Neutral Citation Number: [2026] EWHC 634 (Admin)

Case No: AC-2025-LON-001037

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 17th March 2026

Before:

THE HONOURABLE MR JUSTICE SWEETING

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Between:

Emerald Josephine TOOGOOD	**Claimant**
- and -	
	Defendant
HM Senior Coroner for the Area of Somerset	

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- -

The **Claimant** appeared in person
Bridget Dolan KC (instructed by **Somerset Council**) for the **Defendant**

Hearing dates: 17th February 2026

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Approved Judgment

This judgment was handed down remotely at 11am on 17.03.2026 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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Mr Justice Sweeting:

Introduction

1. This is the Claimant's application for judicial review of the conclusion reached by the Senior Coroner for Somerset ("the Coroner") following an inquest into the death of the Claimant's father, Mr Joseph Toogood. The Claimant appeared in person to present her case. The Senior Coroner was represented by counsel but attended the hearing in person.

2. In Part 3 of the Record of Inquest the Coroner set out the following findings in respect of when where and how Mr Toogood died:

> "Joseph Robert Baker Toogood, aged 72, was pronounced deceased at his home address on the 29th February 2024. He had deliberately and intentionally ended his life by a self-inflicted shotgun wound to his head. Joe was a lifelong cattle farmer and had recently retired and sold his herd. On the evidence, the injury was inflicted on the 28th February 2024, which was a significant date for him."

3. In Part 4 of the Record of Inquest, she went onto conclude that Mr Toogood's death was the result of 'suicide'.

The Claimant's Case

4. The Claimant argues that the Coroner's conclusion was not reasonably open to her on the evidence. She submits that the Coroner failed to grapple with the possibility that Mr Toogood was psychiatrically unwell to the point of lacking the capacity to form an intention to kill himself. Whilst Mr Toogood was not under psychiatric care and received no specialist assessment prior to his death, there was nevertheless a rapid and unexplained deterioration in his mental state which, it is said, had worsened in the two weeks before his death.

5. Mr Toogood discussed his health and medication with his close family yet there was no mention of suicidal ideation nor was this a feature of the medical records. He had been actively pursuing medical assistance, attending multiple appointments for B-12 injections and visiting A&E for abdominal pain shortly before his death. He had, at times, been a heavy user of NHS services when he had a medical need. As far as the family were concerned there was no obvious work, financial or relationship causes that might have led him to take his own life. He was already retired from farming by the time of his death.

6. Contrary to a suggestion made at the inquest, he had not put his affairs in order after selling his animals and in fact had bought a full tank of farm diesel. He had also bought a lottery ticket for the night on which he died. These actions were consistent, it was argued, with someone who was still forward looking rather than contemplating suicide.

7. The Claimant also advanced the possibility that there was accidental discharge of the shotgun. She suggests that Mr Toogood may have loaded the shotgun indoors because of cold weather conditions, intending to then go outside, and may have accidentally

discharged it while lifting it from an upright position, possibly having tripped on an electrical flex or similar obstacle on the floor. She argues that this possibility was sufficiently realistic that the Coroner could not rationally discount it.

8. The Claimant contends that the Coroner failed to ask relevant and necessary questions of the medical expert in relation to the possibility of psychosis affecting Mr Toogood's capacity to form an intent to kill himself. She submits that this omission amounted to a procedural irregularity which undermined the fairness and adequacy of the inquiry. She also suggests there was a lack of evidence from a properly qualified forensic firearms expert, particularly in relation to whether accidental discharge could be excluded.

9. The Claimant challenges aspects of the Coroner's summing up, alleging that certain passages were inaccurate or speculative, and that the Coroner's assessment of intent was perverse or inadequately reasoned. She argues that the evidence did not justify a positive finding that Mr Toogood intended to end his life and that the appropriate conclusion was a narrative determination reflecting uncertainty and an unknown intent.

