificate reporting the presence of asbestos within 8 Eliot Court in August 1984 did not specify that freely circulating amosite fibres had been detected there. It referred only to amosite. Living in close proximity to products or materials that happen to contain asbestos does not necessarily entail exposure to asbestos fibres. The only known event that might conceivably have exposed Mrs Johns to such fibres was the work undertaken by the council's contractors at 8 Eliot Court in October 2003. That is something the coroner implicitly recognised, for she explained in her introductory remarks at the inquest hearing on 5 November that in her investigation she had been "looking at the evidence around the time that asbestos removal was taking place essentially".

41. The evidence available to the inquest was that Mrs Johns and her daughter were not present on the day when the boards were removed from their flat. They could not, therefore, have been exposed to asbestos fibres while the work was in progress. Afterwards, they returned home to find some of their furniture and possessions covered in dust following the malfunction of a vacuum cleaner operated by the

contractors. The composition of that dust is unknown. It may have included asbestos fibres, but there is no evidence that it did. Indeed, Dr Coumbe told the inquest that what he called the "polymeric dust explosion from the vacuum cleaner" would not have caused or contributed to the death of Mrs Johns in any way. The coroner, having recognised that she could not say whether exposure had occurred during the removal of the asbestos, correctly accepted that such exposure was no more than a possibility. Her mistake lay in assuming, without evidence, that Mrs Johns must therefore have been exposed to freely circulating asbestos fibres at some other stage during her occupancy of 8 Eliot Court.

42. Mrs Johns' illness was certainly consistent with exposure to asbestos fibres. The time interval between 2003 and the diagnosis of metastatic adenocarcinoma in 2018 was consistent with the long latency period associated with such exposure. By reference to the fact that Mrs Johns had no history of paid employment, it was possible to exclude an industrial origin for her illness. But those factors, even taken together, could establish no more than a possibility that Mrs Johns' mesothelioma was the result of exposure to asbestos fibres at 8 Eliot Court. They could not support a finding on the balance of probabilities that such exposure had in fact taken place or, if it had, that it had caused her malignant mesothelioma.

43. The only positive suggestion to the contrary came from Dr Coumbe, who declared that it was "reasonable to assume" that exposure to asbestos while Mrs Johns was living at 8 Eliot Court had led to the malignant mesothelioma from which she later died. That, however, was not a matter within his sphere of expertise and it was not an opinion he should have been allowed to express. It was for the coroner to decide on the totality of the evidence available to her.

44. Even if the events of October 2003 had brought Mrs Johns into contact with freely circulating asbestos fibres, the coroner could not safely assume that Mrs Johns had never been exposed to any other source of such a commonplace material during the lengthy latency interval of the illness. In those circumstances, it was impossible to say, on the balance of probabilities, that any exposure that took place at 8 Eliot Court had made an actual and material contribution to her death.

45. The absence of evidence identifying the source of Mrs Johns' illness was not the result of any insufficiency of inquiry. Where this distinguished and experienced coroner fell into uncharacteristic error was not so much in declining to embark upon an exhaustive attempt to exclude all theoretically possible alternative explanations for Mrs Johns' malignant mesothelioma, as in placing greater weight on the limited evidence available than it could properly bear. That evidence was not sufficient to enable the coroner to conclude on the balance of probabilities that Linda Johns had contracted malignant mesothelioma as a result of exposure to asbestos fibres while she was living at 8 Eliot Court.

46. It must be remembered, in fairness to the coroner, that the claimant's failure to raise at the time of the inquest any of the matters it has argued in these proceedings deprived the coroner of the opportunity of considering the submissions this court has heard.

47. If my Lords agree, I would quash the findings in Box 3 and the conclusion in Box 4 of the Record of Inquest dated 5 November 2019. In Box 3 I would substitute the

words: "Linda was diagnosed with malignant mesothelioma in July 2018 and despite treatment this led to and caused her death on 27 August 2018 at St George's Hospital". The conclusion in Box 4 can then read: "Malignant mesothelioma".

Mr Justice Cavanagh:

48. I agree.

Lord Justice Popplewell:

49. I also agree.

COURT OF APPEAL (CIVIL DIVISION)

31 January, 1 February; 17 March 2023

DOVE
v
HM ASSISTANT CORONER FOR TEESSIDE AND HARTLEPOOL AND ANOTHER
(SECRETARY OF STATE FOR WORK AND PENSIONS, INTERESTED PARTY)

[2023] EWCA Civ 289

Before Lord Justice LEWIS,
Lord Justice William DAVIS, and
Lady Justice WHIPPLE

Statutory test for a fresh inquest — New evidence — Whether necessary or desirable in the public interest — Recording of conclusions of suicide — Test for causation — Coroner's role in investigating mental health deterioration where article 2 not engaged — Whether article 2 operational duty in existence.

COMMENTARY

This is a very useful case for those representing families at inquests where suicide is a possible conclusion. It is also a useful primer on: the purpose and scope of an inquest, narrative conclusions, causation and suicide, the modern law in relation to a coroner's conclusion of suicide, the correct approach to the application of the very broad statutory test for a fresh inquest found in section 13(1) of the Coroners Act 1988, and evidential sufficiency in that regard. This commentary focuses on scope, causation and the statutory test.

A coroner conducting an inquest is required to answer four questions. The question " Why? " is not on the list and in a suicide case, the bereaved struggle to accept its absence. They will find para 70 of Whipple LJ's wide ranging and family friendly judgment of considerable assistance. Here we learn that in a suicide case, not only is it open to a coroner to investigate the impact of past events on a person's mental health prior to death, but doing so will often be part of the coroner's role. That is because a deceased's intention to take their own life must be proved before a conclusion of suicide can be entered, and investigation of intention will often encompass consideration of whether the deceased's mind was disturbed. Note that as to state of mind at the time of the deceased killing themselves, the judgment approves Jervis' recommendation that any finding that the deceased's mind was disturbed at the time of death should be evidence based and recorded. It also endorses the alternative formulation "whilst suffering extreme anxiety or distress" (see para 19). In short, where the deceased has taken their own life, state of mind immediately before death is likely to be a key part of the inquest's proper scope.

