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Inquest Law Update

Editors: Jenni Richards QC and Josephine Norris

Introduction

Welcome to the first Thirty Nine Essex Street Inquest Law Update, edited by Jenni Richards QC and Josephine Norris.

This update provides an overview of recent case law and developments in the field of inquest law.

One of the highest profile decisions of the past few months was the High Court's decision in December 2012 to order fresh inquests into the death of ninety six victims in the Hillsborough disaster. This is one of a number of recent decisions in which the Court has emphasised the breadth of a coroner's discretion in relation to the procedure and format of an inquest (in this case in a new inquest yet to be held) subject to a requirement of fairness to those with an interest in the proceedings. Also of note is the decision in ***R (on the application of Evandro Lagos) v HM Coroner for the City of London*** [2013] EWHC 423 which reviews the standard of proof for the return of a verdict of suicide. Other recent cases consider the distinction between Article 2 and Jamieson inquests, and allegations of bias. Finally, the Editors draw your attention to the publication of the latest Rule 43 Coroners Rules 1984 Report Summary by the Ministry of Justice and to the progress towards the implementation of the Coroners and Justice Act 2009.

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Case Law Update

Second Inquests

Two recent decisions consider the circumstances in which a fresh inquest will be ordered pursuant to section 13 of the Coroners Act 1988.

In ***Her Majesty's Attorney General v (1) Her Majesty's Coroner of South Yorkshire (West) (2) Her Majesty's Coroner of West Yorkshire (West)*** [2012] EWHC 3783 (Admin), the High Court considered an application brought by the Attorney General for a second inquest into the deaths of the ninety six individuals who died as a consequence of the Hillsborough disaster. This followed a Report of the Hillsborough Independent Panel which was published in September 2012.

Section 13 (1) (b) of the Coroners Act 1988 makes provision for a second inquest where, *"on an application by or under the authority of the Attorney-General, the High Court is satisfied as respects a coroner ....where an inquest has been held by him, that (whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise) it is necessary or desirable in the interests of justice that another inquest should be held."* By virtue of section 13 (2), the Court has the power to quash the findings of the original inquest. The Court set out the principles to be applied when considering whether the interests of justice make a further

inquest either necessary or desirable and held as follows at §10:

> *"The interests of justice, as they arise in the coronial process, are undefined, but, dealing with it broadly, it seems to us elementary that the emergence of fresh evidence which may reasonably lead to the conclusion that the substantial truth about how an individual met his death was not revealed at the first inquest, will normally make it both desirable and necessary in the interests of justice for a fresh inquest to be ordered. The decision is not based on problems with process, unless the process adopted at the original inquest has caused justice to be diverted or for the inquiry to be insufficient. What is more, it is not a pre-condition to an order for a further inquest that this court should anticipate that a different verdict to the one already reached will be returned. If a different verdict is likely, then the interests of justice will make it necessary for a fresh inquest to be ordered, but even when significant fresh evidence may serve to confirm the correctness of the earlier verdict, it may sometimes nevertheless be desirable for the full extent of the evidence which tends to confirm the correctness of the verdict to be publicly revealed. Without minimising the importance of a proper inquest into every death, where a national disaster of the magnitude of the catastrophe which occurred at Hillsborough on 15 April 1989 has occurred, quite apart from the pressing entitlement of the families of the victims of the disaster to the public revelation of the facts, there is a distinct and separate imperative that the community as a whole should be satisfied that, even if belatedly, the truth should emerge."*

On the facts, the Court accepted that there was evidence which cast new light on the circumstances surrounding the deaths of the victims. In particular, the Court held that the original inquest had been seriously flawed because of the decision to proceed on the assumption that after 3:15pm all deaths were inevitable. The Court identified four linked consequences of this failing (judgment, §20):

i) There was no investigation as to whether, contrary to the evidence of the pathologists at the original inquest, some of those who died might well have survived if they had been rescued and quickly and properly treated.

ii) None of the activities, or omissions, of those involved in the co-ordination of the rescue process, and the rescue process itself after the first ambulance arrived on the scene, were examined to see whether their actions or omissions may have made a causal contribution to any of the deaths of those who might have survived.

iii) If with proper rescue facilities some of the deceased might have survived, then the question arises whether deficiencies in the police control of this part of the rescue operation may have aggravated the level of police culpability found by Taylor LJ.

iv) If the rescue facilities were inadequate or disorganised, then there may have been a level of culpability in the emergency services extending beyond the police which contributed to at least some of the deaths.

Any such considerations (and the Court recognised that others may occur) were precluded by the imposition of the cut off period.