The Defendant's Case

10. The Coroner maintains that she conducted a full, fair, and lawful investigation. She relied upon the physical and scientific evidence, which indicated that the firearm had been purposefully loaded behind locked doors, that the shot was discharged at very close range, and that the injury was located at a recognised site of election for self-inflicted firearm injuries.

11. The Defendant also relies on the medical evidence. Mr Toogood was seen by two healthcare professionals in February 2024, on 8 February by Dr Corfield and 19 February by a nurse; neither identified any concern suggestive of psychosis or lack of capacity. Toxicology revealed no impairment. A Consultant Psychiatrist reviewed the medical records and found no evidence supporting acute psychosis or mental incapacity.

12. The Defendant states that she expressly accepted the family's evidence of Mr Toogood's low mood but concluded that the totality of the evidence permitted an inference that Mr Toogood retained capacity and intended the natural and inevitable consequence of discharging a shotgun beneath his chin. She states that she did not presume intent but drew reasonable inferences from established facts.

13. The Defendant denies any procedural irregularity. She maintains that the expert was questioned appropriately, that further questioning was unnecessary, and that her summing up accurately reflected the evidence. She notes that coroners are not required to call every conceivable witness or explore every theoretical possibility, and that her approach was consistent with the inquisitorial nature of the jurisdiction.

Judicial Review

14. Permission to apply for judicial review was granted at a renewal hearing on limited grounds, namely the alleged failure to ask appropriate questions of the medical expert (Ground (b)), and the rationality of the Coroner's findings concerning the mechanism of death and Mr Toogood's intent (Grounds 1(c) to 1(f)) as follows:

1c. the Coroner's summing up was inaccurate and speculative;

1d. the Coroner's findings on 'intent' were perverse;

1e. there was sufficient evidence to conclude the inquest with a narrative conclusion (shotgun injury with intent unknown);

1f. there was insufficient evidence to support the Coroner's finding that the death was intentional.

15. Thus, in summary the Claimant contends that the conclusion of suicide was wrong on the evidence available and that the process by which it was arrived at was flawed. The Coroner maintains that the investigation was compliant with her statutory obligations under the Coroners and Justice Act 2009 and that the conclusion reached reflected a proper evaluation of the evidence, including the expert, medical and circumstantial material.

16. The Claimant, helpfully, provided a transcript of the evidence and summary reasons given by the Coroner which, it was agreed, was broadly accurate. She had also prepared a comprehensive electronic and paper bundle and a bundle of authorities.

The Factual Background and Evidence

17. The inquest took place on 18 December 2024. The evidence comprised oral evidence from three witnesses, a written psychiatric expert report, admitted under rule 23 of the Coroners (Inquests) Rules 2013, and ten witness statements.

18. The Coroner gave an extempore decision stating her factual findings. In broad terms she inferred Mr Toogood's suicidal intent from the factual and circumstantial evidence, to which I now turn. Whilst I may not refer to each document or statement within the body of evidence before the Coroner, that does not mean they have not been considered for the purpose of this judgment.

19. Mr Toogood, died at his home on or around Wednesday 28 February 2024 from a wound to the head inflicted by the discharge of a shotgun beneath his chin. The pathologist was unable to give a precise time of death within the period bracketed by Mr Toogood's last interaction when alive and the discovery of his body. There was no third-party involvement.

20. Mr Toogood was found by a neighbour who broke into his house shortly before midnight, with the permission of the family and with the police present. Mr Toogood was lying in the hallway of his home with a large wound to his head and a significant quantity of blood around it. The first police officer to enter described him as having "his legs folded under him". Another officer, in evidence at the Inquest, said that "his legs were tucked under behind him". This appears to have been accepted as an accurate observation since counsel for the Claimant at the Inquest, when asking questions of Dr Meehan, (the pathologist), asserted that: "The deceased was found with his legs beneath him."