Turning to causation, the Court of Appeal had no difficulty in saying that the Divisional Court's approach (see the quotations at para 48 of Whipple LJ's judgment) was too restrictive of scope, as well as wrongly appearing to apply the "but for" test. No sharp distinction could be drawn between mental health prior to death and suicide, neither could mental health deterioration be separated from death. Therefore, expert evidence that went to state of mind only was also relevant to death (see paras 68 and 69).

The last sentence of para 70 – "An investigation of the cause or causes of disturbance of the mind may therefore be part of, or lie very close to, the matters which are already before the coroner" – is as close as we are likely to get to authority for the proposition that before answering the "how" question in a narrower scope *Jamieson* inquest, the coroner should undertake what, to families, will look like an investigation into "why" their loved one took their own life.

The statutory test for a fresh inquest is expressed in very broad terms: is it "necessary or desirable in the interests of justice that an investigation (or as the case may be, another investigation) should be held". The Court of Appeal approved the guidance on the ambit of the test provided by the Divisional Court in *Sutovic* and the *Hillsborough* case; paras 6–9 of *Dove* are essential reading here.

The Divisional Court's decision in *Bell v HM Coroner for South Yorkshire (Eastern District)* (KBD (Admin)) [2023] WLUK 342 was published four days after *Dove*. However, in *Bell*, William Davis LJ dismissed the family's application for a fresh inquest on the basis of new evidence. Comparing and contrasting the two cases helps clarify the circumstances in which it will be desirable (not necessary) in the interests of justice to hold a further inquest. Doing so also sheds light on what new evidence will, and will not, be held evidentially sufficient to justify a fresh investigation.

In *Bell*, the deceased suffered from schizophrenia and after two admissions as a

detained patient in a mental health hospital, she worked there as a ward aid. She became pregnant by a colleague student nurse and had a termination in 1988. In December 1991, she died after walking into the path of an oncoming train, and the inquest recorded an open verdict. Years after that, a report identified a culture of unprofessional, degrading practices at the hospital which subsequently closed. The deceased's brother made a complaint to the police. At interview, the nurse explained that the relationship was genuine and consensual, and that the deceased's psychiatrist had known about the termination at the time. The police declined to prosecute. The coroner refused the brother's application for a fresh inquest, brought on the basis of asserted new evidence of a state of mind at the time of death affected by an exploitative relationship, an unplanned pregnancy and termination, the hospital's knowledge of the relationship and failure to disclose it, and the underlying culture at the hospital which permitted the relationship to occur.

The Divisional Court dismissed the brother's appeal from that decision. In contrast to *Dove*, where there was *expert* evidence about the deceased's state of mind when she died, the application for a new inquest in *Bell* was based solely on family opinion and speculation. Neither of these amounted to new facts or new evidence. There was nothing to connect the relationship or termination with the deceased's death three years later, and the 30-year delay, with loss of documents and memory, meant that a new coroner would be in a worse position than the original one. A fresh inquest was not in the interests of justice.

The contrast with *Dove* is stark where Jodey's mother had obtained cogent expert evidence of a likely causal link between the DWP's failings and Jodey's state of mind when she died. It was important that the family have an opportunity to invite a coroner to consider that report. There was also a wider public interest in a public examination of the consequences of terminating benefit payments to vulnerable people dependent on them to survive, in view of the large numbers of people who could be affected. The possibility of a PFD report and evidence from the DWP about any remedial steps which had been taken were also matters of public interest.

Finally, and importantly, practitioners will note that section 13 of the 1988 Act is concerned with the possibility, not the probability, of a different verdict after a fresh inquest. The fact that a second inquest might not result in a different conclusion is not a reason not to direct one (see paras 8, 9 and 73).

Reported by Katie Gollop KC

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Medical Law Reports are the most authoritative set of law reports on major medico legal cases. For further information on this publication please visit
https://www.lloydslistintelligence.com/i-law

Mere bystanders? Obtaining the criminal records of lay inquest witnesses

Written by: Frances McClenaghan
Published: 16 February 2024

Henry Gargan's and Edward Butler's Application **[2023] NIKB 103**

Although often overshadowed by the Bloody Sunday killings a few weeks earlier, the Springhill killings of 9 July 1972 still stand out as one of the most notorious events during 'the Troubles'. The five people shot dead in Belfast that day included three teenagers and a Catholic priest, who was said to have been waving a white flag as he went to try and assist one of the injured children.

The victims' families considered that they were targeted and killed by soldiers who used unjustified and indiscriminate force on unarmed civilians. The army account was that the victims were caught in cross-fire when IRA gunmen shot at soldiers who used legitimate and justified force at a time of heightened tension in response to specific threats.

The original inquest into the five deaths, held in 1973, provided no closure when it returned an open verdict. Against that background the fresh inquest ordered by the Attorney General was always going to be a source of controversy. The particular issue that arose for consideration in this judicial review claim was whether a Coroner obtaining the criminal records of witnesses who were at the scene of a death was a reasonable and proportionate step within coronial discretion or a disproportionate action that hampered the statutory function of the inquest through the chilling effect discouraging witnesses from coming forwards?

Background

There was evidence suggesting that members of the IRA were at the scene and were armed on the day of the shootings. The statement of one witness identified an acknowledged member of the IRA "spraying" the location from a Lewis gun. In this context, the Ministry of Defence (MoD) applied to the Coroner for material held by the police (PSNI), including intelligence material on that witness and nine other named individuals.

The Coroner granted the application and set out criteria and parameters as to the further inquiries that should be made. He ordered that in the interests of expedition the criminal records of certain civilian eyewitnesses should be disclosed, but only information relating specifically to the shootings. The applicants challenged this decision on the basis that: (i) it would have a chilling effect, discouraging witnesses from coming forward and therefore unduly impinging the ability of the Coroner to fulfil the statutory function of the inquest to ascertain how the deceased met their deaths; (ii) it was disproportionate, in that it unfairly affected only civilian, and not military, witnesses; (iii) by withholding the names of the persons against whom searches were to be conducted (save for the ten identified), the Coroner had prevented the properly interested persons, including the next of kin, from being able to properly understand the scope of the ruling and from having an opportunity to make representations as to its application.

