



Inquest Law Update

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Introduction

This is the Second Edition of the 39 Essex Street Inquest Law Update, edited by Jenni Richards QC and Josephine Norris. This update provides an overview of recent legislative changes, case law and other developments in the field of inquest law. The most significant recent development has undoubtedly been the implementation of the new statutory regime contained in Part 1 of the Coroners and Justice Act 2009 (and associated secondary legislation), although it is too early at present to assess the full impact of the changes.

The Coroners and Justice Act 2009

With effect from 25 July 2013 various provisions in Chapter 1 of Part 1 of the Coroners and Justice Act 2009 came into force, with the corresponding provisions in the Coroners Act 1988 being repealed. Various statutory instruments also came into effect, including the Coroners (Investigations) Regulations 2013, the Coroners (Inquests) Rules 2013, the Coroners (Allowances, Fees and Expenses) Regulations 2013 and the Coroners and Justice Act 2009 (Alteration of Coroner Areas) Order 2013. New terminology has been introduced: there is a new distinction between investigations and inquests, with the inquest forming the final part of the investigation process; coroner districts are now coroner areas; and the terminology of determinations and conclusions replaces that of verdicts.

The Act: a brief overview

Section 1 of the 2009 Act:

- imposes a duty on a senior coroner to conduct an investigation into a person's death

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as soon as practicable if the coroner has reason to suspect that the deceased died a violent or unnatural death, or the cause of death is unknown, or the deceased died whilst in custody or otherwise in state detention;

- provides for an investigation to be undertaken, pursuant to the direction of the Chief Coroner, where the coroner believes that a death has occurred and considers that the circumstances of death are such that there should be an investigation but there is no body;

- empowers the coroner to make whatever enquiries seem necessary in order to decide if the duty to investigate arises.



Section 4 of the Act sets out the circumstances in which an investigation must or may be discontinued:

- the senior coroner must discontinue the investigation if the post-mortem examination reveals the cause of death before the coroner has begun holding an inquest and the coroner thinks that it is not necessary to continue the investigation (section 4(1));
- this does not apply where the coroner has reason to suspect that the deceased died a violent or unnatural death or died while in custody or otherwise in state detention (section 4(2));
- where a senior coroner discontinues an investigation under section 4, no inquest may be held and no determination or finding under section 10 may be made (but this does not prevent a fresh investigation from being conducted): section 4(3);
- a written explanation of the decision to discontinue must be provided upon request to an interested person: section 4(4).

The Act imposes, for the first time, time limits upon coroners. Thus it is the duty of a coroner under section 16 of the Act to notify the Chief Coroner of any investigation that has not been completed or discontinued within a year (running from the date on which the coroner has been made aware that the person's body is within his area) and to notify him of the date on which the investigation is completed or discontinued. The Chief Coroner is in turn required to maintain a register of such notifications (section 16(2)). The duty is supplemented by provisions in the Coroners (Investigations) Regulations. Thus, where an investigation has not been completed or discontinued within the year, regulation 26(1) requires that the coroner must notify the Chief Coroner of that fact as soon as reasonably practicable and must explain why. Regulation 26(2) applies where such an investigation is subsequently discontinued or completed and requires the coroner to notify the Chief Coroner of the date of completion/discontinuance and to provide a reason for any further delay. An inquest must be completed within 6 months of the date on which the Coroner is made aware of the death or as soon as reasonably

practicable thereafter: rule 8 of the Coroners (Inquests) Rules.

The purpose of the investigation is defined in section 5 of the Act in essentially the same terms as previously but Article 2 compliance is ensured by section 5(2) which provides that where necessary to avoid a breach of Convention rights "purpose" is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death. Section 11 and schedule 1 to the Act make provision for the suspension and resumption of investigations, particularly in the event of criminal charges.

Section 6 of the Act provides that a coroner who conducts an investigation into a person's death must as part of the investigation hold an inquest into the death (unless the investigation has been discontinued). The general rule is that the inquest is without a jury (section 7(1)). Section 7(2) sets out the circumstances where there must be a jury: namely where there is reason to suspect: that the deceased died in state custody or otherwise in state detention and that the death was a violent or unnatural one or the cause of death is unknown; that the death resulted from an act or omission of a police officer or member of a service police force in the purported execution of their duty; or that the death was caused by a notifiable accident, poisoning or disease. Section 7(3) confers a discretion on a coroner to hold an inquest with a jury if the coroner thinks that there is sufficient reason for doing so.

Schedule 5 to the Act confers powers on the coroner to require a person to attend to give evidence or to produce documents or any thing in their custody or control which relates to a relevant matter. Schedule 6 creates various offences relating to witnesses and evidence, including doing anything intended to have the effect of preventing any evidence, document or other thing from being given, produced or provided for the investigation.

The outcome of an inquest now takes the form of a determination of the statutory questions (section 10).

The Investigations Regulations

These impose various duties upon coroners, including a duty to be available at all times for



urgent matters; a duty to attempt to identify the next of kin or personal representative and inform that person of the decision to begin an investigation; a duty to release the body for burial or cremation as soon as reasonably practicable; duties in the event of the transfer of an investigation to another coroner; and duties to provide information to the Chief Coroner and to the Local Safeguarding Children Board.

The Inquests Rules

The new rules apply to any inquest not completed before 25 July 2013. The inquest must be opened as soon as reasonably practicable and at the opening the coroner must where possible set the dates for any subsequent hearings. Whilst both inquest hearings and pre-inquest reviews should be in public, rule 11 allows the coroner to direct the exclusion of the public from the inquest hearing on national security grounds, or from a pre-inquest review hearing on national security grounds or in the interests of justice. Rule 13 imposes a duty on the coroner to provide disclosure to interested persons, save in the circumstances set out in rule 15. The Rules make provision for evidence to be given by live video-link or behind a screen. The admission of written evidence is governed by rule 23. The provisions for the summoning and attendance of jurors have been simplified and are now contained in rules 29-31.