21. The shotgun was found in close proximity to the body. The weapon was a double-barrelled, 12 bore, side-by-side shotgun which was at least 50 years old. Cartridges had

been loaded in both barrels, and one had been discharged. Mr Toogood had spent his working life as a farmer and was known to be familiar with firearms. He had a firearms' licence. He owned another shotgun, which was not in a usable condition, as well as a 22-calibre rifle. Prior to his death it appears that he had been researching the servicing or recommissioning of old shotguns. Mr Toogood was found close to the downstairs gun cabinet which contained his rifle. He was over 6 feet tall and right-handed. "Gun-residue", the remains of propellant from the discharged cartridge, was found on his left hand.

22. The post-mortem reports concluded that the fatal shot was fired at very close range. Toxicology reports identified no alcohol or drugs in his body. When asked if the shotgun was likely to have been close to the chin before discharge Dr Meehan replied: "If the shot was significantly away you'd actually have pellets all over the face whereas actually it was actually likely to be very close." It was common ground that there was an electrical flex in the hallway which ran to an electric heater in the adjacent bathroom. The Claimant suggested that this could have been a tripping hazard. Dr Meehan described the possibility of a trip and accidental discharge along the axis of the fatal wound as possible but not probable. In his view a discharge of the weapon in such a configuration "stretched possibility", so that accidental firing was unlikely.

23. The Coroner obtained evidence from the firearms officer who had attended the scene.

24. It was not in issue that Mr Toogood must have loaded the weapon himself. As to why he did so, Mr Toogood was (according to the Claimant) dressed as if he meant to go outside and was wearing blue overalls according to the police. The Claimant suggested that he might have intended to go into the yard to shoot a poisoned rat rather than see it suffer, but there was no direct evidence to support this hypothesis.

25. Police Constable Megan Day, who was first on the scene, said of the shotgun "the barrel was broken as if it was going to be loaded" and it was "propped up next to him". This description is not easy to reconcile with the use of the shotgun to inflict the fatal wound but, in any event, it is inconsistent with the evidence of the firearms officer who attended later that night and whose focus was on the weapon. He said:

> "I then inspected the shotgun in order to make it safe. On inspection, the firearm was in good condition with the barrel closed. However, I cannot recall what position the safety catch was in. I then broke open the barrel of the shotgun, where I located two cartridges inside. I inspected both cartridges and identified that one of these cartridges had been used and discharged while the other remained unused. I removed both cartridges which I passed to the local officers for seizure. Following my brief inspection of the shotgun, it was then made safe and passed on to the local officers for seizure. I believe that the firearm was in a fully working condition and I did not identify anything wrong with it."

26. In his evidence at the Inquest, Detective Constable McGregor, who attended the scene to investigate whether there were any suspicious circumstances, described the shotgun as lying on the floor with its barrel on a toolbox.

27. Police Constable Ashman was on patrol with Police Constable Day and recorded a number of short statements from witnesses at the scene. These included the following information attributed to a neighbour, Mr Bond:

> "- Next door neighbour of deceased. Knows family very well. Last saw him 27/02/2024 in the mid-morning in his garden. Joe wasn't very talkative. He hasn't been for a long time. He used to talk for hours and it would be hard to get away but for the last few months he has been different. He was aware that Joe wasn't in a good place with his mental health. He took the decision around a month ago to sell all of their cows at the farm. Has been a family farm handed down for many generations so was very unlike him to do this. 28/09/2024 is his mother's death anniversary. Used to talk about his parents a lot."

28. Mr Toogood's sister, Valerie, is recorded as having told the police officer that:

> "On the 13th January Joe sold his cows which is something he has been talking about for some time but they never thought he'd do as it was a family farm. Last saw Joe on 25/02/2024. He had dinner at her house. They then spoke on the phone on the evening of the 26/02/2024. The phone call lasted 1min 10secs. It was very brief. Asked if he was alright, if he has eaten and if he has been out. He said that he had been around. Valerie didn't know what else to talk about so the phone call ended. Valerie said that her sister Susan had sent Joe a parcel and she got a photo confirmation that he had received it at 10:30hrs on the 28/02/2024. He takes diazapam and has also started some anti-depressants within the last week but she doesn't think that he has been taking them. He said the doctor will tell me off because I haven't been taking my statins. He gets very nervous and anxious about little things. He worries about everything. He has been diagnosed with depression. 28/02/2024 was the 18-year anniversary of their mum's passing"

29. Mr Toogood had recently retired from farming. As mentioned earlier, he had made some ordinary purchases shortly before his death, including a lottery ticket and a full tank of diesel. No suicide note was found.