Decision

In this renewed application, Mr Justice Colton, refused permission.

He made clear that a person challenging a Coroner's procedural ruling faces a high bar. Colton J cited *Re Officer & Others* [1] where the Court of Appeal in Northern Ireland stated that the High Court should not intervene unless it is apparent that a procedural ruling should not have been made. A Coroner will only have acted unlawfully if he has exceeded the generous width of the discretion vested in him to regulate the inquest in the interest of what he considers to be a full, fair and fearless inquiry. Coroners are therefore afforded a wide margin of appreciation. The High Court should be slow to exercise its supervisory jurisdiction and intervene. In general, the applicant must establish that the conduct of the inquest following the procedural ruling would deprive them of an opportunity to properly participate in the inquest and that, unless restrained, the Coroner would be proceeding to carry out an inquest in a manner that breached Article 2 ECHR.

Colton J found that the Coroner's ruling was clearly designed to elicit potentially relevant material, which may assist in addressing the MoD's central contention, that civilians were armed and fired at military personnel at the location. Such a ruling was clearly within the Coroner's discretion and in furtherance of the objective of conducting a full, fair and fearless inquest. He was satisfied that both the basis for and the parameters of the search were clearly set out in the ruling.

On the first ground, the fears of the potential chilling effect had not been borne out. The searches had been conducted and the information was available for viewing. The assessment of relevance could be completed within the schedule currently set for the inquest.

As to the second ground of challenge, the Coroner justified the differential treatment of civilian and military witnesses in a fair and comprehensive manner. The Coroner explained that:

"[T]here is an obvious distinction to be drawn between soldiers on the ground, whom we know were openly armed, and civilians who (on the soldiers' case) were operating covertly in plain clothes and likely under the auspices of a proscribed organisation."

Further, he made it plain that the outcome of his ruling would be kept under review as the evidence developed. As to the third ground of challenge, in the event that the searches would result in relevant material being disclosed, all properly interested persons would have the opportunity to make submissions about its relevance or admissibility. This would include issues relating to the identity of the persons concerned. In the event that the Article 8 ECHR rights of any individual would be affected, this could be dealt with by the Coroner. This would include notification to the persons potentially affected and the opportunity for them to make representations. In fact, disclosing the identities of the witnesses affected by the ruling at this stage could amount to a disproportionate interference with their Article 8 rights.

Comment

Obtaining the criminal records of witnesses at the scene of a death may be reasonable in a range of circumstances. For example, in inquests involving the police, where fatal use of force (not limited to firearms) is used because of a volatile situation involving bystanders (riot situations, for instance).

Further the case serves as a reminder of the staged approach to be applied to disclosure in inquests (disclosure to the Coroner first, and then to Interested Persons subject to submission and consideration by the Coroner) pursuant to the Worcestershire case.

The context of this inquest ('the Springhill Inquest') as one of the 'Legacy Inquests' into events during 'the Troubles' is significant and explains the central importance of ensuring that any disclosure request did not delay the final hearing. Under the Northern Ireland Troubles (Legacy and Reconciliation) Act 2023 all inquests arising from the Troubles which have not reached the stage of the coroner or any jury making their final determination by 1 May 2024 must be stopped, even if the inquest is already part heard [2]. After this time, the means for investigating deaths arising from the Troubles will be through a new body, the Independent Commission for Reconciliation and Information Recovery. Whether this new body will be able to fulfil society's need for truth first, then reconciliation remains to be seen.

Footnotes

[1] [2012] NICA 47

[2] see s.44(1)

Are presumptions and burdens of proof relevant in inquests? Insanity and unlawful killing considered

Written by: Bridget Dolan KC
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R (Bryan) v HM Assistant Coroner for Buckinghamshire **[2024] EWHC (Admin) 26 12 January 2024**

This most tragic of cases concerned the loss of two precious and irreplaceable lives when Ms Redmond put herself in the path of a train whilst holding her three year old daughter.

The inevitable conclusion of suicide in Ms Redmond's inquest was not contested. But the Coroner did not agree with the position of the Claimant (supported by the paternal side of the child's family) that the child had been unlawfully killed by her mother. In a long and detailed narrative conclusion regarding the child's death the Coroner addressed her mother's state of mind and determined that this was not an unlawful killing because Ms Redmond had probably been 'insane' when she had jumped.

The Claimant challenged both the form and substance of the Coroner's conclusion, arguing that the Coroner's finding had impermissibly reversed the presumption of sanity and, in its place, substituted a presumption of insanity. The challenge failed on all grounds, however, as the Court held that not only was the Coroner entitled to make this finding on the evidence but, given the inquisitorial nature of an inquest, it would be inappropriate to attempt to transpose directly the concepts of a presumption of sanity and the burden of proof as they apply in the context of criminal proceedings to the very different context of inquisitorial coronial proceedings.

The Inquests

The conjoined Article 2 inquests that followed these two deaths had been protracted and complicated. There were ten interested persons with evidence admitted from 68 witnesses and 2,000 pages of documents to consider. The inquests' scope addressed Ms Redmond's mental ill health, looking at her behaviour over the months before the deaths and her interaction with various social and medical services. Evidence ranged far and wide, including very detailed analysis of her movements and state of mind alongside the investigation of other concerns related to the circumstances of the deaths and the public bodies' involvement with the family.
At the end of the child's inquest the Coroner had stated in his narrative conclusion that "*it was not possible to determine that [Ms Redmond] was not suffering from such a disease of the mind as to be incapable of distinguishing between right and wrong and was therefore likely to be legally insane.*"

The Judicial Review grounds

Two challenges to this narrative conclusion were raised by the Claimant:[1]

- that the Coroner erred in law by mistakenly adopting the presumption that Ms Redmond was insane at the time of the incident when he should have adopted a presumption of sanity; and
- that returning anything other than a short-form conclusion that the child was 'unlawfully killed' was irrational.

The Claimant submitted that the Coroner's approach impermissibly reversed the presumption of sanity that the Coroner should have adopted and, in its place, substituted a presumption of insanity.

A presumption of sanity or of insanity?