The Court concluded that there was a body of credible evidence sufficient to justify quashing the original inquest. The Court attached weight to the findings of the Independent Panel who had rejected the unchallenged evidence of the pathologists which had formed the basis of the conclusions of the Coroner, the High Court and the Stuart-Smith Scrutiny whilst noting the importance of the conclusion of the expert pathologist, Professor Crane, that forensic pathologists could even now provide the necessary advice and assistance to enable a coroner to carry out "effective inquests" in relation to the victims.

Notwithstanding the finding that the issue of the 3:15pm cut off was in itself sufficient to justify a second inquest, the Court identified a number of further considerations which reinforced the conclusion that a second inquest was appropriate, namely: the prominence attached to evidence of alcohol consumption among fans; the fact that the inquest jury was ignorant of the extent of the amendments and alterations to the police statements, some of which may have had the effect of concealing evidence relevant to neglect and breach of duty; and the evidence before the Independent Panel revealing the safety concerns as to the suitability of the stadium as a venue.

When ruling that there should be a new inquest, the Court emphasised that it would not be a public inquiry and noted that it would be for the coroner

to decide:

(i) what evidence bears on the questions which the inquest is required to answer;

(ii) the format of the inquest;

(iii) whether Article 2 of the European Convention on Human Rights is engaged in this inquest, and, if so, the form that it should take to address these issues; and

(iv) the state of any investigation being made into possible criminal offences and whether or not that investigation might be prejudiced or held back by the order for an inquest.

However, the Court also expressly recorded in its judgment that they would deprecate the new inquest descending into "the kind of adversarial battle which … scarred the original inquest."

It is of note that whilst the need to vindicate the families of those who died and to respect the memory of each victim was explicitly recognised by the Court, the decisive factors in granting the application for a second inquest were related to the availability of fresh evidence, as uncovered by the Independent Panel Report.

Since the Court's judgment, Lord Justice Goldring has been appointed to act as coroner and has ruled that the inquest will take place in early 2014, without awaiting the outcome of the criminal investigations that are currently underway. The repeal of section 5(2) of the Coroners Act 1998 means that there is no longer an absolute legal requirement for inquests to be held in a particular geographical area. In a ruling dated 2 May 2013 Lord Justice Goldring has confirmed that the inquest will take place in the north west (although not in Liverpool) explaining that:

"In the ordinary course of events, inquests can be expected to take place at a location which is most convenient to the bereaved and other interested persons and witnesses. In this case it is reasonably to be expected that these inquests will also attract considerable and justifiable interest both from survivors and the local community".

His ruling can be read at http://hillsboroughinquests.independent.gov.uk/documents-and-rulings.

In the second recent decision considering the application of section 13, the Court also focused on the availability of new evidence, again in circumstances in which the family members had persisted in their efforts to have a fresh inquest. In ***R (on the application of Markham) v HM Coroner for the Western District of Greater London*** **[2013] EWHC 253 (Admin),** the Claimant brought an application with the Attorney General's *fiat* for a fresh inquest into the death of his son, James Markham, a seemingly healthy music student who collapsed and died on 20 November 2001. The evidence before the first inquest was inconclusive as to the cause of death and the coroner had pronounced a verdict of "unknown natural causes", with the cause of death being "unascertained". Subsequently, his family had blood samples of James's DNA tested which revealed that he had suffered from a genetic fault known as Long QT Syndrome which had caused him to suffer a cardiac arrest. James's father (the Claimant) had applied to have the death certificate amended to reflect the true cause of death but the General Register Office was unable to make the amendment without a fresh inquest as it would be an alteration of substance relating to the cause of death within the meaning of section 29 (4) of the Births and Deaths Registration Act 1953. The coroner supported the father's application to have the inquest and inquisition quashed. In a brief judgment given by HHJ Thornton, the Chief Coroner, sitting as a Judge of the High Court, the Court held that having read the new medical evidence and the genetic testing reports, it was satisfied that it is necessary and desirable in the interests of justice, under section 13(1)(b) of the Coroners Act 1988, that another inquest should be held.

Article 2 Inquests v Jamieson Inquests

The distinction between Article 2 compliant ("*Middleton*") inquests and "*Jamieson*" inquests continues to generate litigation. In three recent decisions the Court has considered issues including the threshold for ordering an Article 2 inquest and the appropriate scope of such an inquest.

In ***R (on the application of Kent CC) v HM Coroner for Kent (North-West District)*** [2012] EWHC 2768 (Admin), (2013) 177 J.P. 82, Kent County Council challenged a decision by the coroner that Article 2 of the ECHR applied to the inquest into the death of a 14-year-old boy (Edward Barry) who had been assessed as being in need within the meaning of section 17 of the Children Act 1989. Edward had been involved with social services for some nine months before he died after drinking methadone. He had not been taken into care and no proceedings under section 31 of the Children Act had been commenced. Following his death, a serious case review identified a number of shortcomings on the part of the local authority.

