

INQUEST SEMINAR

17 June 2026

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INQUESTS: CANDOUR AND THE PUBLIC OFFICE (ACCOUNTABILITY) BILL

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Jenni Richards KC

CANDOUR: EXISTING SOURCES OF CANDOUR DUTY

- Public law duty of candour
- Statutory duty of candour: Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Professional duty of candour

PUBLIC LAW DUTY OF CANDOUR

- Duty now well-established and well-recognised in public law
- *“the obligation of candour places a very high duty on public authority respondents, not least central government, to assist the court with full and accurate explanations of all the facts relevant to the issue the court must decide”* : R (Quark Fishing Ltd) v Secretary of State for Foreign and Commonwealth Affairs [2002] EWCA Civ 1409; R (IAB) v Secretary of State for Home Department [2024] EWCA Civ 66.
- *“There is a special duty – the duty of candour and cooperation with the Court – which applies to all parties to judicial review claims. Parties are obliged to ensure that all relevant information and all material facts are put before the Court. This means that parties must disclose relevant information or material facts which either support or undermine their case.”* Administrative Court Guide 2025 para 7.5.1 and part 15.

STATUTORY DUTY OF CANDOUR

- Introduced following the recommendations of the Mid Staffs Public Inquiry
- Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 imposes a duty of candour on “registered persons”
- Duty is regulated by the CQC; applies to every health and social care provider CQC regulates (applicable to England only – Wales has a similar organisational duty of candour on providers of NHS services under Health and Social Care (Quality and Engagement) (Wales) Act 2000)
- General duty to “*act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity*”: Reg 20(1)
- Specific duty of notification of “*notifiable safety incident*”: Reg 20(2) (as defined in Reg 20(8))

STATUTORY DUTY OF CANDOUR

- The notification must, amongst other matters,
 - *“provide an account, which to the best of the registered person's knowledge is true, of all the facts the registered person knows about the incident as at the date of the notification”,*
 - *“advise the relevant person what further enquiries into the incident the registered person believes are appropriate” and “*
 - *include an apology”*: Reg 20(3)
- Compliance with the duty monitored by CQC – can be the subject of criminal enforcement action

PROFESSIONAL DUTY OF CANDOUR

- *Good Medical Practice* (applicable to doctors and physician/anaesthesia associates/assistants) para 45:

“You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you must follow our guidance on Openness and honesty when things go wrong: the professional duty of candour, and you should:

- a. put matters right, if possible*
- b. apologise (apologising does not, of itself, mean that you are admitting legal liability for what's happened)*
- c. explain fully and promptly what has happened and the likely short-term and long-term effects*
- d. report the incident in line with your organisation's policy ...”*

PROFESSIONAL DUTY OF CANDOUR

- Joint GMC and NMC guidance:
- https://www.gmc-uk.org/cdn/documents/openness-and-honesty-when-things-go-wrong--the-professional-duty-of-candour_pdf-61540594.pdf
- Duty to be open and honest with patients and those close to them when things go wrong
- Duty to be open and honest with the organisation and to encourage a learning culture by reporting adverse incidents that lead to harm and near misses
- Non-compliance can lead to fitness to practise proceedings
- See also the *Joint Statement from the Chief Executives of statutory regulators of healthcare professionals on Openness and honesty – the professional duty of candour*: co-signed by General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Nursing and Midwifery Council, Pharmaceutical Society NI

OBLIGATIONS UNDER CORONERS AND JUSTICE ACT 2009

- *“The duty of disclosure, both to and by the coroner, arises from the commencement of an investigation, it continues through the pre-inquest stages and remains a continuing obligation to be kept under review throughout the inquest hearing”*: Chief Coroner’s Guidance for Coroners on the Bench, chapter 12
- Schedule 5 to the 2009 Act para 1(1) and 1(2) – coroner’s power to require a person by notice to give evidence or produce any documents in the person’s custody or control which relate to a matter that is relevant to an inquest or investigation
- Schedule 5 para 1(5) – in deciding whether to revoke or vary a notice on the ground that it is not reasonable in all the circumstances to expect the person to comply, the coroner *“must consider the public interest in the information in question being obtained for the purpose of the inquest or investigation, having regard to the likely importance of the information”*
- Schedule 6 para 6 – coroner may fine a person who fails without reasonable excuse to do anything required by a notice under Schedule 5 para 1