Reports to prevent future deaths

Rule 43 of the old Rules has been replaced by a new regime for making reports to prevent other deaths (referred to by the Chief Coroner as PFD – prevention of further deaths – reports). Paragraph 7(1) of Schedule 5 to the Act imposes a duty to report a matter to a person who the coroner believes may have the power to take action, where anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur or continue to exist in the future and in the coroner’s opinion action should be taken to prevent the occurrence or continuance of such occurrences or to reduce or eliminate the risk of death. The report may not be made until the coroner has considered all the documents, evidence and information that s/he considers relevant to the investigation. The report must be sent to the Chief Coroner, who can publish a copy or summary of it in such manner as he thinks fit. Paragraph 7(2) of

Schedule 5 imposes a duty on the recipient of the report to respond within 56 days, giving details of any action that has been taken or which it is proposed will be taken and a timetable of the action taken or proposed. If no action is proposed, an explanation must be provided.

The Chief Coroner has prepared a useful Guide to the Coroners and Justice Act 2009, which can be found on the www.judiciary.gov.uk website.

Case Law Update

Disclosure and public interest immunity

In *Worcestershire County Council & Worcestershire Safeguarding Children Board v HM Coroner For Worcestershire* [2013] EWHC 1711 (QB), Baker J considered the extent of disclosure duties in the context of an inquest into the death of a 16 year old girl, Dana Baker, who committed suicide whilst accommodated with foster carers under section 20 of the Children Act pursuant to arrangements made by Worcestershire County Council.

The Coroner for the County of Worcestershire opened and adjourned an inquest into Dana’s death. Worcestershire Safeguarding Children Board (“the Board”) undertook a Serious Case Review (“SCR”). In the course of this review, the Board obtained 10 Individual Management Reviews (“IMRs”) and 6 Information Reports (“IRs”), and produced an SCR Overview Report, which was in draft form pending the outcome of the inquest. The Coroner requested to be provided with a copy of the draft overview report together with copies of the IMRs and IRs. The Board was initially resistant to the disclosure of the draft report but did provide a copy. It declined to provide the Coroner with any of the IMRs or IRs.

In November 2012 the Coroner succeeded in an application to the High Court for permission to issue witness summonses requiring the Board and Worcestershire County Council to produce these and other documents to him, pursuant to CPR 34.3(2)(c) and CPR 34.4(1). The Board and the Council applied to set aside these witness summonses on the basis that their contents were protected by public interest immunity and/or



their disclosure was unnecessary, pursuant to CPR 34.4(2) (although the Council's application was later withdrawn, as it became apparent that the documents were in the possession and control of the Board and that a witness summons did not need to be pursued against the Council). In particular, it was submitted that the purpose of the IMRs and IRs was to enable the contributing agencies to look openly and critically at individual and organisational practice, and that to ensure candour for this purpose it was essential that they remained confidential to those undertaking the SCR. Further, the Board contended that should these reports be disclosed to the Coroner, there was a risk that they would also have to be disclosed to interested parties to the inquest and that the draft overview report provided sufficient information to the Coroner for the purposes of his inquiry.

Baker J acknowledged that the ethos underlying a SCR *"is not one of individual retribution for past conduct rather it is one of individually and collectively learning lessons for the future, with a focus upon inter-agency cooperation."* He further accepted that the efficacy of the SCR requires cooperation and that the statutory guidance envisages that IMRs and IRs will remain confidential to the SCR and a limited number of properly interested bodies. Accordingly, in principle and by analogy with *Taylor v Anderton (Police Complaints Authority intervening)* they were documents against which a claim for public interest immunity could lie. However as with any claim for non-disclosure on the basis of public interest immunity, it was necessary to balance the perceived public benefit it affords against the public benefit of disclosure, both in relation the principle of open justice and the particular requirements of justice in the context in which it is being examined. At paragraph 92 of his judgment, Baker J outlined a number of factors which he considered would weigh in that balancing exercise:

- i) *HM Coroner has an equally crucial role in investigating suspicious deaths within his area, including the death of a "looked after" child who has died a "violent or unnatural death."*
- ii) *Subject to the supervisory jurisdiction of this court, the scope of an inquest is essentially a matter for the coroner, (Regina v HM Coroner for North Humberside and Scunthorpe ex-parte Jamieson, supra). Indeed in cases involving*

the death of a "looked after" child, and where an Article 2 type of inquiry is required, it may be that the State's procedural investigative obligations would not be satisfied by the SCR process, and would require that inquiry to be carried out in the context of a Middleton type inquest. (Plymouth City Council v Her Majesty's Coroner for the County of Devon (Plymouth and South West District) and the Secretary of State for Education and Skills, supra). Even where such an inquest is not required, the coroner's Rule 43 powers may require a fuller investigation into the circumstances in which the death occurred. Moreover, a Jamieson type inquest may require the investigation of systematic failures (The Queen (on the application of Butler) v HM Coroner for the Black Country District, supra).

- iii) *Reflecting the pre-eminent role of HM Coroner in deciding the scope of an inquest, this court will only interfere with such a decision in exceptional circumstances, (Regina v Inner West London Coroner ex-parte Dallaglio & Another, supra)*
- iv) *The role of HM Coroner is not an adversarial one, but an investigative one, such that questions of relevance and necessity are unlikely to be as decisive as they would be in the context of civil litigation, (Inner West London Assistant Deputy Coroner v Channel Four Television Corporation, supra).*
- v) *Where in the context of a claim of public interest immunity a balance has to be struck between competing public interests, it may be that because of the nature of his inquiry the balance ought normally to be in favour of disclosure to HM Coroner, (Re A subpoena (Adoption Commissioner for Local Administration, supra).*
- vi) *What is sought is not disclosure of the IMRs and IRs to the public in general or indeed anyone else, save and except HM Coroner. Thus the argument in favour of non-disclosure arising out of the need to encourage openness within the IMRs and IRs is likely to be significantly diluted, (McCaughey (Judicial Review Application), supra). This being in contradistinction to the situation which may arise with the question of disclosure to members of the public (ICO Decision Notice Plymouth City Council Reference*



FS50084360 and ICO Decision Notice London Borough of Haringey Reference FS50234513).

vii) *The question of any further disclosure is a matter for HM Coroner, having taken into account any further arguments in favour of non-disclosure and subject to the supervisory jurisdiction of this court; thus maintaining sufficient safeguards to those properly seeking non-disclosure of these documents (Inner West London Assistant Deputy Coroner v Channel Four Television Corporation, supra).*