It was not contested by the Claimant that there was evidence of episodic mental disturbance that may properly have led to a finding of insanity if the act had happened at some other time. But the Claimant asserted that the Coroner, despite having identified deliberate acts by Ms Redmond, had mistakenly adopted a presumption of insanity and applied this to the time of the deaths.

The Court however disagreed, holding that the question of insanity must fall to be considered by a Coroner if there is evidence that properly raises it.

The relevant criteria for the determination of sanity/insanity are found in the M'Naghten rules, which in summary state as follows:

1. Everyone is presumed to be sane, and to possess a sufficient degree of reason to be responsible for their crimes, until the contrary is proved.
2. To establish the defence of insanity, it must be clearly proved that, at the time of committing the act, the accused was suffering such a defect of reason, from a disease of the mind, as not to know the nature and quality of the act they were doing, or, if they did know it, that they did not know that what they were doing was wrong.

In a criminal setting it is clear that the presumption of sanity must be the starting point; and so the burden of proof lies upon the accused to establish on the balance of probabilities that the requisite defect of reasoning was present. However Lord Justice Stuart-Smith, giving the judgment of the Court, considered that such presumptions and burdens were wholly inapplicable in the context of inquests due to the nature of coronial proceedings.

In an inquest there is no defendant and therefore no one upon whom the relevant burden of proof might lie. As an inquisitorial, non-adversarial, fact-finding inquiry the rights and protections afforded to a person accused of a crime in criminal proceedings are absent in an inquest where the same person is suggested to have acted unlawfully.

In the inquisitorial context the concepts of presumptions and burdens of proof are particularly inapposite to be applied to the deceased person or to interested persons for basic reasons of fairness (this being particularly important where the person whose conduct is at issue is themself deceased).

The approach required at inquests

The judgment goes on to explain that when addressing the question of insanity in the context of a possible finding of unlawful killing the two questions for the Coroner should be:

1. whether, on all the available evidence, the issue of insanity is properly raised and then if there is sufficient evidence of insanity for it not to be withdrawn from consideration? (either by the Coroner or, if there is one, the jury)
2. whether, on all of the relevant evidence, the correct conclusion on the balance of probabilities is that the person in question was not insane?

No burden of proof is required to address those questions. Rather, this approach preserves the protections required by the considerations of fairness. If it was more likely than not that the person was insane at the time of committing the act that led to the death in question, a conclusion of unlawful killing would be unsafe and so should not be reached.

The Claimant had also argued that a finding of insanity it was incompatible with the Coroner's factual finding that Ms Redmond's actions at the railway station were deliberate. But as the Court found, a person's continuing capacity to act deliberately is not necessarily removed when they are in the grip of a psychosis and so is not determinative of the issue of insanity. The Coroner's conclusions were well within the bounds of conclusions which were open to him on the available evidence.

The Narrative Conclusion

The court commented that such a detailed, complicated and sensitive case, particularly in relation to Ms Redmond's state of mind, had fully justified the Coroner's decision to give a narrative conclusion.
That conclusion was however described by the Court as "less than immaculately expressed" as in seeking to follow the advice of §32 of the Chief Coroner's guidance on Unlawful Killing the Coroner had introduced a "clunky" double negative.

However, the Court considered that it was reasonably clear that the Coroners findings were that (a) he was not satisfied that Ms Redmond was not insane at the time of the act, and (b) he was satisfied that she was likely to have been insane at the time of the act.

In such a tricky case as this one, one's narrative conclusion being "less than immaculate" is perhaps a criticism most coroners would be happy to live with.

Footnotes

[1] The Chief Coroner was also drawn into the proceedings as an interested party, as paragraph 32 of the Chief Coroner's Law Sheet: No. 1 on Unlawful Killing also came under scrutiny.

Supreme Court outlines Art 2 obligations in community & healthcare setting

Written by: Bridget Dolan KC
Published: 22 June 2023

R (Maguire) v HM Senior Coroner for Blackpool and Fylde, **[2023] UKSC 20**

Anyone who had been holding their breath waiting for the Supreme Court's decision in Maguire can now breathe out. **Nothing has changed.** The Senior Coroner, the Chief Coroner,[1] a High Court judge, and four Court of Appeal judges were all right. Article 2 procedural obligations are not engaged when someone who was living in the community and deprived of their liberty using powers in the Mental Capacity Act falls fatally ill and there is some delay to them receiving NHS care.

In a detailed and close analysis of the authorities and the relevant principles, this recent judgment helpfully distils the many complex issues around the application of Art 2 and healthcare into a lengthy, but extremely clear, exposition of the applicable law.

Background

Jacqueline Maguire lived in a residential care-home in the community, funded by the local authority. When she became unwell an ambulance was called and paramedics attended but Ms Maguire declined their advice to go to hospital. The paramedics' assessment was that the situation did not warrant restraining Ms Maguire and manhandling her to get her to hospital. On the advice of a GP, she was permitted to stay at the care-home overnight (although the GP accepted at the inquest that her triage decision was poor and that she should have advised an immediate admission to hospital). When her condition had worsened the next day Ms Maguire was taken to hospital, where she died as a result of pneumonia and a perforated gastric ulcer with peritonitis.

The appellant's case was that, as she lacked the mental capacity to make the decision herself, a protocol should have been in place for admitting Ms Maguire to hospital despite her refusal. It was argued the absence of such a system arguably breached Ms Maguire's Art 2 rights, and consequently the state had a procedural obligation under Art 2 ECHR to investigate her death with s.5(2) CJA 2009 requiring an extended conclusion by the inquest jury.

The Senior Coroner did not agree. Indeed the Coroner found that there had been no failure by the care home or the ambulance service to have appropriate systems in place, and that what was being alleged amounted to no more than medical negligence by healthcare staff.

The inquest concluded in July 2018 with the jury finding that Ms Maguire's death had been from natural causes. The case then went on a 5 year journey through our court system, ending in the Supreme Court where Lord Sales took the opportunity to provide his erudite exposition of Art 2 as it relates to coronial investigations.