The County Council contended that there was no arguable breach of the substantive obligation under Article 2. Statutory systems for children in need of care were in place and wholly adequate and there was no systemic failure which could lead to an arguable breach. The Council further argued that there was no operational obligation under Article 2 because Edward was not sufficiently under the state's control, nor was there any real or immediate risk to his life of which the Council knew or ought to have known. On this basis, the Council contended that the coroner had erred in ordering an Article 2 inquest.

The Court upheld the Council's challenge on this ground. In doing so, it reiterated that there are three possible obligations on the state pursuant to Article 2 ECHR: the general duty (which comprises two parts: a negative duty not to take life without justification and a positive duty to establish a framework of laws and procedures to protect the right to life); the "operational" duty; and the procedural duty to investigate any arguable breaches of the substantive duty. The operational duty arises, the Court suggested, where there is an allegation that the state has violated its general duty and at the material time the authorities knew or ought to have known of the existence of a real and immediate risk to the life of an identified individual and failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk. The Court emphasised that the test of "real and immediate risk to life" is a stringent one with a very high threshold to be met.

The Court held that while there could potentially be an operational duty in circumstances such as those arising in the present case, on the facts there was insufficient evidence of a real and immediate risk to life. In the months before his death, Edward had undoubtedly been vulnerable and at risk but, viewed objectively, that risk was not a risk to life. It was a risk of harm, and that was not to be equated, with the wisdom of hindsight, with a risk to life. In those circumstances there was no operational duty in place at the time of his death. Although the local authority had some measure of responsibility for Edward because he was vulnerable and had been assessed as being "in need" for the purposes of s.17, it did not have parental responsibility for him. It would not be proportionate to require a local authority to exercise sufficient control over all children in a similar position to Edward within its jurisdiction so that an operational duty was owed in every case. It followed that no procedural duty arose, and the state was not required to hold a *Middleton* inquest.

Local authorities will no doubt be relieved by this decision which serves as a reminder that the operational duty does not arise in every case in which a vulnerable person comes to harm and that it only arises where there is a real and immediate risk to life. Nonetheless, the Court acknowledged that the circumstances were in the "potential territory" of Article 2. The outcome might well have been different had Edward been the subject of a care order, or had there been evidence of a real and immediate risk to life.

It is clear from another recent decision that once an Article 2 inquest has been conducted, the Court will be very reluctant to uphold challenges brought on the ground that the coroner has exceeded the legitimate scope of his inquiries.

In ***R (on the application of Sreedharan) v HM Coroner for the County of Greater Manchester and others*** **[2013] EWCA Civ 181** the Court of Appeal (Hallett, Maurice Kay LJJ and Lord Dyson) considered an appeal brought by a General Practitioner who had prescribed the deceased

the medication on which he had then overdosed resulting in his death. At the inquest, both the role of the emergency services and that of the Appellant GP had fallen to be considered but as the inquest progressed, increasing focus was placed on the actions and conduct of the GP. The jury returned a verdict of unlawful killing having been directed by the coroner that they were not entitled to return a verdict of suicide.

The appeal was brought on various grounds including that the coroner had erred in focusing too much attention on the credibility of the Appellant, had exceeded the appropriate scope of legitimate inquiry into the cause of death and had failed adequately to investigate the role of the emergency services. The Appellant contended that the coroner had erred in admitting evidence which related to his conduct some years after the death of the deceased including details of proceedings before the GMC and allegations that amendments had been made to the deceased's medical records.

Giving the judgment (with which Maurice Kay LJ and Lord Dyson concurred), Lady Justice Hallett summarised the key legal principles arising in the case. In relation to the scope of an Article 2 inquest she reiterated the principle that the inquiry is not restricted to the "last link in the chain of causation": *R v Inner West London Coroner, ex p. Dallaglio* [1994] 4 All ER139. She held as follows:

> *"v. The incorporation of Article 2 of the ECHR into domestic law brings with it the procedural obligation to carry out an effective investigation and to ensure, so far as possible, "that the full facts are brought to light; that culpable and discreditable conduct is exposed; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons from his death may save the lives of others." (R (Amin) v Secretary of State for the Home Department [2004] 1 AC 653 ,)*
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> *vi. Where Article 2 is engaged the wording of rule 36 should be interpreted so that when considering 'how' the deceased came by his death the Coroner or jury must decide not simply 'by what means' but ' by what means and in what circumstances' he met his death. (R (Middleton) v West Somerset Coroner 2004 AC 182)*
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> *vii. There is now in practice little difference between the Jamieson and Middleton type inquest as far as inquisitorial scope is concerned. The difference is likely to come only in the verdict and the findings. (R (Smith v Oxford Assistant Deputy Coroner 2011 1 AC)*
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> *viii. Rule 43 enables a Coroner at the end of the inquest to make a report to relevant parties where the evidence gives rise to a concern that circumstances creating a risk of other deaths will occur or continue to exist in the future. This now forms part of the means by which the state discharges its Article 2 obligation. (R (Lewis) v HM Coroner for the Mid & North Division of Shropshire [2010] 1 WLR 1836). "*