On the facts, and having read the undisclosed material, Baker J concluded that the IMRs and IRs did contain significantly more detailed information of potential relevance to the Coroner for the purposes of his inquiry, over and above that which he had already obtained. The Judge further accepted that the undisclosed material would be relevant to allowing the Coroner to consider the scope of his inquiry in its proper context, including the necessity or otherwise of an Article 2 inquiry/ Rule 43 report, and to provide him with appropriate guidance as to the identity of potential witness and documents, the pursuance of relevant lines of inquiry and the framing of questions for those witnesses in the course of the inquest. Accordingly the application by the Board was rejected albeit that Baker J made it clear that this was not a determination of the appropriateness of any subsequent disclosure to members of the public (including interested parties at the inquest), this being a matter for determination by the Coroner in due course, subject to the supervisory jurisdiction of the Court. The Coroner's undertaking not to make any such disclosure without first notifying the Board and relevant contributing agencies, allowing them sufficient time to make submissions to him and if necessary to invoke the court's supervisory jurisdiction, provided sufficient safeguards to protect the proper interests of the Board, the contributing agencies and the individual professionals who had been involved.

This is a significant decision in terms of defining – prior to the recent legislative changes - the parameters of disclosure in all types of inquest and emphasises the importance of ensuring that the Coroner has access to the widest possible range of material when exercising his statutory powers of investigation, including at the early stage where the scope of that investigation remains to

be determined. Local authorities and other public bodies will no doubt welcome the recognition that public interest immunity may attach to documents of this nature and that each disclosure application will necessarily turn on the facts of the particular case. The decision, and in particular the issue of onward disclosure to interested parties, will now need to be considered in light of the new statutory regime.

Baker J's summary of the principles which are likely to apply when applications for disclosure of SCRs or similar documents, together with the underlying material, is particularly helpful given the prominence given to disclosure obligations in the new statutory framework. The judgment is an indication that the balance is likely to weigh in favour of openness.

Extra – territoriality and the scope of Article 2

In Smith & Ors v Ministry of Defence: Ellis v Ministry of Defence, Allbutt & Ors v Ministry of Defence [2013] UKSC 4, seven Justices of the Supreme Court considered a number of claims arising from the deaths of three soldiers and the injuries sustained by two other soldiers whilst on active duty in Iraq. A central issue was the scope of the doctrine of 'combat immunity'.

Private Hewett and Private Lee Ellis were both killed when IED devices exploded in close proximity to the Snatch Land Rovers in which they were patrolling. Neither vehicle involved was equipped with Electronic Counter Measures (ECMs) to protect against IED devices. Susan Smith, the mother of Private Hewett, and Courtney and Karla Ellis, the father and sister of Private Ellis, claimed (*inter alia*) that the United Kingdom had breached Article 2 ECHR by failing to take measures within the scope of its powers which, judged reasonably, the state might have been expected to take in the light of the real and immediate risk to the life of soldiers who were required to patrol in Snatch Land Rovers.

The Ministry of Defence applied successfully to strike out the Article 2 claims on the grounds that:

- (1) Privates Hewett and Ellis were not within the jurisdiction of the United Kingdom for the



purposes of Article 1 of the Convention when they died; and

(2) On the facts as pleaded the MOD did not owe a duty to them at the time of their deaths under Article 2.

At first instance Owen J had accepted the MOD's case on jurisdiction and further held that there was no sound basis for extending the scope of the implied positive duty under Article 2 to decisions made in the course of military operations by commanders. The findings in respect of jurisdiction were upheld by the Court of Appeal who therefore considered that it was unnecessary to address the issue of the substantive scope of Article 2. Both points were argued before the Supreme Court.

In reversing the ruling on jurisdiction, the Supreme Court reviewed the existing authorities (both domestic and from Strasbourg) in relation to the doctrine of extra-territoriality. The Court concluded that, in view of the decision of the ECtHR in the case of *Al Skeini*, it is no longer good law to regard the rights and obligations under the Convention as indivisible in this context. Rather, the extra-territorial obligation of the contracting state is to ensure the observance of the rights and freedoms that are relevant to the individuals who are under its agents' authority and control. Serving soldiers remain under the authority of the United Kingdom and are subject to English law. No other State is claiming jurisdiction over them. Accordingly, the jurisdiction of the United Kingdom under Article 1 of the Convention extends to securing the protection of Article 2 to members of the armed forces when they are serving outside its territory. At the time of their deaths Pte Hewett and Pte Ellis were within the jurisdiction of the United Kingdom for the purposes of that Article.

The Court then considered the substantive scope of the duties under Article 2 in a combat context. In his leading judgment (with which judgment three other members of the Court agreed, with the remaining three members dissenting), Lord Hope reiterated the key elements of the Strasbourg jurisprudence, namely that when the substantive scope of a Convention right is in issue, a fair balance must be struck between the competing interests of the individual and of the community as a whole. Further, there will usually be a wide margin of appreciation if the state is required to strike a

balance between private and public interests and Convention rights. He emphasised that the guarantee in the first sentence of Article 2(1) is not violated simply by deploying servicemen and women on active service overseas as part of an organised military force which is properly equipped and capable of defending itself, even though the risk of their being killed is inherent in what they are being asked to do. However, in respect of the procedural duty under Article 2, there have been many cases where the death of service personnel indicates a systemic or operational failure on the part of the state, ranging from a failure to provide them with the equipment that was needed to protect life on the one hand to mistakes in the way they are deployed due to bad planning or inadequate appreciation of the risks that had to be faced on the other. Failures of that kind ought not to be immune from scrutiny in pursuance of the procedural obligation under Article 2 of the Convention.

At paragraph 76 Lord Hope concluded:

"...the court must avoid imposing positive obligations on the state in connection with the planning for and conduct of military operations in situations of armed conflict which are unrealistic or disproportionate. But it must give effect to those obligations where it would be reasonable to expect the individual to be afforded the protection of the article. It will be easy to find that allegations are beyond the reach of article 2 if the decisions that were or ought to have been taken about training, procurement or the conduct of operations were at a high level of command and closely linked to the exercise of political judgment and issues of policy. So too if they relate to things done or not done when those who might be thought to be responsible for avoiding the risk of death or injury to others were actively engaged in direct contact with the enemy. But finding whether there is room for claims to be brought in the middle ground, so that the wide margin of appreciation which must be given to the authorities or to those actively engaged in armed conflict is fully recognised without depriving the article of content, is much more difficult. No hard and fast rules can be laid down. It will require the exercise of judgment. This can only be done in the light of the facts of each case."