Article 2 framework of obligations

The relevant national and ECHR jurisprudence has already clearly established that a state's duty under Art 2 to take 'appropriate steps to safeguard the lives of those within their jurisdiction' could give rise to two types of **substantive positive obligations**: first the **systems duty**, which requires appropriate legal regimes and administrative systems to be in place to provide general protection for the lives of citizens, and second, the **operational duty**, to take operational steps to protect a specific person (or group of people) if it is known (or should be known) they are at a real and immediate risk to life.

It is also well established that Art 2 additionally imposes **procedural obligations** regarding the investigation of potential breaches of those substantive duties, thereby giving the opportunity to call state authorities to account.

No monolithic procedural obligation

The Supreme Court drew on the earlier 'meticulous' first instance judgment of Popplewell LJ in the case of *Morahan*[2] when identifying the three different levels at which different aspects of the Art 2 procedural obligation might apply. As Lord Sales put it – there is no simple monolithic form of procedural obligation which applies in every case. Rather, the procedural obligation applies in a graduated way depending on the circumstances of the case and the way in which in a particular context the state:

- **A basic procedural obligation**: requiring state authorities to take some steps to establish whether the cause of a death is from natural causes, so as to check whether there might be any question of a potential breach of a person's right to life under Art 2.

This obligation, which arises immediately upon death, and will inform whether other procedural obligations come into play, is already satisfied in England and Wales by providing a system requiring medical certification of deaths with coronial oversight of those cases where a MCCD is not given and/or that are not natural deaths and/or occur in state custody (see s.1 CJA 2009):

- **An enhanced procedural obligation**: which requires the state to take additional proactive steps to investigate possible breaches of an Art 2 substantive obligation and ensure appropriate accountability.

This enhanced procedural obligation applies where there is a particularly compelling reason why the state should be required to give an account of how a person came by their death.[3] This obligation is most often satisfied in England and Wales by the a statutory obligation placed on a coroner or jury at an inquest to state an expanded form of conclusion under s.5(2) CJA 2009:

- **A redress procedural obligation**: which arises where there is no relevant compelling reason giving rise to the 'enhanced procedural obligation', but there is still a possibility that a substantive Art 2 obligation has been breached, and so the state should provide a means by which a person complaining of possible breaches can raise that complaint, have it investigated and obtain redress for any breach found.

A combination of an inquest that can determine the cause of death (without any requirement of an expanded conclusion) and the availability of a civil claim for damages for negligence will often satisfy this obligation.

Against that background the Supreme Court considered the specifics of Ms Maguire's case, recognising that the appeal raised an important issue about the boundary between the systems duty and the operational duty if, as was postulated in *Fernandes*,[4] it might be shown that the public authorities had put an individual's life at risk through the denial to them of the health care which they had undertaken to make available to the population generally.

Issues for the Court

The questions the Court considered were:

Was there an arguable breach of the systems duty on the part of the care home or healthcare providers, so as to trigger the enhanced procedural obligation?

In the context of care homes, just as in the context of healthcare services, the systems duty operates at a high level and is relatively easily satisfied. It will only be in rare cases that it will be found to have been breached. Where the duty to have an adequate system in place has been met, then lapses in individual performances within those state systems, even negligent professional performance, will not, generally, amount to failures of the systems duty.

The Supreme Court held that even though there may have been individual lapses in putting those systems into effect, the systems in place were capable of being operated in a way which would ensure that a proper standard of care was provided to Ms Maguire.

The Court criticised the applicant's case as involving "*a strong element of 'reverse engineering' in terms of trying to formulate the obligations said to be owed under the umbrella of the systems duty, by looking at what happens to have gone wrong and then trying to formulate an alleged obligation tailored to that case.*" It was said that what the authorities show is that the proper approach to the systems duty is to look forward and assess the systems which it is generally reasonable to expect the relevant body to have in place in advance of any incident. Lord Sales considered that the view of a domestic regulator such as the CQC or the bodies responsible for oversight of the healthcare providers that suitable systems are in place will usually be powerful evidence that the systems duty has been satisfied, since that is precisely how they approach that question. Furthermore, one can almost always say that a system could be improved by dedicating more resources to its operation, but that a system can be improved does not mean it is inadequate. It is not for the Court to consider how limited resources should be allocated between competing priorities.

In the present case the Coroner had examined the care home and healthcare systems in place, and his conclusion that there was no arguable breach of the systems duty was one he was entitled to come to on the evidence.

Was there an arguable breach of the operational duty on the part of the care home, so as to trigger that obligation?

When a person is resident in a care home, a nursing home or a hospital, this does not mean the state assumes responsibility for all aspects of their physical health. Even though the individual may not be at liberty, the state is not made the guarantor of the adequacy of healthcare provided to them in all respects.

To determine the existence of an operational duty one must focus on the specific risks to life of which the authorities were aware. The operational duty applies in a graduated way depending on the perception of the risk. In this case the care home's responsibility was to look after Ms Maguire on behalf of the state in substitution for her family. Their task was to ensure that she could access the healthcare which was available to the population generally. The care home staff had sought to do this in calling an ambulance and a GP to attend on her. There was therefore no arguable breach of the operational duty by the care home.

Was there an arguable breach of the operational duty on the part of any of the healthcare providers, so as to trigger that obligation?

When assessing whether any operational duty fell on healthcare providers, it was relevant that none of the healthcare professionals involved was on notice that Ms Maguire's life was in danger when first called to attend her. When she declined admission although she lacked capacity,

it was considered desirable to foster her sense of personal autonomy and preserve trust between her and her carers, by respecting her wishes. Proper consideration was given to whether to remove her forcibly to hospital. It was a reasonable assessment that the magnitude of the risk to her did not make that appropriate. The concerns expressed in *Fernandes*, that Art 2 may be breached by the denial of healthcare, referred to a specific situation that did not arise here (where an individual patient's life was knowingly put in danger by denial of access to life-saving emergency treatment). This did not extend to circumstances where a patient was considered to have received deficient, incorrect or delayed treatment.

In Ms Maguire's case there had, therefore, been no arguable breach of the operational duty by any of the healthcare providers. The appeal was dismissed.