CORONIAL EXPECTATIONS OF CANDOUR: PFDS

- PFD report 15 December 2025 (deceased: Lee Eustace): despite evidence that jejunostomy feeding protocol was insufficient and in part not followed, a Datix was never raised and a Duty of Candour letter was not sent to the family in accordance with Reg 20.
- *“Furthermore, information about the identification of this clearly relevant issue was not provided to the Coroner ahead of the inquest hearing ... or in response to any further requests for evidence. It was only when a specific question was put to the Trust by the Coroner in relation to the existence of a protocol and whether it was followed that this information was provided.”*
- Coroner’s concern that Trust had not complied with Reg 20 duty, had not provided relevant documentation to the Coroner in accordance with Schedule 5 obligations, and had not investigated the incident.
- Information sought regarding Trust’s governance processes to ensure proper investigation of incidents, compliance with Reg 20 duty and adherence to Schedule 5 disclosure duties.

CORONIAL EXPECTATIONS OF CANDOUR: PFDS

- PFD report 26 March 2025 (deceased: Ida Lock):
 - Concern that there is not a culture of candour within the NHS Trust – urgent action required to meaningfully embed the duty
 - Trust’s approach to the inquest *“has been one of a lack of transparency and openness, failure to provide relevant information and a failure to identify with candour the defective clinical governance processes that have operated at the Trust from 2019 to the present day”*
 - Trust did not disclose its failure to notify CQC, the CCG and the Trust’s own Serious Incidents Reporting Investigation panel

CORONIAL EXPECTATIONS OF CANDOUR: PFDS

- PFD report 13 February 2025 (deceased: Anthony Binfield, David Richards and Rolandas Karbauskas)
 - *“The quality of any post-death investigation is predicated by the openness, honesty and transparency of the agencies involved”*
 - The inquest was *“beset with disclosure failures by HMPPS”*
 - The healthcare Trust was subject to the statutory duty of candour – the prison operators *“failed to embrace the same ethos during these investigations”*
 - *“It is most concerning that there is a marked discrepancy between the failings that were admitted in oral evidence by the vast majority of witnesses when faced with irrefutable evidence, against the written statements submitted to the coronial investigations which contained very little, if any, reflection and candour”*

CORONIAL EXPECTATIONS OF CANDOUR: PFDS

- PFD report 17 September 2025 (deceased: Keith Hankin)
- Failure of the Integrated Care Board to independently review the circumstances of death to confirm if there was any learning or changed in practice to prevent further deaths
- Concern that the systems within the ICB and the private provider it commissioned *“are insufficiently robust and could – as it was with Mr Hankin – prevent transparency and openness as to the circumstances of his death and limit any learning and/or necessary changes in practice to prevent future deaths”*

CORONIAL EXPECTATIONS OF CANDOUR: PFDS

- PFD 17 January 2024 (deceased: Kane Boyce)

"I would be very interested to understand how the duty of candour applies to the prison service and those individuals within the employ of the service (whether employed directly or through a private provider, as in this case).

There is a statutory duty of candour applicable to healthcare organisations and professionals, as well as a more recent agreement by the College of Policy for members to adhere to a Code of Candour.

In practice, candour creates a culture of being open and honest with all stakeholders by accepting when things go wrong, taking remedial steps as soon as practicable, and thus reducing the events repeating themselves. In the context of a death, candour from the outset is essential in order to support the bereaved family.

The position adopted [by the prison provider] in this inquest ... could be said to represent the very opposite of candour ...

The inquest is not an adversarial process, there is no burden of proof. The Interested Persons are under a duty to assist the investigative process in an open and honest manner by identifying those issues that genuinely require determination by the jury, and those on which there is agreement ..."

CORONIAL EXPECTATIONS OF CANDOUR: PFDS

PFD report 6 November 2023 (deceased: Christopher Smith)

“Without exception, each witness from the healthcare trust accepted some level of failing in the care they provided to Christopher. Yet none of the witness statements submitted in advance contained any such reflection of what went wrong or what should have happened. Despite a Direction from the court that the Head of Healthcare was to submit a statement “nailing colours to the mast” as to what the genuine issues of care were i.e. what policies were in place at the material time and whether care had departed from those policies, a candid statement satisfying this Direction was not forthcoming. This left the Coroner and the other Interested Persons, especially Christopher’s family, at a distinct disadvantage in identifying the actual issues, because of an overwhelming unwillingness to act in an open and honest manner, contrary to the expectations of a state agency when engaging in an inquest.”