On the facts, the question of liability was to be deferred to trial, as the question of whether the



actions fell within Article 2 could not be determined without a factual inquiry.

This is a significant decision in relation to Article 2 more generally. The reversal of the limitative stance on extra-territorial jurisdiction opens a possibility for a greater number of claims arising from the actions of the armed forces overseas – including towards their own personnel – and widens the category of cases in which an Article 2 compliant inquest will be required.

“Effective Investigations” and Article 2 ECHR

In a recent decision, the High Court (Mitting J and Aitkens LJ) was asked to determine whether Article 2 ECHR obliges the State to conduct an *immediate* and *independent* inquiry into the circumstances of the death of a patient detained under the Mental Health Act 1983.

The proceedings for judicial review in *R (on the application of Antoniou) v (1) Central and North West London NHS Foundation Trust and (2) The Secretary of State for Health and (3) NHS England* [2013] EWHC 3055 (Admin) were brought by Dr Antoniou, whose wife (JA) died in October 2010 whilst detained under section 3 of the Mental Health Act in the Mental Health Unit of Northwick Park Hospital. Following her death, an investigation was carried out by the hospital in accordance with the ‘Serious Untoward Incident Policy’. In the course of that investigation, statements were taken from a number of hospital staff. The SUI Panel report was eventually produced on 6 July 2011 despite the applicable policy indicating it should be produced within 90 days. In addition, there was a police investigation which culminated in a police report being produced in December 2010. This examined the events after JA’s death but not the developments beforehand.

Dr Antoniou first requested an independent review of the circumstances leading to JA’s death in April 2011. Proceedings for judicial review were issued in August 2011 but were stayed pending the outcome of an inquest. On 16 May 2012, the jury recorded a narrative verdict. They concluded that JA’s death was inadvertent following self-harming by use of a ligature. The jury further made certain criticisms

of the actions taken prior to JA’s death, including a finding that not all relevant information had been passed to the nursing team.

Legal and Policy Framework

At the material time, the provisions of the Coroners and Justice Act 2009 had not come into force and the relevant legal framework was the Coroners Act 1988. Under that statutory framework, there was no statutory obligation to carry out an inquest into a death in a psychiatric custody as opposed to death in prison or other circumstances defined by section 8 (3) of the Act. Nor was there a duty, but merely a power to carry out an inquest with a jury. Further, whereas deaths in police custody or in prison trigger an investigation by the PPO or the IPPC, there is no equivalent body to investigate deaths in psychiatric custody. The DoH Guidance in force (which was replicated by the CNWL guidance) identified 3 different degrees of investigation that should occur – (1) an ‘initial management review’ (2) An Internal Mental Health Trust investigation and (3) a Strategic Health Authority Independent investigation. The guidance stipulated that an SHA independent investigation should be undertaken in three identified circumstances:

- (a) where a homicide has been committed by a person who is or has been under the care of specialist mental health services in the six months prior to the event;
- (b) when it is necessary to comply with the State’s obligations under Article 2 ECHR – that obligation being triggered “*Whenever the State agent is or may be responsible for a death or where the victim sustains life-threatening injuries*”;
- (c) when the SHA determines that an adverse event warrants independent investigation, for example where there have been a cluster of suicide or restraint related deaths.

In practice, SHA investigations have rarely been commissioned and typically only in circumstances (a) or (c).

Arguments

By his claim, Dr Antoniou sought to establish that the policies and procedures applied by the Defendants in respect of investigations into a



death in psychiatric custody were unlawful in that they unduly confined the extent of the procedural obligation to carry out an 'effective investigation' pursuant to Article 2 ECHR. On the Claimant's case, the Article 2 duty to carry out an effective investigation required the State to:

- i. take the initiative to carry out the investigation;
- ii. take adequate steps to secure the evidence;
- iii. carry out an investigation independent of the institution involved;
- iv. carry out an investigation with diligence and promptness;
- v. ensure a sufficient degree of public scrutiny for it to be accountable;
- vi. involve the next of kin effectively;
- vii. establish the circumstances of the death/near death.

Further, an independent investigation should be carried out immediately even though it may not be clear that the State was in breach of its Article 2 obligations and even in circumstances in which there might be an inquest.

Criticism was therefore made of the DoH, CNWL and NPSA Guidance, all of which were said to unduly circumscribe the duty of investigation as outlined by the Claimant.

The Claimant further contended that on the facts, these requirements had been breached, inter alia because the SUI investigation lacked independence and because there had been operational failures at several points in securing the evidence and failures in the process of disclosure in the inquest. It was also asserted that the investigative regime was discriminatory in that JA's death had been subject to a different (and lesser) degree of scrutiny than that which would have been applied to other detainees in other settings and therefore this contravened the Equality Act 2010.

CNWL submitted that the requirements of an effective investigation do not extend to an immediate independent investigation – the totality of the investigations has to be examined to ascertain whether or not there has been

compliance with Article 2. On the facts, there had been no breach of Article 2. As to discrimination, the Equality Act was not in force at the time of JA's death, there had been no discrimination during her lifetime and she had none of the protected characteristics. The Secretary of Health and NHS England similarly submitted that there was no duty to carry out an independent pre-inquest investigation to comply with Article 2.