Other musings

As an aside within his ruling, Lord Sales drew attention to the problem posed to the Supreme Court Justices by the Coroner having adopted a neutral stance on this appeal throughout.[5] At first instance and in the Court of Appeal, the main submissions in opposition to the application had been presented by the organisation responsible for the Care Home. In the Supreme Court, however, no respondent apart from the Senior Coroner made any submissions.

The Coroner's own contribution had been by way of submissions about the general legal framework in which inquests take place, but the court did not have the assistance of full argument to understand the detailed factual circumstances of this case and how they might bear upon the issues in the appeal.

In future, Lord Sales suggested, the onus should be on counsel for a Coroner, whilst remaining neutral, to act as an advocate to the Court (*amicus curiae*) and assist to ensure that the Court is given the full factual picture, including if necessary by drawing the Court's attention to matters not emphasised or omitted by a claimant, as well as alerting the Court to relevant law and authorities. Such argument need not be inappropriately adversarial but would save the Court from the need to inform itself about the factual circumstances of the case by going back to the underlying materials and evidence before the Coroner. In future, it is suggested, neutral Coroners heeding these words should have less fear that attending through counsel to assist the Court on the facts, inquest procedure and coronial law will be seen as a green light to paying the costs of a judicial review should the claimant succeed.

And as a final note (if your blogger might be forgiven for being presumptuous enough to pick a minor fault with such an erudite Court's judgment) it is a shame that the Supreme Court chose not to adopt the preferable language to be used in the coronial jurisdiction. A quick word search of the judgment tells us that there are 59 references sprinkled throughout to the inquest ***'verdict'*** – a term which has not been in use in coroner's courts for over a decade, having been abolished in the 2009 Act.

Also in three places the phrase '*committed suicide*' is used. The most recent edition of the Equal Treatment Bench Book(at §167) encourages all judges and coroners not to use this term: it implies a criminal act and is considered to be language that may offend or stigmatise. It is not a phrase that should still be heard in any coroners' court.

Footnotes

[1] HH Judge Lucraft QC sitting as a Judge of the High Court was one of the Divisional Court first instance bench

[2] *R (Morahan) v West London Assistant Coroner* [2021] EWHC 1603 (Admin); [2021] QB 1205; [2021] Inquest LR 126. Later upheld on appeal.

[3] There are some are categories of case (such as after self-inflicted injuries in prison) where the application of this enhanced procedural obligation is automatic, because all such deaths raise a sufficient possibility of state responsibility and the importance attached to the need for the state in these contexts to provide full accountability in relation to the death.

[4] *Lopes de Sousa Fernandes v Portugal* (2017) 66 EHRR 28

[5] Adopting a neutral position will generally avoid a defendant coroner being held liable for any costs of the action, in line with the suggestion by Brooke LJ in *R (Davies) v Birmingham Corone*r [2004] 1 WLR 2739, [2004] Inquest LR 96 at §47 and §49.

Safe conclusions in inquests: the beginning of the end for Galbraith Plus?

Written by: Aaron Rathmell
Published: 01 February 2023

R.(Police Officer B50) v HM Coroner for East Yorkshire and Kingston Upon Hull **[2023] EWHC 81 (Admin)**

This case raised two very different questions of 'safety'.

The first, to be decided by police firearms officers:

A man was in the street carrying an axe and walking with purpose. Police were aware the man had at least some mental health illness. He had not injured anyone, or directly threatened anyone. But he did not stop when police asked him to, or indeed after they Tasered him.

How close should police let a mentally ill, unpredictable man with an axe get to other persons on the street? To what extent should police risk their own safety, getting close enough to disarm him? For how long was it safe to permit this scenario to run?

Officer B50 ultimately discharged his firearm into the man's back. The bullet hit him, but he did not stop. B50 shot a second time, again in the man's back, and then wrestled him to the ground. Sadly the man died.

The second question of 'safety' was for the coroner, and ultimately the Divisional Court:

Was it safe to leave to an inquest jury the option of a conclusion of unlawful killing?

That would require the jury to answer one or both the following questions in the negative: *did the officer honestly believe that the force he used was necessary? Was that force reasonable, in the circumstances as the officer honestly believed them to be?*

At the inquest, B50 – supported by his separately represented Chief Constable – made a *Galbraith* 'plus' submission: the coroner should not leave to the jury the option of an unlawful killing conclusion, because there was insufficient evidence to support it. Perhaps not 'no' evidence; but insufficient evidence. B50 had undoubtedly been faced with a risk to the public, and he was undoubtedly seeking to protect the public. Why else would he have shot the man when he did?

But the coroner did leave unlawful killing to the jury, and that is the conclusion they reached.

The fact that the deceased had been shot in the back, and had not posed an immediate threat to anyone at that time he was shot, was undoubtedly significant in the analysis.

The judicial review

B50 challenged the inquest by judicial review, on the grounds that the coroner had not applied the *Galbraith* 'plus' test correctly and in any event his summing up was so defective as to render the jury's unlawful killing conclusion unsafe.

The Divisional Court (Stuart-Smith LJ and Fordham J) rejected the claim. See especially (with emphasis added):

"[81] Although B50 points to the role of the 'plus' part of the [Galbraith] test as providing a "more subjective filter" than the first limb, comprehending situations where the interests of justice require a particular conclusion not to be left to the jury, we are not able to identify ***any*** *feature of the case that required unlawful killing not to be left to the Jury despite there being a sufficiency of evidence …"*

"[87] The strength or weakness of the evidence relied on both by B50 and by the Family ***depends on the Jury's view of the reliability of the witnesses*** *and, in particular, of their view of the reliability of B50 and [another officer], both of whom they were able to observe in detail as they gave their evidence …"*

"[88] … we are unable to identify anything, either evidential ***or*** *arising from the process of the inquest* ***or*** *otherwise, that suggests (far less shows) that it would not be* ***safe*** *for the Jury to reach such a conclusion. Adopting the compendious approach, this was a case where it would be safe for the Jury to come to conclusion that there had been an unlawful killing. Whether we would agree with such a conclusion or whether we think such a conclusion would or should have been more likely than not is not merely irrelevant but an impermissible trespass into the proper province of the Jury."*

As to the coroner's summing up, this was acknowledged by all to be sub-optimal in some respects, and overly long, but not so defective as to give rise to a risk of an unsafe conclusion [101].