30. In the weeks prior to his death, Mr Toogood was reported by family members to have been experiencing low mood and increased psychological strain. He attended his GP, Dr Corfield, on 8 February 2024 and was seen again by a nurse on 19 February 2024. Mr Toogood had been treated by his GP intermittently since 2006 for low mood and anxiety, which historically had responded to medication. In February 2024, shortly before his death, he presented with "flat affect", leading to a prescription for Mirtazapine, an antidepressant. Toxicology later showed no trace of this medication, suggesting that he had not taken it.

31. Neither medical professional recorded any concern about his capacity or noted any indications of psychosis. Dr Corfield's witness statement said:

> "He presented with weight loss, anxiety and low mood and had been prompted to attend by his daughter who was concerned that he may have Parkinson's disease. His daughter had previously spoken to a colleague of mine earlier that week on the telephone and a face-to-face appointment with me was arranged as a result. He told me that his daughter had raised a concern that he might have Parkinson's disease and although he had a flat effect and moved slowly there was no evidence of a tremor. I was aware of Joseph's previous history of episodes of low mood and anxiety and questioned him directly about suicidal intent. He denied this and smiled at me at that point. We agreed that he would start taking Mirtazapine 15mg tablets once daily again. (These tablets are an antidepressant and anti-anxiety tablet that he has previously taken with good effect). We agreed that he would have some blood tests to repeat a test that had been done a few weeks earlier and found low vitamin B-12 and have a review of this and his mood with me when the results were available. He did make an appointment for the blood test and for the follow up visit to see me but died before these were due."

32. The family had raised a concern with the Coroner that Mr Toogood may have been affected by hypothyroidism (a condition where the thyroid gland fails to produce enough thyroid hormone). The Claimant said that around February her father had told her that he had stopped taking his thyroid medication at Christmas because one of the side effects is excessive sweating and he was experiencing discomfort with his skin. Her contention was that it was possible that by the end of February, he would likely have been suffering from hypothyroidism and that a 'common symptom' of hypothyroidism, according to an NHS leaflet, is "difficulty concentrating or thinking clearly." She coupled this with the observation that her father had also stopped taking opioids (since he had ceased manual work at Christmas), given to him on a rolling prescription, so that he was likely to have been experiencing withdrawal symptoms.

33. Since severe depression can also lead to difficulties with weighing up information, all of these factors taken together meant, the Claimant submitted, that there was "proper doubt" as to whether her father had capacity at the time of his death. She pointed to his agitation when seen by the nurse in February and evidence from the family of sleep disturbance, shouting, hallucinations and unusual behaviour.

34. In his oral evidence at the inquest, Dr Corfield confirmed that Mr Toogood's thyroid blood test in November 2023 was normal, indicating that he was compliant with his medication at that time. As far as Dr Corfield was concerned, he did not know whether Mr Toogood later stopped taking his thyroid medication, or whether his thyroid levels had fallen before death.

35. Dr Corfield explained that significant hypothyroidism can cause mood changes, but he emphasised this was a general possibility, not something he could confirm had occurred in this case. His discussions with the family, after Mr Toogood's death, about psychological effects were therefore speculative. Dr Corfield made clear that he was not qualified to diagnose psychosis and did not assess Mr Toogood in the period immediately before death. He could not say whether an acute psychotic episode occurred or whether thyroid dysfunction contributed to any such state. He also said that

no hallucinations were reported to him at the final consultation on 8 February, and he could not link later-reported hallucinations to thyroid issues or medication withdrawal. Dr Meehan, when asked, appears to have been sceptical about whether hyperthyroidism could have played any significant role but emphasised the limited ambit within which he could offer any opinion on the topic.