Scope of the obligation under Article 2 ECHR in a case where a patient detained under section 3 or 5 MHA has died in hospital

The Court considered the Strasbourg jurisprudence and the domestic decisions in *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653, *R (L) v Secretary of State for Justice* [2009] 1 AC 588 and *R (Smith) v Oxfordshire Assistant Deputy Coroner* [2011] 1 AC 1. *Amin* was recognised as authority for the proposition that an inquest is the means by which under domestic law, the State's duties under Article 2 are to be discharged but it was not accepted that it established that there must be an independent and prompt inquiry in addition to an inquest. *L* was held to provide useful guidance as to the constituent elements of an Article 2 compliant inquiry, but as it concerned a death in prison, it was held that the House of Lords plainly did not have the circumstances applicable in the present proceedings in mind. Whilst it was acknowledged to be the high point of the Claimant's case, on the facts of *L*, it was a near miss situation and so there could have been no inquest. *Smith* was also rejected as authority for the proposition that there must be an immediate Article 2 compliant investigation as opposed to an enhanced or staged investigation. Accordingly, the Court found that there is no existing domestic authority requiring that in order to fulfil the State's Article 2 obligations, there must be an independent investigation from the outset where a detained patient has died in mental health custody.

As to the submission that the law should be extended to encompass such a duty, the Court concluded that a *Middleton* inquest would be sufficient to discharge the State's Article 2 procedural obligations and that on the facts of the case, there was no basis to conclude that this would be an inappropriate means of doing so. Further, whilst there were different regimes for deaths in custody, there was no requirement under the



Strasbourg jurisprudence or domestic law that the obligation under Article 2 had to be discharged in the same way in the context of mental health detention.

Lawfulness of the Guidance

The Court held that given its findings as to the need for an immediate independent investigation, the claim that there had been a breach of an obligation to undertake one was bound to fail. Whilst the DoH/CNWL and NPSA guidance could be clearer, it did not disclose an error of law.

Curing of defects

Although in view of the findings on the first issue, the question of whether a defective independent investigation could be cured by a subsequent inquest did not fall to be determined, the Court commented nonetheless that, if this type of investigation were (contrary to its primary finding) a requirement under Article 2, any defect in its conduct could not be cured. The only situation in which a 'cure' might be relevant is where the adequacy of the overall investigation procedure was challenged.

Breach of Article 2 on the facts?

The Court considered in some detail the various defects in the SUI investigation process identified by the Claimant. In essence, the Court concluded that regarded overall, the investigation procedure was not defective. Even though the SUI investigation was not 'independent', the Coroner's inquest was. Further, the loss of evidence did not materially impede the investigation, nor did the failure to provide full disclosure which was not material to the events leading up to JA's death. The investigation process, which took 19 months, should be regarded as prompt and JA's family had been suitably involved. Accordingly, there had been no breach of the duty to provide an Article 2 ECHR compliant investigation.

Discrimination

The Court accepted that superficially it might appear that there is differential treatment within the meaning of Article 14 ECHR if the investigative obligation into suicide is more stringent in circumstances where an individual is detained in prison as opposed to mental health custody.

However, that differentiation is not attributable to the fact that an individual suffers from mental health issues – it is attributable to the objectives of the detention. If the obligation is more stringent in the context of prison custody, this is due to the difference in the nature and circumstances of the place in which they are detained. However, where a prisoner is detained in the psychiatric wing of a prison hospital, the more stringent obligation continues to apply as he would still be detained for deterrent purposes.

As to the arguments under the Equality Act 2010, the Court found that the duty not to discriminate both under section 6 and the public sector equality duty, only applies to a living person and the death of JA extinguished any discrimination.

Accordingly, the proceedings for judicial review were dismissed.

Mousa: the scope of the investigative obligation

The scope of the State's investigative obligation under Articles 2 and 3 has received further consideration by the Divisional Court in *R (Ali Zaki Mousa & Others) v Secretary of State for the Home Department* [2013] EWHC 1412 (Admin) and [2013] EWHC 2941 (Admin).

The case concerned a judicial review by a number of Iraqi civilians who sought a single public inquiry into allegations of abuse by British Soldiers in Iraq between 2003 and 2008. Following the Court of Appeal decision in the first *Mousa* challenge [2011] EWCA Civ 1334, the Secretary of State for Defence had reformed the Iraq Historic Allegations Team (IHAT) – the body charged with investigating past allegations in Iraq - with a view to making it more independent. In particular members of the Royal Military Police had been removed from IHAT and instead replaced with more civilian investigators and some members of the Royal Navy Police.

Before the Divisional Court in *Mousa (No. 2)* the Claimants contended that the IHAT investigations were still lacking in independence (because of the involvement of the Royal Navy in Iraq) and were also ineffective. They sought a single public inquiry tasked with investigating and reporting in respect



of all of the allegations of abuse, together with an examination of wider systemic issues in order to ensure that lessons were learned for the future.

The Divisional Court rejected the contention that IHAT was not sufficiently independent. It also rejected the call for a single overarching public inquiry as unmanageable in terms of time, cost and delay.

However the Court concluded that the IHAT investigations alone were not enough to satisfy the State's investigative obligation under the ECHR, particularly in the death in custody cases and it therefore proposed a process based on coroner's inquests in which an inquisitorial investigation would be carried out (by a single independent person) of the circumstances surrounding the death, after the criminal investigations had concluded. In reaching this conclusion the Court was heavily influenced by "*the need for expedition, the practicality of what can be done... and the proportionate cost*" and the court gave guidance as to how streamlined and focused investigations could be established without the need for the full 'bells and whistles' which have come to characterise most recent public inquiries.

Following further legal argument about the parameters for any such coronial-style investigations, the Divisional Court very recently gave further guidance on the form which such investigations should take ([2013] EWHC 2941 (Admin)). In that judgment the Court indicated that there would be a need to ensure that witnesses were compellable, but that the investigations could be structured in such a way as to avoid extensive legal representation.

As recognised by the Divisional Court the situation facing the Secretary of State is unprecedented. Following *Al-Skeini v United Kingdom* (2012) 53 EHRR 18 and the evolving interpretation of Article 1 of the ECHR in the Iraq context, there were possibly as many as 150-160 cases involving death and 700-800 cases involving alleged mistreatment in breach of Article 3. Against that background this is an attempt by the Divisional Court to redefine the way in which the state discharges its investigative obligation and marks a shift away from expensive and time-consuming public inquiries. Conscious of the immense burdens on the public purse, the Court is keen to find ways in which the

State can satisfy the requirement to investigate the wider circumstances surrounding the death/incident, without incurring unnecessary delay and expense. To that extent it represents an interesting development in the case law which has the potential to affect not merely the State's response to the Iraq legacy, but also wider contexts where the investigative obligation arises.