That is the case in a nutshell.

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But of particular interest to inquest practitioners will be the detailed analysis by the Divisional Court of the origins and scope of the *Galbraith* 'plus' test.

Galbraith evolves

The effect of the 'classic' *Galbraith* test, in a criminal trial, is that the judge should withdraw a case from the jury if – and only if – there is no evidence upon which a jury could 'properly' convict. That is an evidential test, intended to preserve the constitutional function of the jury.
Applying the *Galbraith* test to inquest proceedings, Lord Woolf said in *R. v HM Coroner for Exeter and East Devon ex. parte Palmer* [2000] Inquest LR 78 that "*The coroner's duty is only to leave to a jury those verdicts which it would be safe for a jury to return. He is under a duty not to leave to a jury a verdict which it would be unsafe for them to return. To that extent he acts as a filter to avoid injustice*".

And from that judgment evolved the *Galbraith* 'plus' test.

To cut a long story short, in *R. (on the application of the Secretary of State for Justice) v HM Deputy Coroner for the Eastern District of West Yorkshire* [2012] EWHC 1634 (Admin), Haddon-Cave J said:

"[23] It is clear, therefore, that when coroners are deciding whether or not to leave a particular verdict to a jury, they should apply a dual test comprising both limbs or 'schools of thought', i.e. coroners should (a) ask the classic pure Galbraith question "Is there evidence on which a jury properly directed could properly convict etc.?" (see above) ***plus*** *(b) also ask the question "Would it be safe for the jury to convict on the evidence before it?". The second limb, arguably, provides a wider and more subjective filter than the first in certain cases. In my view, this extra layer of protection makes sense in the context of a coronial inquiry where the process is inquisitorial rather than adversarial, the rights of interested parties to engage in the proceedings are necessarily curtailed and coronial verdicts are at large" (emphasis in original)."*

That approach has been endorsed and applied since. It is currently reflected in the Chief Coroner's Law Sheet No.2.

Has *Galbraith* plus had its day?

But in B50 the Divisional Court did not endorse that approach. See for instance:

"[37] It may reasonably be doubted whether Lord Woolf intended to add anything of substance to the test in Galbraith …"

"[38] … it is not obvious that Lord Woolf was seeking to add some additional test …"

As to the statement of the test by Haddon-Cave J in the West Yorkshire case, the Divisional Court said:

"[56] We observe that the outcome in that case did not turn on that point, because there was a misdirection on the Galbraith test in any event".

Nevertheless, following a close review of the leading High Court and Court of Appeal decisions, the Divisional Court concluded that it was bound to acknowledge that the *Galbraith* 'plus' test was something different – even if only slightly – to the *Galbraith* test applied in criminal trials. See the following passages in particular, with emphasis added:

"[64] As this review of the authorities shows, it is established by authority that is ***binding*** *upon us that there is* ***some (if small) distinction*** *between the position of a coroner deciding what verdict to leave to a jury after hearing all the evidence and of a judge considering whether to stop a case after the conclusion of the prosecution case. The distinction flows from the differences in process between the two jurisdictions, as explained by Lord Woolf in Douglas-Williams at 348-349 and Collins J in Anderson at [21]-[22]: see [41] and [44] above.* ***Although the Court of Appeal has identified considerations of safety as relevant to the coroner's decision, there is limited guidance from the Court of Appeal about what should inform those considerations.*** *Though he used the word "safe" at [46] of Palmer Lord Woolf MR provided no guidance in Palmer; and such guidance as he gave in Douglas-Williams suggested that questions of safety would involve considerations that were not directly related to the sufficiency of the evidence: see the italicised passage set out at [41] above. We reiterate that in Galbraith itself Lord Lane emphasised that "safe" and "unsafe" can mean sufficiency or insufficiency of evidence on which a jury could properly reach a guilty verdict. In contrast, Bennett suggests that* ***the concept of safety is an evidential one: see [54] above.***"

*"**This seems to us to be in accordance with conventional principle** and, in almost all cases, to provide the answer to Leveson J's rhetorical question: on the face of it, if a verdict is (properly) open to the (properly directed) jury on the evidence how can it be said to be in the interests of justice that it not be left for the jury to consider? **Any other approach, save for one based upon the wider interests of justice as suggested in Douglas-Williams runs straight into the risk of usurping the proper function of the jury**. This risk is, to our minds, accentuated in the light of Maughan now that all short form conclusions, including suicide and unlawful killing, may now be reached on the balance of probabilities: see the Chief Coroner's Leeming Lecture delivered on 22 July 2022, at paragraph 51."*

*"[65] We are not strictly bound by other first instance decisions, but should follow them unless convinced that they are wrong. **We doubt whether we would have formalised the "Galbraith plus" test as was done in the West Yorkshire case;** but it has been endorsed by subsequent first instance decisions even though the parameters of the "plus" element have not been made clear. **We are not convinced that the formulation is wrong; but the devil is in the detail** of what may render it unsafe to leave a conclusion to the jury in a case where, without usurping the function of the jury, it appears that there is evidence sufficient to enable a properly directed jury properly to return that conclusion. **What is clear is that it is not open to a coroner, in a case which passes the classic Galbraith test of evidential sufficiency, to withdraw a conclusion under the guise of lack of "safety" just because they might not agree with a particular outcome, however strongly.** While being fully alert to the need for the coroner (and the court) to act as a filter to avoid injustice, we agree with the observation of Pepperall J that "where there is evidence upon which a jury properly directed could properly reach a particular conclusion or finding then it is **likely to follow** that the jury could safely reach such conclusion or finding." **Likely but not inevitable**; and, on present authority, it appears that the categories of consideration that could (at least in theory) render it unsafe to leave a suitably evidenced conclusion to the jury are **not closed**."*

One cannot help but notice that the words proper/properly are used more than 60 times in the Divisional Court's judgment (including quotes from other decisions) and appear in every variation of the *Galbraith* tests. 'Proper' is not a precise word; it gives scope to import subjective notions of appropriateness into an otherwise rigorous-sounding test.