On the facts, Lady Justice Hallett found that the coroner's conduct of the inquest disclosed no error of law. In terms of the appropriate scope of an inquest, she noted that the phrase "*in what circumstances"* appears very broad and that to date the courts have avoided being overly prescriptive about precisely what comes within the ambit of *'other factors which are relevant to the circumstances of the death'.* The Court of Appeal rejected the argument that this was a "hybrid" inquest, in which the procedural duty under Article 2 was triggered only by the involvement of the emergency services (as state agents). It was not right, the Court found, that once a coroner has embarked upon an Article 2 compliant inquest there should be less intensive scrutiny of the conduct of the non-state agent than of the conduct of the state agent - *"it is only by examining the roles of each fully and fairly that the role of the state agent can be put into its proper perspective and the truth ascertained".*

As the role of the non-state party was crucial to the investigation, the coroner was entitled to investigate the circumstances in which the medication had been prescribed. In relation to the control of admissible evidence, the Appellant had a high threshold to meet in establishing that the coroner had erred in admitting the evidence complained of. The Court concluded that most of the evidence to which the Appellant took exception was undoubtedly within the legitimate scope of the inquiry. Although there were several pieces of evidence which were of marginal or peripheral relevance to the death, such complaints did not amount to a proper ground for challenging the lawfulness of the process.

The third decision which has touched upon the distinction between Article 2 and Jamieson inquests is ***R (on the application of Shaw) v HM Coroner and Assistant Deputy Coroner for Leicester City and South Leicestershire*** [2013] EWHC 386 (Admin). This case concerned an Article 2 inquest into the death of William Ewan who died in the course of surgery to replace a defective heart valve. The coroner had returned a narrative verdict, namely that the death had been the *"unintended outcome of a therapeutic medical procedure."* The deceased's daughter, Ms Shaw, challenged the conduct of the inquest on a number of grounds including delay and an allegation of bias (on which see further below). Although Ms Shaw had been represented at the original inquest, she acted in person in the judicial review proceedings.

The Court took the opportunity to set out again the authorities on the distinction between Article 2 and Jamieson Inquests, reiterating that the difference between the two centres on the nature of the verdict and citing the judgment of Lord Philips in *R (on the application of Smith) v Oxfordshire Assistant Deputy Coroner* [2011] 1 AC 1 to this effect. The Court quoted Lord Philip's summary of the procedural obligations which apply:

> *"The procedural obligation requires a state, of its own motion, to carry out an investigation into a death that has the following features: (i) It must have a sufficient element of public scrutiny of the investigation or its results. (ii) It must be conducted by a tribunal that is independent of the state agents who may bear some responsibility for the death. (iii) The relatives of the deceased must be able to play an appropriate part in it. (iv) It must be prompt and effective. This means that it must perform its essential purposes. These are to secure the effective implementation of the domestic laws which protect the right to life and to ensure the accountability of state agents or bodies for deaths occurring under their responsibility. These features are derived from the Strasbourg jurisprudence, as analysed in the Middleton case and R (L(A Patient)) v. Secretary of State for Justice [2009] AC 588."*

The Court then considered the Claimant's ground of unacceptable delay in light of the nature of the inquest. The Court noted that section 8(1) of the 1988 Act requires a coroner to hold an inquest as soon as practicable and that the procedural obligation under Article 2 ECHR includes the requirement for a prompt investigation. However, whilst the delay of 3 ¼ years between the deceased's death and the date of the inquest was far from desirable, it was not uncommon. In the context of a complex medical inquest which, in due course, occupied a jury for 13 working days, the Court found that the delay which occurred was *"not inappropriate, still less unlawful either in domestic law terms or in the context of article 2."*

Bias

It is not uncommon for verdicts to be challenged on the grounds of alleged bias. This issue arose in ***R (on the application of Shaw) v HM Coroner and Assistant Deputy Coroner for Leicester City and South Leicestershire*** (above). The assistant deputy coroner had indicated in the course of the final pre-inquest review (held some three weeks before the inquest was due to start) that a former Chief Executive of the Trust was a personal friend. The Chief Executive in question had left his post before the date of the procedure on Mr Ewan which had resulted in his death. Ms Shaw contended that this connection gave rise to presumed bias or at least apparent bias on the part of the assistant deputy coroner. Counsel for the Claimant at the inquest had indicated to the deputy assistant coroner that Ms Shaw had concerns as the inquest would touch upon the management of the Trust and that the friend of the Assistant Deputy Coroner had been responsible for putting the relevant policies or systems in place. In the exchange with counsel that followed, the assistant deputy coroner had declined to recuse himself, having interpreted the observations by counsel as an application that he should do so. In these proceedings, the issues that arose were twofold – namely:

(i) whether there was apparent bias; and

(ii) whether the Claimant had effectively waived the challenge of presumed bias as the inquest had continued and she had been in possession of the relevant information.