Other cases

Armstrong v James Hipwell (deceased)

On 29 July 2013, Dingemans J and Judge Peter Thornton QC quashed the verdict of an inquest that had been held over 20 years previously into the death of an unidentified man whose body had washed ashore. DNA profiling now provided strong scientific evidence that he was an individual identified on the Missing Persons Database. He had had a history of mental health issues and learning difficulties and was suicidal. He was last seen in September 1989 when he was 34 years old in a psychiatric unit of a hospital and had tried on that day to take his own life. Given this fresh evidence, the Court accepted that it was necessary or desirable in the interests of justice to order a fresh inquest pursuant to section 13 (2) of the Coroners Act.

R (John Duffy) v (1) Her Majesty's Deputy Coroner for the County of Worcestershire (2) Worcestershire Acute Hospitals Trust [2013] EWHC 1654 (Admin)

The Claimant was the father of a young child, Thomas, who died aged 14 months. A deputy coroner entered a verdict of death by natural causes. The Claimant challenged the sufficiency of the inquiry at the inquest and the safety of the verdict. A significant issue at the inquest had been the question of whether those treating Thomas in hospital had failed to recognise that he had a heart condition and what treatment should have been given to him in hospital. During the course of the inquest the coroner's appointed expert, Dr Shinebourne, stated that he had been out of intensive care practice as regards children for 15 years. The family sought an adjournment of the inquest to enable the instruction of an expert with current experience and knowledge. The coroner declined. The basis of the Claimant's judicial review



was that the decision not to adjourn, and then to proceed to a verdict of death by natural causes, was fundamentally flawed.

Whilst noting that successful challenges to the decision of a coroner on a matter such as an adjournment are rare, Kenneth Parker J considered that this was an unusual case. He pointed to four particular factors – the material before the inquest that raised very serious questions about the level of hospital medical care that Thomas had received, the fact that Dr Shinebourne made clear that he had not been concerned with the intensive care of children for 15 years (the intensive care of Thomas being the issue that lay at the heart of the immediate circumstances leading to his death), the fact that Dr Shinebourne did not regard the issue of causation as straightforward and the fact that Dr Shinebourne had been unable to deal with an important issue (as to the appropriate level of fluids to be administered to an infant of Thomas' weight and age) which had already been identified as a potential contributory cause of Thomas' death. The combination of these factors pointed to only one conclusion, namely that the inquest should be adjourned and evidence should be obtained from an expert with current experience in the intensive care of children. The interests of justice required an adjournment, notwithstanding any regrettable consequences in terms of the planned course of the inquests.

It has become increasingly common for coroners to obtain their own expert medical evidence. This case is a salutary reminder of the importance of ensuring that such expert evidence is obtained from someone with relevant and up-to-date medical expertise. It is also a salutary reminder that, where the facts are sufficiently compelling (such as unanswered questions as to the care of a very young child) the coroner should take all necessary steps to ensure an adequate investigation, including adjournment of the inquest if that is the only means of obtaining the necessary evidence.

R (Chief Constable of Devon and Cornwall Police) v HM Coroner for Plymouth, Torbay and South Devon [2013] EWHC 3729 (Admin)

In July 2012 in Torquay a collision between two cars led to the death of Oisín Twomey (a 16 month old boy) and his father, Connie Twomey. Mrs Twomey survived but had been 24 weeks pregnant and her

unborn baby did not survive. The driver of the other car, Mark Wojciechowski ("MW"), also died. Before the collision, the police had received a call reporting that MW had left his home address in his vehicle, leaving a note stating that he was sorry and was going to end it. At the point at which the collision occurred, the police had caught up with MW's vehicle and signalled for it to pull over, but it had suddenly accelerated and driven onto the other side of the carriageway and into a head-on collision with the car carrying the Twomey family. The inquest commenced, and the Coroner indicated that he intended to conduct a wide-ranging inquiry. Having heard a substantial range of evidence, the Coroner decided to ask the jury a number of questions, including whether there were any defects in the state organisations that day which contributed to the death. The police challenged the inclusion of that question.

Stuart-Smith J accepted that there could be no justification for asking a jury to make a finding for which there is no evidence, and that juries could not be asked to speculate without any evidence to support their speculation. He observed that matters of concern about which there was no evidence could be addressed in an Article 2 compliant way through the coroner's duty to report. The Judge concluded that there was no evidence adduced at the inquest that could properly have supported a finding that the failure to have a procedure specifically designed for dealing with suicide risks was a breach of the police's obligations under Article 2. There was, he found, no evidence to suggest that suicide risk motorists should be treated differently from other groups or that the police procedures were inappropriate for dealing with suicide risks. Further he added (paragraph 20) that:

"if something as complex as procedures for dealing with particular groups of vulnerable people are to be criticised, the criticism must in all fairness be based upon evidence and cannot be left to the well intentioned but necessarily speculative and uninformed views of a jury in the absence of relevant evidence."

In response to a criticism that the police should have issued proceedings at the outset of the inquest rather than part-way through, the judge pointed out that the coroner has a broad discretion about the width of the evidential inquiry that he will undertake or permit others to pursue, and that



it is only when the inquest approaches the question of verdicts that the question of scope is likely to be critical.

CM v Executor of the Estate of EJ (deceased) and HM Coroner for South London

This was an application brought by way of originating summons under the inherent jurisdiction for a declaration that it was lawful to take and test samples of blood and tissue from a deceased person (EJ). The application was made by CM, a doctor, who whilst off duty performed emergency first aid in the street on EJ, a woman who had fallen from a nearby building. During the resuscitative efforts, CM's hands had become covered with EJ's blood. CM noticed that she had a number of abrasions on her hands and was anxious about the risk of being infected with a blood-borne disease from the deceased. CM wished to establish whether there was any risk that she had been contaminated by any serious blood-borne illness, which could be done by testing EJ's blood or human tissue. The Coroner into whose custody EJ's body had been placed was contacted and asked for his co-operation in obtaining samples of EJ's blood or tissue. The Coroner had no free-standing power to permit the sampling of EJ's blood or tissue for this purpose but had no objection to the proposed course.