36. In response to pre-inquest representations from the family, the Coroner obtained an expert report from a consultant psychiatrist, Dr Cheruki, who was asked to review the medical records. She provided a written report addressing issues raised by the family. She confirmed a history of anxiety and low mood, typically associated with stressful events which was responsive to treatment. She noted increased anxiety and possible rumination in the weeks prior to death but concluded there was no clear evidence of hallucinations or psychosis. She emphasised the inherent limitations in conducting any form of post-mortem psychiatric assessment without direct evaluation of the patient.

37. She found no evidence suggestive of acute psychosis on her review of the medical records. She noted that Mr Toogood was taking levothyroxine to treat hyperthyroidism, but this was "not likely to lead to an acute psychosis." She explained that hypothyroidism may, but rarely does, lead to acute psychosis in the form of myxoedema psychosis. She had not come across any cases of psychosis related to withdrawal from levothyroxine over the last 17 years. The Claimant's criticism of this conclusion is that it was based upon an incomplete review of the relevant material since, she argued, it ignored important evidence of context which could only be given by the family and which was not brought to the attention of the expert; hence Ground 1b that the questions to the expert should not have been confined to the medical material.

38. In reaching her overall view of the evidence in relation to Mr Toogood's mental wellbeing the Coroner found that:

> "the evidence of the family was that Joe was different in the lead up to his death. and it did appear to be a new decline in his mental health following changes in his circumstances."

39. The Coroner adopted a neutral stance in response to the present claim, consistent with established authority, but provided detailed grounds and evidence to assist the Court by setting out the relevant factual background, law, and procedural history.

40. In her witness statement for the hearing before me, the Coroner succinctly summarised the reasoning she had set out at the conclusion of the inquest:

> "The foreseeable and highly likely outcome of discharging a shotgun under one's chin would be death. It was known that Mr Toogood was not intoxicated at the material time, from the postmortem toxicology results. Even if he was in poor mental health there was no evidence that he lacked the mental capacity to form the relevant intent. I concluded that Mr Toogood's intention in self-inflicting the shotgun injury had, on the balance of probabilities, been to end his own life. A Coroner is only required under s.5 Coroners and Justice Act 2009, to determine the four statutory questions of who the deceased was, where they died, when they died and how the deceased came by their death. A

> Coroner is not required to determine why a person might take their own life. However in Mr Toogood's case I considered that the information provided by his family regarding his deterioration in mental health was consistent with the proposition that his death was from suicide. I therefore recorded a conclusion of 'suicide."

The Legal Framework

41. As the Coroner had said in her witness statement, the statutory duties of a Coroner, as prescribed by sections.5 and 10 of the Coroners and Justice Act 2009, require findings as to identity, time, place, and how Mr Toogood came by his death. The inquiry is inquisitorial in nature, directed to establishing the essential facts of the death in the public interest. The term "how" is concerned with the means by which death occurred rather than its wider circumstances (see *R v North Humberside Coroner, ex p Jamieson* [1995] QB 1).

42. The scope of an inquest, including the evidential breadth and choice of witnesses, lies within the Coroner's discretionary judgment. A reviewing court will intervene only on public-law grounds, applying the familiar principles of irrationality under *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* (1948) 1 KB 223, and *CCSU v Minister for the Civil Service* [1985] AC 374.