PUBLIC OFFICE (ACCOUNTABILITY) BILL (THE “HILLSBOROUGH LAW”)

- *“A Bill to impose a duty on public authorities and public officials to act with candour, transparency and frankness; to make provision for the enforcement of that duty in their dealing with inquiries and investigations; to require public authorities to promote and take steps to maintain ethical conduct within all parts of the authority; to create an offence in relation to public authorities and public officials who mislead the public; to create further offences in relation to the misconduct of persons who hold public office and to abolish the common law offence of misconduct in public office; to make provisions enabling persons to participate at inquiries and investigations where the conduct of public authorities may be in issue; and for connected purposes.”*
- Bill has gone through 1st and 2nd reading in House of Commons and the Committee stage and is now at the Report Stage having been reintroduced on 14 May 2026.

PUBLIC OFFICE (ACCOUNTABILITY) BILL: KEY PROVISIONS RELEVANT TO INQUESTS

- Section 2: Creation of statutory duty of candour and assistance
 - Public authorities and public officials *“must at all times act with candour, transparency and frankness in their dealings with inquiries and investigations”* (investigation includes coronial investigation)
 - Duty to notify the person leading an inquiry or investigation where the authority or official has grounds to believe that their acts may be relevant or they have information likely to be relevant
 - Duty to provide *“all such assistance as they can reasonably give”* to assist inquiry or investigation
 - In particular must:
 - Provide relevant information they hold to the inquiry or investigation
 - Draw attention to any particular significance of that information
 - Correct any errors or omissions discovered in information previously provided
 - Provide a position statement (if a public authority)
 - Comply with requests for further information or clarification
 - Act expeditiously *“and without favour to their own, or another person’s, position”*

PUBLIC OFFICE (ACCOUNTABILITY) BILL: KEY PROVISIONS RELEVANT TO INQUESTS

- Creation of a criminal offence if the person fails to comply with the duty of candour and assistance in respect of an inquiry or investigation (section 5)
- Mens rea: they intend that their failure will impede the inquiry or investigation achieving its objectives, or are reckless as to whether it will do so
- Liability to imprisonment or fine

PUBLIC OFFICE (ACCOUNTABILITY) BILL: KEY PROVISIONS RELEVANT TO INQUESTS

- Duty on public authority to promote and maintain high standards of ethical conduct at all times by people who work for the authority: section 9
- Ethical conduct defined by reference to the Nolan Principles: selflessness, integrity, objectivity, accountability, openness, honesty, leadership
- In discharge of duty public authority must
 - Adopt a code of ethical conduct and publish it
 - Take steps to make people who work for the authority aware of the code and consequences for failing to act in accordance with it (i.e. disciplinary consequences)
- Code must amongst other matters set expectations that people act in accordance with duty of candour and explain practical ways in which standards are to be met

PUBLIC OFFICE (ACCOUNTABILITY) BILL: KEY PROVISIONS RELEVANT TO INQUESTS

New offences created in chapter 3

- Offence of misleading the public
- New statutory offence of misconduct in public office (involving “seriously improper acts”) and abolition of common law offence
- Breach of duty to prevent death or serious injury under section 13 where a person holding public office
 - Is under a duty to prevent or prevent a risk of another person suffering critical harm
 - Knows or ought to know they are under the duty
 - In breach of the duty, intentionally or recklessly causes or creates a significant risk of causing another person to suffer critical harm
 - The act constituting the breach falls far below what could reasonably be expected of the person in the circumstances

PUBLIC OFFICE (ACCOUNTABILITY) BILL: KEY PROVISIONS RELEVANT TO INQUESTS

- Requirement of parity at inquiries and investigations (section 18, schedule 6).
- Includes
 - Engaging legal representatives to act for the public authority only if and so far as necessary and proportionate (having regard to a number of factors including the comparative position of affected persons in respect of their means to engage legal representatives)
 - Enabling concerns to be raised over the conduct of a public authority or its legal reps and requiring a response to any such concerns
 - Requiring those participating in statutory inquiries and inquests to have regard to an overriding objective aimed at insuring the full and effective participation of affected persons
 - Providing for non means tested legal aid to bereaved family members at inquests where a public authority is an interested person