The application was heard urgently by Mr Justice Cobb whose judgment is reported at [2013] EWHC 1680 (Fam). He noted that the collection, removal, storage and use of human tissue is governed by the Human Tissue Act 2004, and that in the absence of requisite consent the removal, testing or storing of human tissue would be a criminal offence. The sources of appropriate consent are set out in section 3 of the 2004 Act. Where a person has died, appropriate consent means the deceased's consent (if in force immediately before death); the consent of a person appointed to deal with the issue of consent in relation to the specific activity; or the consent of a person who stood in a qualifying relationship to the deceased immediately prior to death. Various relatives are listed as falling within the relationship of qualifying person. The Act also provides for the removal, storage and use of human tissue and blood for any purpose associated with the functions of a Coroner. The Judge was satisfied that it was not reasonably practicable to seek the consent of EJ's parents within the time available but that the relative of EJ (a cousin of her mother)

who had been contacted (and who had indicated his agreement to the proposed course of action) was sufficient for the purposes of giving consent, and that this opened the gateway for the exercise of the Court's discretion under the inherent jurisdiction. Whilst paying high regard to the importance of respecting the integrity of the deceased's body, the Court took particular account of the fact that CM's application only arose because she undertook an act of great humanity in attempting to save EJ's life and that if the testing were not to be undertaken CM would live for the foreseeable future in a state of profoundly serious uncertainty which would affect both her personal and her professional life. The Judge had little hesitation in granting the relief sought by CM.

The Litvinenko inquest

The Litvinenko inquest continues to generate controversy and satellite litigation. On 4 June 2013 the coroner, Sir Robert Owen, requested the Secretary of State for Justice to establish a public inquiry into the circumstances of Mr Litvinenko's death. The Secretary of State refused, and Mr Litvinenko's widow sought to challenge that refusal. In *R (Litvinenko) v Secretary of State for the Home Department* [2013] EWHC 3135 (Admin), the Court refused to grant his widow a protective costs order in respect of her application for judicial review of the Secretary of State's refusal to hold a public inquiry into his death. The Court accepted that her private interest in the proceedings was merely a factor to be considered rather than a bar to a protective costs order being made, and accepted that the public importance of the application was self-evident. However, it nonetheless concluded that given her financial means (£500,000 of unencumbered assets and thus means considerably greater than those of many litigants), it would be unjust to grant the order sought.

The Divisional Court has entertained a further challenge, this time by the Secretary of State, to the Coroner's decision to reject, in part, the Secretary of State's public interest immunity (PII) claim in *Secretary of State for Foreign and Commonwealth Affairs v Assistant Deputy Coroner for Inner North London* [2013] EWHC 3724 (Admin) (this is a reference to the open judgment, the Court having delivered also a closed judgment). The PII claim was made on the basis of a real risk that disclosure would cause serious harm to the national security



and/or international relations interests of the UK. The Secretary of State challenged the Coroner's decision on three principal grounds: failure to accord adequate respect to the Secretary of State's assessment as to how the balance of the competing public interests should be struck; failure properly to undertake the balancing exercise by treating the desire to conduct a full and proper inquest as a trump card overriding all other considerations; and reaching a decision which no reasonable coroner applying the correct legal principles could reach.

Lord Justice Goldring's judgment contains, at paragraphs 53-61, a useful summary of the principles to be applied in relation to the balancing exercise. He emphasised that when carrying out the balancing exercise the Secretary of State's view regarding the nature and extent of damage to national security should be accepted unless there are cogent or solid reasons to reject it, in which case such reasons must be set out. A real and significant risk of damage to national security will generally, but not invariably, preclude disclosure, but the decision is for the Coroner not the Secretary of State. In rejecting the certificate, the Coroner must be taken to have concluded that the damage to national security, as assessed by the Secretary of State, was outweighed by the damage to the administration of justice by upholding the certificate; it was therefore incumbent upon the Coroner to explain how he arrived at his decision.

The Court concluded that the Coroner did not really explain the reasoning which drove him to decide that the need for a full and proper inquiry outweighed the real risk of damage to national security, and that the Coroner gave insufficient weight to the views of the Secretary of State. Had the Coroner approached the balancing exercise in the way required by the authorities, he would have been bound to conclude that the prejudice to the inquest process was outweighed by the real risk of significant damage to national security.

Other Publications

Guidance from the Chief Coroner

Over the last few months the Chief Coroner has published 11 Guidance notes: Guidance No. 1 on the Use of Post-Mortem Imaging; Guidance No. 2 on

the Location of Inquests; Guidance No. 3 on Oaths and Robes (making clear that robes should not be worn for any court hearings); Guidance No. 4 on the Recordings of Inquest Hearings; Guidance No. 5 on Reports to Prevent Future Deaths (supplemented by Guidance No. 5A), which emphasises the importance of reports to prevent future deaths and suggests that they should be "*clear, brief, focused, meaningful and, wherever possible, designed to have practical effect*"; Guidance No. 6 which is designed to assist local authorities in making coroner appointments; Guidance No. 7 which details the establishment of a cadre of specialist coroners to conduct inquiries and investigations into the deaths of service personnel on active service; Guidance No. 8 on Pre-Signed Forms (pointing out that their use is unlawful and must cease); Guidance No. 9 on Opening Inquests; and Guidance No. 10 on Warnings to Juries. The most recent note – Guidance No. 11, published on 5 December 2013 – is concerned with the use of juries in railway accident cases and aims to provide a more consistent approach. In cases of possible suicide, juries will not usually be required; but the coroner will usually be required to summon a jury where there is reason to suspect a work-related accident on the railway.

The Chief Coroner has also published two Law Sheets: one on unlawful killing and the other (entitled Galbraith plus) on the approach to take when deciding whether to leave a case to the jury.

Reports

In June 2013, the Ministry of Justice published its **Ninth Summary of Reports and Responses under Rule 43 of the Coroners Rules** which covers the period from 1 October 2012 to 31 March 2013. This is the final report to be published by the Ministry of Justice, as the Chief Coroner will now assume responsibility for Prevention of Future Death Reports following the implementation of powers under the Coroners and Justice Act 2009.