43. Appellate courts are slow to disturb decisions as to scope or evidential sufficiency. In *Coroner for the Birmingham Inquests v Hambleton* [2018] EWCA Civ 2801; [2018] Inquest LR 239, the Court of Appeal observed at [48]:

> "A decision on scope represents a coroner's view about what is necessary, desirable and proportionate by way of investigation to enable the statutory functions to be discharged. These are not hard-edged questions. The decision on scope, just as a decision on which witnesses to call, and the breadth of evidence adduced, is for the coroner. A court exercising supervisory jurisdiction can interfere with such a decision only if it is infected with a public law failing. It has long been the case that a court exercising supervisory jurisdiction will be slow to disturb a decision of this sort (see Simon Brown LJ in *Dallaglio* at [155] cited in [21] above) and will do so only on what is described in omnibus terms as *Wednesbury* grounds. That envisages the supervisory jurisdiction of the High Court being exercised when the decision of the coroner can be demonstrated to disable him from performing his statutory function, when the decision is one which no reasonable coroner could have come to on the basis of the information available, involves a material error of law or on a number of other well-established public law failings"

44. Expert evidence is to be deployed only so far as is necessary to enable the Coroner to answer the statutory questions, consistent with the investigative duty under section 1 of the 2009 Act (see the Chief Coroner's Guidance, at Ch. 14).

45. As to suicide, the governing law remains that articulated by the Supreme Court in *R (Maughan) v HM Senior Coroner for Oxfordshire* [2020] UKSC 46. Two elements are

required: (1) that the deceased intentionally performed the act that caused death; and (2) that they intended thereby to kill themselves. Although no statutory definition exists, these common-law elements continue to bind coroners. Following *Maughan*, all inquest findings, including suicide, are determined on the civil standard of the balance of probabilities. Whilst the Claimant's grounds might suggest that she was challenging, as a proposition of law, that a finding of suicide requires fatal intent, she did not advance that submission at the hearing. Her position was more, by way of observation, that reported cases in this area demonstrate that issues as to intent do arise in doubtful cases, and that their determination by Coroners was likely, in her view, to have been the source of much anguish for the families involved.

46. She pointed to the fact that the Chief Coroner's Guidance for Coroners on the Bench (published Jan 2025) notes (chapter 15, at paragraph 71) states that the Office of National Statistics (ONS) will record death as suicide when there is a finding of "intentional self-harm". However, the ONS definition of suicide includes deaths from intentional self-harm for persons aged 10 years and over, and deaths caused by injury or poisoning where the intent was undetermined. Thus, in her written renewal grounds she argued that it was irrational and unnecessary to continue to insist on finding suicidal intent in order to establish a short form conclusion of suicide and that societal attitudes had shifted. Whatever the merits of that argument as a matter of proposed legal reform, it does not reflect the law as it stands and could not be a basis for a review of the Coroner's conclusion.

47. The Claimant's argument on the facts of the present case was that "it was necessary to consider and weigh the various possibilities in an unprejudiced way". Whilst this is a truism, it is of course premised on the submission that there was prejudice because the Coroner was wrong to conclude that she could reach any decision at all about Mr Toogood's intent where, the Claimant asserted, there were non-suicidal possibilities which could not be discounted.

48. However the Coroner is not obliged to exclude every alternative hypothesis, particularly speculative or remote ones. Earlier authorities (e.g. *Lagos v Coroner for City of London* [2013] EWHC 423 (Admin); [2013] Inquest Law Reports 34) required suicide to be found only if all other explanations were excluded, but this approach was based on the application of the former criminal standard and are no longer compatible with *Maughan*. Authorities requiring the exclusion of all other possibilities pre-date *Maughan, and* the application of the civil standard, and cannot now be reconciled with it. What is required is a determination of what probably occurred, based on the totality of the evidence and the reasonable inferences that may properly be drawn from it.

49. Nevertheless, suicide may not be presumed. There must be some evidential foundation for each element; gaps in the evidence are not to be filled by speculation. Once there is evidence capable of supporting a conclusion of suicide, it is for the coroner to evaluate the weight of that evidence. The coroner may draw inferences from circumstantial matters and is not confined to direct evidence. Such inferences have long been recognised as permissible (see *Lockley v Huntbach* [1994] KB 606). Suicide may be inferred from the mode of death alone. In *R v HM Coroner for the County of Devon, ex parte Glover* (1985) 149 JP 208, taking 25 tablets in a very short space of time by someone who was well aware of the prescribed dose and frequency led to a verdict of suicide notwithstanding the absence of any other evidence of suicidal intent.