PROPOSED ADDITION TO SCHEDULE 5 2009 ACT – BY VIRTUE OF PART 4 OF SCHEDULE 1 OF THE BILL

- Proposed insertion of para 2A into Schedule 5:
- *“(1) A senior coroner who is conducting an investigation under this Part must (subject to sub-paragraph (9)) give a compliance direction –*
- *(a) to a person who is a public authority or public official, or*
- *(b) to a person who had a relevant public responsibility in connection with an incident to which the investigation relates,*
- *if the person is an interested person in relation to the investigation.*
- *(2) Sub-paragraph (1) does not limited the power of the senior coroner to give a compliance direction at any other time during the course of the investigation.*
- *(3) where a compliance direction is given to a public authority or a body within sub-paragraph (1)(b), a compliance direction must also be given to the individual appearing to the senior coroner to be in charge of that authority or body, unless the senior coroner considers it would be contrary to the efficient and effective conduct of the investigation.*

PROPOSED ADDITION TO SCHEDULE 5

(4) A “compliance direction” is a direction to comply with the obligations under the duty of candour and assistance imposed by (a) section 2(4) of the Public Office (Accountability) Act 2025 and (b) in the case of a direction given to an individual under sub-paragraph (3), section 2(5) of that Act.

(5) A compliance direction

(a) must be given in writing;

(b) must set out the purpose of the investigation (see section 5(1));

(c) may specify particular requirements to be complied with (and for that purpose may specify the form and manner in which, and the period within which, those requirements are to be complied with);

(d) may be varied, supplemented or revoked by the giving of a further direction.”

See also paras 2A(6) to (11) of the proposed draft.

PROPOSED ADDITION TO SCHEDULE 5

- Proposed para 7A to be added to Schedule 5: where *“(a) a senior coroner is, or has been, conducting an investigation under this Part into a person’s death, (b) anything occurring in the investigation gives rise to a concern about the conduct of a public authority, or of its legal representatives, and (c) in the coroner’s opinion, action should be taken to prevent the occurrence or continuation of such conduct”*, the senior coroner may report the matter to *“the person appearing to the coroner to have overall responsibility for the management of the authority”* or *“such other person as the coroner believes has power to take the action mentioned in sub-paragraph 1(c)”*
- A person to whom the coroner makes a report must give a written response
- A copy of the report and response must be sent to the Chief Coroner

PRACTICAL ADVICE FOR PUBLIC AUTHORITIES AND THEIR REPRESENTATIVES

- Approaching disclosure from a “cards face up” perspective
- Adequate and prompt investigation of the death
- Early identification of lessons to be learned
- Compliance with notification requirements
- Identification of the public official in charge of the authority
- Early consideration of Tainton admissions
- Equipping individual witnesses to understand what the duty means for them in practice
- Addressing awareness of and compliance with the ethical code in witness statements
- Careful consideration of approach to be taken in legal submissions regarding issues for jury/questionnaires/narrative conclusions/ determination
- If acting for a person who is not a public authority or public official, early consideration of whether they fall within section 4 (extension of the duty of candour to people who “had a relevant public responsibility in connection with an incident”)

WHAT WILL CHANGE? FOR DISCUSSION ...

- If judicial review is (as the Courts have described it) a “*partnership based on a common aim, namely the maintenance of the highest standards of public administration*” (R v Lancashire County Council ex p Huddleston [1986] 2 All ER 941), then inquests – inquisitorial, no “parties”, no “case” – should already be conducted in the spirit of openness and transparency: “*with all cards face upwards on the table*”
- Experience – and the PFDs referred to above – suggest that this is not the case
- As the Institute for Government has recognised, a duty of candour needs more than legislation to work: it needs real and substantial cultural change.

TITLE

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INQUESTS: JR CASE LAW UPDATE

17 June 2026

Alan Payne KC
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CAUSATION

R (O'Brien) v HM Assistant Coroner for Sefton, Knowsley and St Helens [2026] **EWCA Civ 499**

- Low threshold for causation test: - *R (Tainton) v HM Coroner* [2016] EWHC 1396:
“whether, on the balance of probabilities, the conduct in question more than minimally, negligibly or trivially contributed to death” (at [41]).
- Missed opportunity to arrest the deceased’s partner which would have resulted in the partner being in custody at the time of death:
“if the coroner had obtained ... Alan McMahon's antecedents, it would have become rapidly clear that he would not have been granted bail, and that, when sentenced, he would have received an immediate custodial sentence of some length” (at [46]).