In relation to the issue of apparent bias, Mr Justice Burnett set out the relevant authorities and the circumstances in which a judge is disqualified from continuing to act, referring both to the central test in *Porter v. Magill* [2002] 2AC 357 and to the decision in *Locabail (UK) Ltd v Bayfield*

Properties Ltd [1999] EWCA Civ 3004, (2000) QB 451 in which the Court of Appeal set out a series of circumstances which would not give rise to questions of apparent bias. He concluded that the facts did not raise any question of presumed bias in the relevant sense: a fair-minded and independent observer would not conclude that the conduct of the inquest by the assistant deputy coroner might be biased on the basis that he might unconsciously seek to protect those who worked in a hospital for which his friend was once responsible. The Judge emphasised that the focus of the inquest was not upon the way in which the Trust or hospital were managed and that it was a case about medical failings not management failure. Any lingering doubt about the matter was resolved by the fact that the friend had left his post as chief executive before Mr Ewan's procedure and death.

The issue of waiver arose as counsel for the Defendant contended (i) that no formal application to recuse had been made and (ii) Ms Shaw had been in possession of all relevant information and in allowing the inquest to proceed, had waived her right to any further challenge on this ground. Ms Shaw contended that relevant information had been withheld as the true extent of the relationship between the deputy assistant coroner and the Chief Executive of the Trust had only been revealed in a subsequent witness statement. She relied on the judgment in *Peter Smith v Kvaerner Cementation Foundations Ltd* [2006] EWCA Civ 242, and in particular the guidance from Lady Justice Hale (as she then was) as to the circumstances in which an individual will be considered to have sufficient information to decide whether to waive an application. The Judge accepted that a formal application to recuse had been made. However, he found against Ms Shaw on the issue of waiver. He noted that the decision in *Peter Smith v Kvaerner Cementation Foundations Ltd* [2006] EWCA Civ 242 provides a useful framework and that no question of waiver can arise unless the party who is being invited to waive an objection based upon apparent bias (or is said by his conduct to have waived an objection) is in possession of the full facts relevant to the decision whether to waive. However, although the witness statement subsequently presented by the assistant deputy coroner provided more details of the friendship at issue and clarified the precise date on which the Chief Executive had left the employment of the Trust, Ms Shaw had been in possession of the information she required. It was incumbent upon her to challenge the decision before the proceedings had started but no steps to do so were taken in the three week period between the assistant deputy coroner's ruling and the start of the inquest.

The issue of bias was also raised in the case of ***Sreedharan*** (above), where it was argued that the coroner revealed or gave the appearance of bias because he allowed the inquiry to focus too much upon the Appellant's conduct and character, admitted irrelevant or marginally relevant evidence which undermined the Appellant, allowed excessively aggressive questioning of the Appellant and joined in that questioning. The Court of Appeal firmly rejected that argument, observing that the coroner was duty bound to ensure as thorough an investigation of the Appellant's conduct as possible and to follow where the evidence led.

The decision in ***Shaw*** should serve as a salutary reminder to practitioners that a person may be regarded as having waived an objection to a decision made at the pre-inquest stage if no attempt is made to challenge that decision prior to the commencement of the inquest. It is clear from the judgment that the Court was influenced by the fact that there would have been sufficient time between the pre-inquest hearing and the commencement of the hearing to issue judicial review proceedings and if necessary seek interim relief. More problematic is the situation where the information relevant to the objection only becomes known at the commencement of the inquest itself.

In his concurring judgment, the Chief Coroner gave some practical guidance as to the circumstances in which coroners should disclose relevant interests or relationships, which we set out in full:

> *"102 … Although in this case there was no bias, no actual, presumed or apparent (or perceived) bias, on the part of the assistant deputy coroner, he was right to raise the matter at the pre-inquest review. All coroners, doing their best to maintain independence and impartiality, should be alert to the risk of a real possibility of failing the objective test of the fair-minded and informed observer and to the need to disclose as early as possible a relevant interest or relationship to all interested persons for discussion.*
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> *103 Although much guidance has been given (such as in Locabail, Jones and Smith, supra) no two sets of facts are likely to be the same. Chapter 7 of the Guide to Judicial Conduct (revised version August 2011), headed 'Personal relationships and Perceived Bias', while recognising that there are 'few hard and fast rules', sets out for judicial office holders a number of 'signposts for guidance', especially in relation to 'parties' to the litigation. In inquests there are no parties, but, amongst a number of possible interests, a personal friendship or close acquaintance (or animosity) or business relationship with an interested person or a witness or an organisation coming under scrutiny, particularly where credibility is an issue, should put the coroner on notice. These are only examples. Each case must be considered on its individual circumstances.*
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> *104. It is inevitable that coroners, by the very nature of their work and the localness of coroner arrangements, will develop close contacts with some persons who enter the arena of the coroner investigation and inquest, for example senior members of hospitals and health trusts. If the close contact strays beyond the bounds of a working relationship into a personal one, the coroner should examine the circumstances carefully and decide whether to make disclosure, but not otherwise. So too should a part-time coroner who as a lawyer has clients (or his firm or chambers has clients) which might require open disclosure of a particular interest, for example acting for a company in the same group as an impugned company (as in Jones, supra).*
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> *105. Once on notice the case law advises the coroner to disclose as much as possible of his interest. This disclosure should be put in writing or otherwise recorded in a permanent record. The coroner should then usually advise any interested person affected of the options: (i) consent to the hearing going ahead and losing the right to object later (waiver); (ii) apply to the coroner to recuse himself (which the coroner will not take amiss), and if he recuses himself, what effect recusal would have on the timing of the inquest. Any person affected should have adequate time to reflect and, if necessary, take legal or other advice before making a free and informed decision. All of this is guidance, not a hard and fast checklist,"*

Verdicts of Suicide

In ***R (on the application of Evandro Lagos) v HM Coroner for the City of London*** [2013] EWHC 423 (Admin), the Court considered and gave guidance on the standard of proof to be applied when returning a verdict of suicide as well as the rationale for applying that standard.

Mrs Lagos was found dead in July 2010. There was evidence that she had been mentally disturbed in the period preceding her death and had previously self-harmed. The Claimant, her husband, contended that the only conclusion the coroner could have reached in the circumstances was that his wife had committed suicide. Accordingly, he challenged the decision of the coroner, who sat without a jury, to record an open verdict on the grounds that this infringed Article 1 of the Universal Declaration of Human Rights. A verdict of suicide would, he argued, have acknowledged and respected the way in which she chose to end her life and thus accorded her the dignity to which she was entitled under Article 1. Mr Lagos also challenged the findings of the coroner on a number of additional grounds including a refusal to disclose a police report, the change of an interpreter and the controlling of witness evidence at the inquest.

In considering the challenge to the return of an open verdict, Mrs Justice Lang emphasised that the conclusion of a coroner sitting alone as to the appropriate verdict involves an evaluation of the evidence and provided that he directs himself correctly as to the ingredients of the verdict, his decision may only be impugned if it is unreasonable in the *Wednesbury* sense: *R v City of London Coroner, Ex Parte Barber* [1975] 1 WLR 1310 at 1313 (Lord Widgery CJ). In the context of a verdict of suicide, the standard of proof to be applied is the criminal standard of proof (in contrast to that generally applicable which is the civil standard of the balance of probabilities). Thus, in order to return a verdict of suicide, the coroner or jury must be sure "beyond reasonable doubt"

(i) that the deceased intended his own death; and

(ii) that he did an act with that intention which caused his death.

Mrs Justice Lang noted that the only other verdict to which this standard applies is that of unlawful killing and reiterated that a high standard is deliberately set in order to ensure that such serious findings are only made on the basis of absolutely clear and compelling evidence: *R v West London Coroner, Ex Parte Gray* [1988] 1 QB 467. Further, consistently with the high standard of proof, suicide must not be presumed simply because it seems a likely, or the most likely, explanation of events. Mrs Justice Lang set out in some detail the authorities in support of the principle that suicide cannot be presumed including the relatively recent decision in *R (Jenkins) v HM Coroner for Bridgend and Glamorgan Valleys* [2012] EWHC 3175 (Admin), in which the Divisional Court quashed the result of inquest proceedings in part because the coroner's direction to the jury had paid insufficient regard to the important principle that suicidal intention and action cannot be presumed and must be proved to the strict standard of proof. She summarised the rationale behind these principles as follows:

> *"..the approach of the Courts to suicide verdicts reflects (a) the fact that a finding of suicide is a serious matter which can cause serious distress and stigma, and other adverse consequences; and (b) the complexities of human psychology which can cause people to harm themselves seriously or to put themselves in very dangerous positions without the clear intention to end their lives."*

On the facts, she held that there had been no misdirection as to the appropriate test and the argument that failure to return a suicide verdict amounted to a breach of Article 1 of the Universal Declaration of Human Rights failed – the open verdict was simply the consequence of applying the relevant legal tests.