235 rule 43 reports were issued in this period (bringing the numbers of Rule 43 reports issued from July 2008 to March 2013 to 1,794). The MOJ report noted that just over a third of reports relate to death in hospitals, and that these reports frequently identify concerns over policies or in relation to note taking, staffing, training, communication and the recording of medication.



Mental health related deaths featured prominently as did deaths in custody: *“A number of reports cite issues of communication particularly between different agencies and departments within hospitals. They also raise the importance of training staff in caring for patients at risk of self harm.”*

Three cases were identified as raising wider considerations. The first related to a man who was believed to be under the influence of the drug methylenedioxypropylamphetamine (MDPV) and who came into contact with the police. An ambulance was called but an officer considered him as ‘not safe to be seen’ although the evidence was unclear whether the man refused to be seen by the paramedics or whether it was unsafe. The paramedics left without examining him or agreeing with the police how he should be dealt with. The man subsequently began to throw items out of a window including a glass. The police moved to arrest him and perceiving a threat of violence one officer discharged a Taser and the man fell to the ground. He was restrained by handcuffs and leg restraints and transported to hospital where he suffered a cardiac arrest and was pronounced dead. Whilst the inquest found the death was most likely caused by the MDPV, following the inquest the coroner reported issues for consideration to a number of organisations including the College of Policing who were asked to consider (*inter alia*) whether guidance in the Personal Safety Training manual needed to be revised and training in medical implications reviewed. In their response, the College of Policing confirmed that national guidance for custody and detention would be reviewed and updated during 2013. The College also responded to the questions as to training on medical implications. Questions were also asked of the North West Ambulance Service who confirmed that they had significantly improved the staff training and information on how to jointly manage with the police drug overdose patients who lack capacity and may be violent. Inter-agency training had been organised to ensure that paramedics and police officers have the same level of understanding of how to manage these types of patients in line with the Mental Capacity Act 2005 and Mental Health Act 1983.

The second case concerned the death of an in-patient at Southend University Hospital NHS Foundation Trust who died when he fell from a second floor window, having removed the single

hook restrictor to open the window. At the time he was in an acutely confused, delusional and paranoid state following major surgery. The hospital believed that the single hook restrictor would prevent the window from being forcibly opened although during the inquest the coroner heard evidence that this type of restrictor would not stop a determined effort to force open a window. Following the inquest, the coroner wrote to the Department of Health (DOH) asking them to reconsider using single hook restrictors on hospital windows. The coroner was concerned that other hospitals were placing undue faith in this type of restrictor and thought they should be reminded of the importance of reviewing the safety and efficiency of their window restrictors. In response the DOH acknowledged the coroner’s concerns and issued alerts to the NHS in England and the devolved administrations for Wales, Scotland and Northern Ireland advising NHS providers that window restrictors may be inadequate in preventing determined effort to force a window open beyond the 100mm restriction, and asking them to review guidance, inspect windows and consider replacing single hook restrictors with more substantial devices. The DOH has proposed updating its technical guidance relating to windows in their draft programme of work for 2013-14. The HSE are currently undertaking research into window restrictors, the outcome of which will be incorporated into the guidance.

The third case concerned a private tenant who died following a leak from a portable gas heater which operated on bottled gas. The deceased was only found when a carbon monoxide alarm was triggered in the neighbouring terraced property and the fire brigade were called to investigate. Following the inquest the coroner wrote to the National Landlords Association (NLA) asking them to consider recommending to their members that carbon monoxide alarms be installed in their rental properties to avoid further deaths of this nature.

In response, the NLA updated their guidance to members which now states unequivocally that they should install audible carbon monoxide alarms in all properties. They also issued a press release during Gas Safety Week. North East Lincolnshire Council passed the coroner’s considerations to private and social landlords through their e-communication group, encouraging them to install carbon monoxide alarms and inviting them to work collaboratively with the Council on this issue.



In September 2013, the **Prison and Probation Ombudsman** published his annual report for the year 2012 – 2013. Thirteen pages of the report are dedicated to the issue of investigating fatal incidents. There were 201 deaths in custody in 2012 – 2013 of which 118 were of natural causes and 55 were apparently self-inflicted. The report acknowledges that a number of learning points have emerged about the need to safeguard vulnerable children in custody. The report also noted that there is not much evidence of enhanced case reviews being used although in five of the investigations into self-inflicted deaths, this might have improved the outcome. Other areas of concern included the management of personality disorders, food refusal, diabetes care, family liaison and emergency responses. In respect of the latter, the report identifies that 143 recommendations had been made in respect of emergency responses

many of which repeated concerns identified in the 2012 thematic study. This, therefore, remains a significant area of concern.

The annual report follows the July 2013 thematic report entitled **“Learning from PPO Investigations”**. Statistically, the greatest number of fatal incident recommendations were made in respect of healthcare provision and emergency response. Failures in the Assessment, Care in Detention and Teamwork procedures resulted in the highest numbers of recommendations in the context of self-inflicted deaths. The recommendations in respect of mental and physical health issues highlighted the need for clear and comprehensive record keeping, effective communication with others involved in the individual’s care, and ensuring that appropriate referrals are made swiftly.

OTHER NEWS

Developments in the fresh Hillsborough Inquiry, the Litvinenko inquest and the inquest into the death of Mark Duggan have continued to dominate headlines. Further pre-inquest review hearings have taken place in relation to the Hillsborough investigation and Lord Justice Goldring has confirmed that the inquest will commence on 31 March 2014 and will take place in Warrington. Sir Robert Owen, who is conducting the investigation into the death of Alexander Litvinenko, ruled on 18 December 2013 that (in light of the PII position) issues of preventability and Russian state responsibility would be removed from the scope of the inquest. On 8 January 2014 the jury in the inquest into the death of Mark Duggan returned a majority verdict of lawful killing, although the jury did find that there were failures in planning and in the gathering of intelligence and that Mark Duggan did not have a gun in his hand when he was shot. The Coroner has now invited representations from interested parties as to whether to make a PFD report.

Please do email us with any judgments or news items which you think should be included in the next update. Josephine is now a Member of the Legal Service at the European Commission so the next update will be edited by Jenni Richards QC, Catherine Dobson (Catherine.dobson@39essex.com) and Annabel Lee (Annabel.lee@39essex.com).

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