APPOINTMENT OF EXPERTS

R (Gamesys Operations Limited) v HM Senior Coroner for London Inner South **[2025] EWHC 659 (Admin)**

- Reminder of the Coroner's "*wide discretion – or perhaps more appropriately a wide area of judgment – whom it is expedient to call*", per *R (Mack) v HM Coroner for Birmingham* [2011] EWCA Civ 712 (at [8-9]).
- The Coroner had invited detailed submissions from both parties, appointed both sides' preferred experts, and held that the political aspects of safeguarding potential gamblers could be controlled through the Inquest process. This sufficed.

BAR ON DETERMINING CIVIL OR CRIMINAL LIABILITY

R (Glaister & Carr) v HM Asst Coroner for North Wales [2025] EWHC 167 **(Admin)**

- Section 10(2) CJA 2009 prohibits the determination of ‘how’ a death occurred as being *‘framed in such a way as to appear to determine any question of criminal liability on the part of a named person, or civil liability.’*
- Fordham J held that a finding of ‘unlawful killing’ is not a determination of any question of criminal or civil liability. Rather, the jury is performing its distinct statutory inquisitorial function of deciding how, when and where the deceased died. Challenge dismissed.

ARTICLE 2: PROCEDURAL DUTY

***R (Robinson) v HM Assistant Coroner for Blackpool & Fylde* [2025] EWHC 781**

- Article 2 ECHR applies where there are legitimate grounds to suspect state responsibility for a death, *R (Morahan) v HM Assistant Coroner for West London* [2021] EWHC 1603 [122(7)].
- For Article 2 to apply automatically a death must be such that “they fall into a category which necessarily gives rise, in every case falling within the category, to a legitimate ground to suspect state responsibility...” [55].
- “Misadventure cases are not apt to attract the automatic application of article 2 because the misadventure may be unpredictable; the state agents may bear no blame for it...” [61].

ARTICLE 2: OPERATIONAL DUTY

R (Ferguson) v HM Assistant Coroner for Sefton, Knowsley and St Helens **[2025] EWHC 1901**

- Reminder of low threshold for arguability of the existence and breach of the operational duty is low, following *Morahan* at [134(i)].
- The Coroner “erred in finding that it was not arguable that the police officers knew or ought reasonably to have known of a real and immediate risk to [the deceased’s] life” (at [174]).
- There was a “significant or substantial” risk of the deceased taking his own life, which was “present and continuing”, rather than the risk of serious harm (at [173]).

SUICIDE

Toogood v HM Senior Coroner for the Area of Somerset [2026] EWHC 634 **(Admin)**

- Requirements for suicide: - *R (Maughan) v HM Senior Coroner for Oxfordshire [2020] UKSC 46*:
 1. The deceased intentionally performed the act that caused death, and
 2. Intended thereby to kill themselves.
- No longer a need to exclude all other possibilities before making a finding of suicide.
- Rather Coroners are required to determine what probably occurred, based on the totality of the evidence, and the reasonable inferences that could be drawn from it.

INQUEST UPDATE: FIAT APPLICATIONS

17 June 2026

Scarlett Milligan

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FIAT APPLICATIONS

- S.13 Coroners Act 1988
- Either necessary or desirable
- Procedure
- Practice points
- Case law update

WHAT'S A FIAT?

- Authorisation required in England and Wales that grants an applicant standing to initiate specific types of legal proceedings. Acting as a constitutional gatekeeper, the Attorney General (or Solicitor General) reviews these applications on the papers to filter out unmeritorious, frivolous, or vexatious claims in the public interest.
- Delays? HM Senior Coroner for West Yorkshire [2025] EWHC 1672

SECTION 13(1) (A) CORONERS ACT 1988

- (1) This section applies where, on an application by or under the authority of the Attorney-General, the High Court is satisfied as respects a coroner (“the coroner concerned”) either—
 - (a) that he **refuses or neglects to hold an inquest or an investigation** which ought to be held; or...