50. The current guidance from the Chief Coroner includes the following:

> "A conclusion of suicide should not be avoided (or returned) simply to reflect the wishes of the family. It is the coroner's judicial duty, when suicide is proved on the evidence, to record the conclusion of suicide according to the law and the findings which justify it. It would be wrong, for example, to record an 'open' conclusion when the evidence is clear."

51. The Claimant's submission that the task for the Coroner was to determine whether Mr Toogood had capacity within the meaning of that term for the purpose of the Mental Capacity Act 2005, and that on this issue the Coroner bore a burden of proof was, in my view, misconceived. In the context of an Inquest, the concepts of burdens and presumptions are generally inapposite (see *R (Bryan) v HM Assistant Coroner for Buckinghamshire* [2024] EWHC 26 (Admin)). The coroner's task is to ascertain facts rather than to discharge a burden in adversarial proceedings. Issues of intent, mental capacity, or psychiatric impairment are to be determined by reference to the evidence actually before the coroner, and not on hypothetical or unsubstantiated possibilities. The question for the Coroner was whether at the time Mr Toogood deliberately shot himself, as she found he had, he intended to kill himself.

52. The supervisory jurisdiction of the court is exercised on well-established public law principles, and the decision of a coroner may be quashed only if it is shown to be irrational in the *Wednesbury* sense or otherwise legally flawed. The central question is whether, viewing the evidence fairly and as a whole, the Coroner's finding of suicide was reasonably open to her. A reviewing court will only quash a conclusion if satisfied that no reasonable coroner, properly directing themselves, could have reached it on the evidence. This is a high threshold. Disagreement with the Coroner's evaluative judgment, or the existence of competing interpretations of the evidence, does not suffice. Thus, the question is not whether another coroner might have reached a different conclusion, nor whether the Claimant's alternative construction of events and the conclusions to be drawn from them is logically possible.

Discussion and Conclusions

53. The issues for this Court are therefore:

    i) whether any procedural irregularity occurred in relation to the expert evidence; and

    ii) whether the Coroner's conclusion was one that a reasonable Coroner could have reached on the evidence available.

54. Grounds 1(c), 1(d) and 1(f) essentially all concern the Coroner's reasoning on intent. The Claimant maintains that the Coroner's summing up was speculative, that findings on intent were perverse, and that there was insufficient evidence to support a conclusion of intentional self-harm.

55. The Claimant's case rests principally on the contention that accidental discharge could not be ruled out, and that Mr Toogood's mental state may have deprived him of capacity or intention. The Claimant points to various features said to be inconsistent with

suicidal intent, including the absence of a suicide note and evidence of ordinary activities shortly before the death.

56. The Claimant sought to identify factual errors within the Coroner's summing up which, it was said, indicated an absence of rigour in assessing the evidence. The first of these in the Claimant's written submissions, by way of example, was that in the summing up the Coroner said "front and back doors were locked and they had keys on the inside". The Claimant's issue with this statement was that the front door did not have a keyhole on the inside but was a lever lock which was locked once it was closed. It was only the back door which had the key in the lock. This strikes me as hair splitting; the Coroner's point, which she made elsewhere, was that all of the doors and windows were locked. That was plainly the case since forced entry was necessary.

57. In relation to whether the anniversary of his mother's death was significant for Mr Toogood the Claimant submitted: "The family has no reason to think the anniversary is connected to the deceased's death. We do not even know whether the deceased remembered the date". I have already set out the evidence obtained by the police from neighbours and a family member in this respect and it seems to me to be clear that the Coroner was entitled to make the observation she did on the basis of that evidence.

58. In all, I did not find the criticisms of asserted factual errors in the Coroner's summing up to be matters of substance rather than disagreement with her evaluative conclusions and narrative comments, often on points which could not possibly be regarded as determinative of the questions that the Coroner properly answered by reference to all of the evidence.