As to the procedural challenges, namely, the refusal to disclose a police report, a change in the Claimant's interpreter and the decisions of the coroner to restrict certain questioning of witness evidence, in dealing with these matters (and in rejecting the challenges in each case), the Judge emphasised the broad discretion that is conferred upon a coroner and the relatively high threshold for establishing that this discretion has been unlawfully exercised. Thus, for example, in relation to the coroner's power to control witness evidence (as defined by section 11 of the Act), the provision involves a two-limb test of relevance and expediency, and a coroner's selection of witnesses may only be challenged if unreasonable in the *Wednesbury* sense. Equally, Lang J held that it is an established principle that the scope of inquiry at an

inquest can extend wider than is strictly required for the production of the verdict, and that the Courts will only rarely interfere with decisions as to scope: *R v Inner West London Coroner, Ex Parte Dallaglio* [1994] 4 All ER 139. Whilst on the facts the Judge accepted that the coroner had intervened in the questioning of certain witnesses, this did not meet the threshold for a finding of procedural unfairness.

The issue of when it will be appropriate to leave it to the jury to return a verdict of suicide was raised in ***R (on the application of Sreedharan) v HM Coroner for the County of Greater Manchester and others*** [2013] EWCA Civ 181 (see above). The Appellant in that case contended that the coroner had erred in directing the jury that they were not entitled to return a verdict of suicide.

Lady Justice Hallett indicated that she had initially been attracted by the force of the Appellant's arguments as to the weight of the evidence justifying a verdict of suicide. In particular, the deceased had a history of self-harm and suicide attempts and had threatened to kill himself in the days before his death. However, the evidence was "far from all one way":

> *"The question of whether or not a judge or coroner should leave an issue to a jury may sometimes be a difficult one to answer; not all cases are clear cut. It then becomes very much a matter for the judgement of the judge or coroner who has seen and heard the evidence tested to decide. An appellate court will rarely intervene. In my judgment, this is such a case. The Coroner having seen and heard the evidence concluded that a properly directed jury could not exclude the possibility that this was not a suicide. That was a reasonable approach to take and not one with which I would interfere. There was no error of law."*

Further, Lady Justice Hallett concluded that a failure to leave suicide could not be said to have undermined the integrity of the verdict which was returned. The Coroner left to the jury the possibility of accident and an open verdict. They were directed to start with consideration of unlawful killing and work their way down the list if necessary. Had they not been satisfied as to unlawful killing they had other options:

> *"The jury system in this country depends on our trusting a jury to follow directions. Thus, their verdict indicates they had no doubt that the prescription of a dangerous drug to a volatile and vulnerable patient was a material cause of Mr Donohue's death and that whatever roles the emergency services, Mr Donohue, and his mother played, they were not sufficiently potent to break the chain of causation."*

Unlawful Killing

R (on the application of Wilkinson) v HM Coroner for the Greater Manchester South District [2012] EWHC 2755 (Admin) raised the issue of whether evidence of the commission of the criminal offence of causing death by careless driving (contrary to section 2B of the Road Traffic Act 1988) was capable of justifying a verdict of unlawful killing at an inquest, a question on which there was a divergence of view amongst coroners. Having reviewed the history of the verdict of unlawful killing, the Court observed that it was not known whether the expression "unlawful killing" had been used in the context of inquests prior to 1984 but that if it had there was no suggestion that it extended to any criminal offence other than the three homicide offences of murder, manslaughter or infanticide. The Court concluded that the main purpose of having a verdict of unlawful killing was to distinguish between those cases where there had been an accident of some kind (where someone might still be to blame for it) and those cases where it would be an abuse of language to describe the events leading to death as simply an accident. Causing death by careless or inconsiderate driving should not, the Court ruled, be treated as unlawful killing for the purposes of the conclusion of an inquest. Unlawful killing was restricted to murder, manslaughter (including corporate manslaughter) and infanticide. Bad driving cases causing death should only be regarded as unlawful killing for inquest purposes if they satisfy the ingredients for gross negligence manslaughter.

OTHER NEWS

Chief Coroner's address at the annual conference of the Coroners' Society of England and Wales

In his address to the Coroners' Society on 21 September 2012 the Chief Coroner set out a ten point plan for the next twelve months. His full speech can be viewed here: http://www.judiciary.gov.uk/Resources/JCO/Documents/Speeches/chief-coroner-speech-coroners-society-conference.pdf. His speech also identifies the principal changes that will be made by the Coroners and Justice Act 2009.

Government's consultation on implementing Part 1 of the Coroners and Justice Act 2009

On 1 March 2013 the government issued 'Implementing the coroner reforms in Part 1 of the Coroners and Justice Act 2009' – its consultation on rules, regulations, coroner areas and statutory guidance. The consultation closed on 12 April 2013. We hope to report on the government's response to, and in light of, the consultation in our next update.