SECTION 13(1) (B) CORONERS ACT 1988

(b) where an inquest or an investigation has been held by him, that (whether by reason of [1] fraud, [2] rejection of evidence, [3] irregularity of proceedings, [4] insufficiency of inquiry, [5] the discovery of new facts or evidence or [6] otherwise)

it is necessary or desirable in the interests of justice that an investigation (or as the case may be, another investigation) should be held.

THE HIGH COURT'S POWERS

(2) The High Court may—

(a) order an investigation... to be held into the death...

(b) order the coroner concerned to pay such costs of and incidental to the application as to the court may appear just; and

(c) where an inquest has been held, **quash any inquisition on, or determination or finding made at that inquest...**”

- The Coroners and Justice Act 2009 (Consequential Provisions) Order 2013
- **Senior Coroner for South London v Assistant Coroner for South London [2022] EWHC 1388 (Admin)**
- Contrast **Shipsey v Senior Coroner for Worcestershire [2025] EWHC 605 (Admin)**

S.13(1)(B) CASE LAW UPDATE

- **HM Senior Coroner for Northamptonshire v Lovell [2024] EWHC 2331 (Admin):** following a RTC, separate inquests held into the deaths of the passenger (L) and the driver (T). New toxicological evidence that emerged in T's inquest **did not render it 'necessary' or 'desirable'** in the interests of justice to hold a fresh inquest into L's death.
- **HM Senior Coroner for Cornwall v Rowe [2024] EWHC 2673 (Admin):** seemingly unrelated inquests held in 2013 and 2017 - deaths of patients of the same surgeon. A review carried out by the Trust revealed serious patient safety concerns in relation to that surgeon. Potential systemic issues. **Fresh investigation** required.
- **Cherfan v HM Senior Coroner for West London [2024] EWHC 3261 (Admin):** procedural irregularities in an inquest returning a conclusion of suicide. No indication that had taken into consideration the family's view that M had died by an accidental overdose. Decision to hold an inquest in writing was procedurally flawed, as was last minute conversion to a Rule 23 inquest. **Fresh inquest** required.

- **Shipsey v Senior Coroner for Worcestershire [2025] EWHC 605 (Admin)**: new evidence casting doubt on suicidal intent. Parts of ROI quashed, fresh inquest **not required**.
- **HM Senior Coroner for West Yorkshire (East) v Ramsden [2025] EWHC 932 (Admin)**: conclusion of natural causes brought into question by new medical evidence indicating mesothelioma may have contributed to the death. **Fresh inquest** required.
- **Morrow v HM Assistant Coroner for Merseyside [2025] EWHC 935 (Admin)**: alleged insufficient scope of inquest / failure to consider suicide conclusion. **Court disagreed**.
§8: *"Where problems of process are relied on, a fresh inquest will only be required where those problems meant that justice was diverted or the inquiry was insufficient."*
- **Re HM Senior Coroner for West Yorkshire (Western District) [2025] EWHC 1672 (Admin)**: hundreds of pages of documents arguably demonstrating suicidal ideation were given to the coroner's office but not the coroner. Insufficient of inquiry, **fresh inquest** ordered.
- **HM Senior Coroner for South London v Alexei [2025] EWHC 2768 (Admin)**: A provisional post-mortem was the basis for the original inquest's conclusion ("unascertained") A subsequent pathologist's report gave a natural cause of death. **Fresh inquest** required.

PROCEDURE

- Identify grounds
- Application to Attorney General
- AG grants Fiat, s.13 application made as Part 8 Claim
- High Court still retains the right to say no (no ability to settle by consent)

A FEW PRACTICE POINTS

- Think hard before instigating an application
- No time limit but sooner after the inquest (and discovery of error/new evidence) the better
- Role of expert evidence
- Decision of the AG re fiat is not justiciable – but watch this space: **R (Campbell) v HM Attorney General for England and Wales [2025] EWHC 1653 (Admin)**

THANK YOU FOR LISTENING!

ANY QUESTIONS?