Nevertheless, the analysis by the Divisional Court is impressive and it will be helpful to coroners and those making submissions to them on what short form conclusions may be left to the jury. The *Galbraith* 'plus' test remains. A coroner may exercise a discretion not to leave a conclusion which would be unsafe (erroneous, confused, unjust). But the Court has focused minds on the need to relate the concept of safety closely to the evidence, and ultimately to respect the function of the jury.

For those who believe that juries may sometimes not make the best decisions, that is the system we have. And it should not be forgotten that it is the jury that hears and sees the evidence in court, and lives in the communities where the events the subject of inquests take place.

Now that the lower degree of certainty applies (more likely than not, *R.(Maughan) v HM Senior Coroner for Oxfordshire* [2021] A.C. 454) it would not be surprising if there were more unlawful killing conclusions in inquests in the future.

Will the stigma of such conclusions be as powerful as it has been in the past, if they become more common? Will such conclusions carry the same weight with decision-makers in the Crown Prosecution Service?
Will the first type of safety question, posed at the outset of this blog, now be considered even more anxiously by firearms officers, at heightened risk of a manslaughter conclusion?

Keeping it simple: Article 2 inquests are a relatively summary process

Written by: Scott Matthewson
Published: 28 October 2022

***R (Morahan) v HM Coroner for West London and others* [2022] EWCA Civ 1410**

After a flood of Article 2 decisions in the past few years many will be relieved to learn that the Court of Appeal have firmly rejected the challenge in *Morahan* (so there is no new law to get to grips with), whilst at the same time sending out a stern message to lawyers that these Article 2 arguments are getting out of hand!

We should remember that *"an inquest remains an inquisitorial and relatively summary process. It is not a surrogate public inquiry."* Inquests are becoming increasingly legally complex which the Court deprecated as leading to *"lengthy delays....a substantial increase in the length with associated escalation in the costs of involvement in coronial proceedings"*.

Additionally, the implications of Article 2 engagement are limited – whether it is engaged or not the scope of the inquiry will be the same. The availability of legal aid is the main driver for applications for Article 2 engagement but that should not affect the Court's determination of the law.

Facts

Ms Morahan was a voluntary psychiatric patient who had gone AWOL from hospital and was later found dead at her home having ingested recreational drugs. There was no evidence to indicate that she intended to take her life.

The family (Ms Morahan's sister), raised three grounds of appeal, namely that the Divisional Court should have concluded that:

1. The Article 2 operational duty was arguably owed by the hospital trust ('the Trust').
2. An automatic duty to hold an Article 2 compliant inquest arose.
3. There was an arguable breach of the operational duty.

Ground 1: no arguable duty

The Court of Appeal upheld the first instance reasoning of Popplewell LJ describing it as "unassailable". The Court repeated the summary provided by the Divisional Court, and confirmed that there was no operational duty to protect Ms Morahan from the risk that had actually killed her – that is the risk of accidental death due to taking illicit drugs. She was a voluntary patient and the factors identified in *Rabone* were not satisfied.

An accidental death from the recreational use of drugs by a voluntary patient who was genuinely at liberty to come and go was far removed from the circumstances in *Rabone*, where the very purpose of being in hospital was to protect against the risk of suicide. There was not a foreseeable real and immediate risk of overdose. There was no history of accidental overdose. That a period of abstinence in hospital may have increased Ms Morahan's risk was insufficient.

The fresh expert evidence the family sought to introduce from a clinical pharmacologist to support the increased risk of overdose after abstinence was not admissible, but even if it had been the Court considered that it did not support the existence of a real and immediate risk of death for the purposes of Article 2, stating that:

"The sad reality was that, as a long-term drug user, she was at risk, even high risk, of serious harm and accidental death at some stage if she reverted to using drugs. 'Real and immediate risk' as a Strasbourg term of art is much more specific."

Ground 2: no automatic duty in these circumstances

The family also argued for an automatic engagement of Art 2, rather optimistically, suggesting that the death of a voluntary psychiatric patient, wherever they die, required an Article 2 compliant inquest. The Court quickly dismissed this as being a proposition without any authority.

The House of Lords and Supreme Court had made it clear that domestic courts should keep pace with Strasbourg jurisprudence but should not get ahead of it.[1]

The automatic investigative obligation only arises where the death falls into a category which necessarily gives rise to the possibility of a substantive breach (as is the case with prisoners or voluntary patients being treated to manage suicide risk, like Ms Rabone). This was "*self-evidently*" not the case with a voluntary patient at liberty to leave the hospital and in respect of all causes of death.

As no arguable duty arose, it was not even necessary to consider the appellant's third ground.

Take aways

The decision essentially upholds the Divisional Court's decision for the same reasons. It again emphasises the need to consider with respect to what risk a duty was owed, as previously expounded by the Lord Chief Justice in *Maguire* ([2020] EWCA Civ 738).

The Gordian Knot of legal aid and Article 2

The Court was clearly frustrated that legal aid considerations were leading to attempts to stretch the boundaries of Article 2 beyond their appropriate limits. The Court referenced the range of coroners' cases that have come before the High Court and Court of Appeal in recent years which indicate that the summary nature of the inquest regime is being overlooked. Unless legal aid ceases to be so reliant on the engagement of Article 2 – unlikely – this legal pressure will continue. Unfortunately, this in turn leads to more case law, making inquests more legalistic and therefore less accessible to those families who do not have the benefit of legal aid and more costly for the legal aid regime in relation to those cases that do qualify. There is, as yet, no simple solution to this apparently intractable problem.

The family is considering appealing to the Supreme Court. Given the seniority of the bench (including the Lord Chief Justice), it remains to be seen whether the Supreme Court will grant permission.

Frances McClenaghan and Bridget Dolan KC of Serjeants' Inn Chambers advised and represented the Commissioner of Metropolitan Police in this case.
You can watch the Court of Appeal hearing online.

[1] See *R (Ullah) v. Special Adjudicator* [2004] 2 AC 323, *R (Al-Skeini) v. Secretary of State for Defence* [2008] 1 AC 153 at [106] and *R (AB) v. Secretary of State for Justice* [2022] AC 487 between [54] and [59]).