Rule 43 Coroners Rules 1984 Report Summary

On 20 March 2013, the Ministry of Justice published the 8th Rule 43 Coroners Rules 1984 Report Summary which covers reports and responses from 1 April 2012 to 30 September 2012. Overall, there has been a drop in the number of reports since the last reporting period although hospital deaths are still the largest category, followed by RTAs and mental health related deaths. The Report identifies 3 reports of potentially wider application:

- A report into the death of a baby who was born prematurely and in respiratory distress and who died shortly after being transferred to hospital. Following a review by the North East Ambulance Service NHS Trust, the decision had been made to include paediatric advanced life support training as a refresher to all their operational staff and additional training measures were put in place. The Coroner concluded that these measures, if implemented elsewhere, could save lives.

- A report into the death of an employee of Network Rail who was hit by a train whilst carrying out repairs on track. The Coroner had asked Northern Rail to consider additional training for train drivers on the circumstances in which they should sound the horn the fitting of forward facing cameras in the cabs of its trains. Northern Rail confirmed that measures had been taken.

- A report into the death of a young man who died of a berry aneurism whilst he was being detained at HM Young Offenders Institution (HMYOI) Glen Parva. The man had reported feeling unwell on the Saturday but arrangements were not made for him to be seen until the Sunday afternoon. He collapsed whilst waiting for his GP appointment and died in hospital the following day. The Coroner asked the relevant NHS Trust to consider clarifying how regularly triage clinics are held, what happens when there is an out-of-hours illness and what steps staff should take when prisoners report an illness. The Trust issued new "resting in cell" guidance designed to ensure that prisoners are seen on the same day that they report feeling unwell both during the week and at weekends.

Our next update will be out in September. Feel free to email us with any judgments or other news items which you think should be included.

Jenni Richards QC
Jenni.richards@39essex.com

Josephine Norris
Josephine.norris@39essex.com

CONTRIBUTORS

Jenni Richards QC
Jenni.richards@39essex.com

Jenni Richards QC has an extensive public law and human rights practice acting for individuals, public bodies and public interest groups in all areas affected by public law. Her expertise includes local government, health and social care, education, prison law, immigration/asylum and financial services. Jenni has extensive experience in difficult and sensitive inquests and inquiries, in particular those in which there is a public component such as the responsibility of the state in relation to the cause of death. She has represented families, local authorities, NHS trusts, central government, employers and other interested persons in inquests. Jenni has been involved in many leading cases concerning the investigative and substantive obligations under Article 2 of the European Convention on Human Rights, including Savage v South Essex Partnership NHS Foundation Trust [2008] UKHL 74, Rabone v Pennine Acute Hospitals Trust [2012] UKSC 2, R (AP) v HM Coroner for Worcestershire [2011] EWHC 1453 and R (Lewis) v HM Coroner for Shropshire [2009] EWCA Civ 1403. To view full CV click here.

Josephine Norris
Josephine.norris@39essex.com

Josephine Norris practises in the fields of public law, regulatory law and personal injury law including clinical negligence. She has a particular interest in mental health law. She is regularly instructed in inquests and public inquiries for insurers, family members and public bodies. In 2012, she was instructed by the Treasury Solicitor as Junior Counsel assisting Robert Jay QC in the Leveson Inquiry in to the culture, practices and ethics of the press. She is on the Attorney General's 'C' Panel of Treasury Counsel. To view full CV click here.

Thirty Nine Essex Street Chambers provides specialist advice and representation in a wide range of inquests and public inquiries. The work we undertake encompasses all aspects of coronial law and all types of cases, including deaths in prison or police custody; deaths of psychiatric patients; medical accidents; military deaths; and deaths in which there are health and safety or employers' liability implications. Members of chambers are often involved in high profile Article 2 inquests and inquiries. We can provide training on all aspects of inquest law and procedure.

David Barnes Chief Executive and Director of Clerking
david.barnes@39essex.com

Peter Campbell Practice Manager
peter.campbell@39essex.com

Sheraton Doyle Practice Manager
sheraton.doyle@39essex.com

Ben Sundborg Practice Manager
ben.sundborg@39essex.com

For further details on Chambers please visit our website: **www.39essex.com**

London 39 Essex Street, London WC2R 3AT Tel: +44 (0)20 7832 1111 Fax: +44 (0)20 7353 3978
Manchester 82 King Street, Manchester M2 4WQ Tel: +44 (0)161 870 0333 Fax: +44 (0)20 7353 3978
Singapore Maxwell Chambers, 32 Maxwell Road, #02-16, Singapore 069115 Tel: +(65) 6634 1336