59. The Claimant's argument that there was speculation and factual error must be considered alongside the scientific evidence, consistent with a deliberate self-inflicted shot; the absence of clinical indicators of psychosis; the psychiatric review; the toxicology findings; and the Coroner's ability to draw reasonable inferences from circumstantial evidence. It is clear that the Coroner was entitled to consider the inherent likelihood of the competing explanations, and that she was not required to exclude every speculative or remote hypothesis advanced. Her findings drew on the totality of the evidence, including the anatomical evidence, Mr Toogood's experience with firearms, the manner of the discharge, the deterioration in his mood, and the absence of any alternative non-speculative explanation. The evidence before the Coroner was consistent with Mr Toogood placing the butt of the shotgun on the floor with the end of the barrel under his chin, held in his left hand, whilst he operated the trigger with his right hand. He may well have been kneeling at the moment of discharge considering the position in which his legs were found (a possibility canvassed by the Claimant although on the basis that he may have been kneeling to reach the toolbox on the floor).

60. The Coroner was required to determine what probably occurred, not to eliminate every remote or speculative possibility. The pathologist's view was that an accidental-discharge was not a plausible explanation for the injuries. The weapon was in working order. The Coroner was entitled to evaluate that expert evidence, and this Court should approach such an evaluative exercise with appropriate restraint.

61. The Coroner's conclusion as to intent rested in part on the inherent nature of the act itself. The discharging of a shotgun beneath the chin is, in ordinary human experience, an act whose natural consequence is likely to be fatal. It was reasonable to conclude

that Mr Toogood by reason of his familiarity with firearms would ordinarily have been aware that what he did would prove to be lethal. The Coroner considered the medical and psychiatric evidence, including the absence of any clinical signs of psychosis or intoxication, and concluded that Mr Toogood retained the capacity to appreciate that consequence. That was a matter of inference, of the sort which coroners are routinely required to draw. There was no evidence that Mr Toogood was in such an advanced psychotic state that he could not appreciate the risk of death or that his intent could not in those circumstances be gauged from the nature of his act. His change in mood and depressed state, noticed by his family and neighbours, may explain his actions rather than suggest psychosis.

62. Ground 1(e) concerns whether the Coroner should have reached a narrative conclusion to the effect that Mr Toogood died from a shotgun injury with intent unknown. Such a conclusion was plainly not appropriate given the Coroner's finding that, on the balance of probabilities, Mr Toogood intended to cause his own death. This ground therefore adds nothing to the other grounds.

63. As to the procedural challenge, it was for the Coroner to determine the nature and extent of the questions necessary to put to the witnesses in the context of the inquisitorial character of an inquest and the breadth of the Coroner's discretion in deciding what evidence is necessary and proportionate. Ground 1(b) concerns whether the Coroner failed to ask necessary or appropriate questions of the psychiatric expert. The material before me indicates that the psychiatrist's report addressed the issues that could realistically be determined post-mortem, and that neither the toxicology nor the GP evidence supported the presence of psychosis or medication-related effects. The Claimant contends that further exploration might have elicited evidence relevant to intent. The mere fact that additional questions might have been asked does not establish procedural irregularity unless the omitted questions were necessary for a fair inquiry. The Defendant maintains that they were not, and there is no evidence that the expert's opinion would have been affected by further questioning.

64. The criticisms of the summing up must also be assessed in context. A coroner is not required to produce a lengthy judgment. The question is whether the reasoning process is discernible and whether the decision falls within lawful bounds. The summing up must be read fairly and as a whole.

Conclusion

65. The issue is whether the Coroner's conclusion of suicide was one reasonably open to her on the evidence, or whether, as the Claimant contends, the conclusion was irrational or procedurally flawed. For the reasons set out above, I am satisfied that the inquest was conducted lawfully and that the Coroner reached a conclusion within the range reasonably available to her without procedural error.

66. The claim for judicial review is therefore dismissed.

END