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THE MENTAL HEALTH ACT 1983 REGULATION 28 THEMES

17 June 2026

Francesca P. Gardner

OUTLINE

- Deaths in detention
- Community care/ after care s.117 MHA 1983
- Information sharing
- The role of the police
- Common failings
- Common misunderstandings
- The role of experts at an inquest

DEATHS IN DETENTION

- **Children and young people**

- Inadequate provision of Tier 4 beds
- Inappropriate placing of children on paediatric general medical wards
- Wards often not having the facilities to lock the doors, meaning the child is able to abscond
- Lack of communication between CAMHS and wider mental health services
- Poor or no record keeping
- Poor information sharing

DEATHS IN DETENTION

- **Adults**

- Poor or no record keeping/ inadequate training re record keeping and hand overs
- Poor information sharing
- Inadequate physical care plans to manage and mitigate the often serious side effects of psychiatric medication. E.g clozapine
- Flawed/inadequate discharge process including:
 - Failure to give sufficient notice to the community aftercare team;
 - Failure to liaise with the patient's nearest relative or wider family members
 - Premature discharge.

DEATHS IN THE COMMUNITY – AFTERCARE SERVICES

- Flawed discharge and/or inadequate monitoring
- Delays in triage of referrals to the Trust's Single Point of Access- including reports that triage often not taking place for *14 days post referral*.
- Poor information sharing
- Responsibility disputes- Right Care Right Person, cases where it has resulted in all services saying that they are not the appropriate service, and the person's death has occurred.
- Lack of adequate follow up, once a person has expressed thoughts of self harm/suicide.
- Increasing number of calls to the ambulance service, that are mental health related.

RIGHT CARE RIGHT PERSON

On 18th March 2025 Andrew John Hughes was found by Police who attended his home address following a call indicating there was a risk to life. He declined to attend at hospital but agreed to go to his father's home address. Officers transported him there and his father was updated regarding the concerns. On 20th March at 21:48 a call was received by the ambulance service from a friend of his partner indicating they were concerned as the last contact had been at 7pm and attempts to contact him since then had been unsuccessful. The call had been made to the ambulance service because when the caller rang Greater Manchester Police at 21:38 on 20th March they were signposted to the ambulance service. This was because it did not fall within their definition of an immediate threat to life. However, because the concern related more to mental health, the caller should have been signposted to mental health services. It is not known what steps mental health services would have taken. The ambulance service categorised the call as category 3 (a response within 120 minutes in 90% of cases) under the national call categorisation formula. The call remained at this category level and an ambulance was dispatched at 00:23 to his home address. Entry could not be gained until the Greater Manchester Fire and Rescue Service attended to force entry. He was found deceased. There was no evidence of any activity by him on his phone since 18:52 on 20th March 2025.

S.117 MHA – AFTERCARE

- Does not apply to patients detained under s.2, and discharged before receiving assessment and treatment under s.3
- “**aftercare services**” means services which have both of the following purposes:
 - (a) meeting a need arising from or related to the person’s mental disorder; and
 - Reducing the risk of a deterioration of the person’s mental condition (and accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder.)

THE POLICE

- Mental Health cases and the role of the police
- Numerous concerns raised as to the lack of '*refresher*' training provided for the police force.
- A number of cases reported where prior to the death it was either known that the person was known to mental health services or s.136 MHA had previously been utilised, but then (erroneously) wasn't at the time of death.
- Poor understanding of the MHA 1983
- Poor information sharing.

THE MENTAL CAPACITY ACT 2005– COMMON MISUNDERSTANDINGS

- Repeated reference to a fundamental misunderstanding of the MCA.
- Missed opportunities to act under the MHA 1983, as a result of professional misunderstanding of the MCA 2005.
- Missed opportunities for the person to be admitted to hospital under ss.2 or 3 MHA because they “...*have capacity under the MCA 2005, and object to admission.*”
- Missed opportunities under s.136 MHA 1983.

EXPERTS– THE BENEFIT OF HINDSIGHT...

- Experts will often speculate as to missed opportunities.
- Where there is a mental health related death, it is crucial that the expert has the necessary qualifications and expertise to comment upon the relevant decision making.
- For example, can a psychiatrist comment upon the actions and decision making of an Approved Mental Health Professional?
- “An expert witness is defined as a witness who provides to the court a statement of opinion on any admissible matter calling for expertise and **who is qualified to give such opinion.**”

EXPERT OPINION

- **Mental health professionals**
- Approved Mental Health Professionals
- Registered Mental Health Nurse
- Clinicians responsible for '*gatekeeping assessments*'
- Psychiatrists (are they s.12 qualified? Which aspect of decision making are they being asked to comment on?)
- Community Psychiatric Nurse

THE MENTAL HEALTH ACT 1983 REGULATION 28 THEMES

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