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Welcome from the Editors

Alison Hewitt
& Jonathan Dixey



We welcome you to the third issue of 5 Essex Court's *Inquests and Inquiries: Insight* newsletter.

We write at an extraordinary time when the events of the last four months have affected all our lives. The work of those who practise in the fields of inquests and public inquiries has been significantly disrupted but is now starting to get back on track, albeit subject to our adapted sense of normality.

As you will see, we start with two articles which are concerned with the consequences of coronavirus itself: Alison Hewitt assesses the impact the crisis has had on coroners and inquests, and how "recovery" will progress, and Jonathan Dixey looks at the legal framework in which a public inquiry into the pandemic and its management may take place. You will then find discussion pieces reviewing the judgments in some of

the key recent inquest law cases, as well as their ramifications. The latest decisions in the ever-evolving picture of art.2 of the ECHR are considered by Jason Beer QC and Emma Price (*Maguire*) and Amy Clarke (*Lee*). Francesca Whitelaw writes about the knotty issue of causation and the use of statistics in coronial law (*Carole Smith and Chidlow*) and John Goss brings us up to date on costs and damages (*Fullick, Adath Yisroel Burial Society, and Jordan*).

We hope that you will find this newsletter informative and of use. On behalf of Chambers, we send you all our warmest wishes for the months ahead and we hope that those of you who have managed to salvage a summer holiday will thoroughly enjoy it.

Siân Jones

Many of you will have heard that Siân Jones, of BDB Pitmans, sadly passed away in June, aged only 53.

We were lucky enough in Chambers to have known, and worked with, Siân over the last two decades. She was a lovely lady - she had absolutely no side to her; not a nasty bone in her body; and was always kind, gentle and thoughtful.

Her skills as a lawyer, and her compassion as an individual, attracted important and complex work - but always where the human touch was an absolute necessity. This ranged from acting for the family of Dr David Kelly in the Hutton Inquiry, to the Hillsborough Inquests, and - more recently - as Solicitor to the inquests into the deaths of 30 British tourists gunned down by a terrorist on a beach in Sousse, Tunisia, and the inquests into the deaths arising from the

terrorist attacks on Westminster Bridge, London Bridge and Borough Market, and Fishmongers' Hall.

In all of these cases - and countless others - where we worked for Siân, we saw her humanity and compassion shine through. I am devastated that Siân is no longer with us. A memorial service will be held when conditions allow for it

Jason Beer QC

Alison Hewitt

Coronavirus pandemic: impact on coroners' investigations and inquests



The impact of the coronavirus pandemic on the work of coroners has been significant and now presents two particular areas of challenge. First, in relation to the investigation of COVID-19 related deaths and, secondly, in the management of the inevitable backlog of cases. Both these matters have been the subject of Chief Coroner Guidance and both have ramifications for practitioners. Consideration of the issues arising are set out below, together with some suggested steps legal representatives may take to assist their clients and the investigation.

Since the introduction of 'lockdown', the Chief Coroner has issued the following Guidance:

No. 34: COVID-19 (26 March 2020)

No. 35: Hearings During the Pandemic (27 March 2020)

No. 36: Summary of the Coronavirus Act 2020: Provisions Relevant to Coroners (30 March 2020)

No. 37: COVID-19 Deaths and Possible Exposure in the Workplace (28 April 2020 and amended 1 July 2020)

No. 38: Remote Participation in Coronial Proceedings via Video and Audio Broadcast (11 June 2020)

No. 39: Recovery from the COVID-19 Pandemic (29 June 2020)

COVID-19 Deaths

The majority of the 44,000 plus COVID-19 related deaths which have been recorded to date have been registered on the basis of a doctor's Medical Certificate of Cause of Death alone and without reference to a coroner. The Coronavirus Act 2020 widened the circumstances in which an MCCD could be issued¹ and there is no obligation to refer a death if it has resulted entirely from a naturally-occurring disease running its natural course. The fact that COVID-19 has been designated as a notifiable disease under the Health Protection (Notification) Regulations 2010, making each case notifiable to Public Health England, does not change that.

The Notification of Deaths Regulations 2019 do oblige a medical practitioner to report a death to the coroner if the cause of death is unknown (and an MCCD cannot be issued), or if it is suspected that it falls within any of the circumstances set out in reg.3; these include the disease causing death being "attributable to any employment"² and the death being "unnatural"³. It is impossible to know but, given the potential breadth of these categories and the pressures on the system at the peak of the deaths, it would not be surprising if there has been under-reporting of such deaths to coroners.

It is not yet apparent from publicly available statistics how many of the COVID-19 deaths which have been reported to coroners are proceeding to investigation and inquest. By reason of the Coroners and Justice Act 2009, s.1(2), a coroner must open an investigation if there is reason to suspect - a low threshold⁴ - that the cause of death is unknown, or that the deceased died a violent or unnatural death, or died in custody. Three of those four triggers for an investigation are usually easy to spot but the question of whether a COVID-19 death was or may have been "unnatural" is a fact specific decision for the coroner which may be far less straightforward. In Guidance No. 37, at §3, the Chief Coroner emphasised that decisions in COVID-19 referrals must be reached by applying the usual legal principles. These provide that a death from a naturally occurring disease may be unnatural if it resulted from (i) some culpable human failing or error⁵, (ii) neglect⁶, or (iii) a failure to meet a positive obligation arising under art.2. One can see that an inquest may, therefore, be required if the individual death in question may have resulted from, for example, exposure to the virus at work and in the absence of sufficient protective measures, or the lack of, delayed access to, or inadequacies of medical treatment (whether from GP, 111, or emergency services or in hospital).

As far as "work-related" COVID-19 deaths are concerned, it is interesting to note that the Health and Safety Executive's guidance⁷ indicates its expectation of reporting under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 of any COVID-19 death where there is "reasonable evidence" of likely exposure to the virus at work. The HSE guidance provides that the 'responsible person' (usually an employer) should only make a report under RIDDOR when one of the following circumstances applies:

- an accident or incident at work has, or could have, led to the release or escape of Coronavirus (SARS-CoV-2). This must be reported as a dangerous occurrence;
- a person at work (a worker) has been diagnosed as having COVID-19 attributed to an occupational exposure to Coronavirus. This must be reported as a case of disease; or
- a worker dies as a result of occupational exposure to Coronavirus. This must be reported as a work-related death due to exposure to a biological agent.

Alison Hewitt

Coronavirus pandemic: impact on coroners' investigations and inquests (continued)

Whilst the fact of reporting under RIDDOR does not, of itself, necessitate an inquest, coroners may feel uneasy signing off a death (with a form 100A) as natural, if it is under investigation by the HSE. This will obviously be of particular relevance to the deaths of front-line employees who continued to work through the lockdown, including hospital and emergency services staff, and those working in care homes, public transport and shops.

If an inquest is held, it is for the coroner to decide upon its proper scope and this is a discretionary matter. However, it is foreseeable that this issue will be controversial in some inquests and may become a battleground between the competing interests of different interested persons; it would not be surprising if, in due course, some coroners' rulings on precisely where the lines of proper enquiry should be drawn are challenged in the High Court. This would seem to be on the cards given the critical reaction of some to the Chief Coroner's Guidance No.37 in which, at §13, he reminded coroners that the question of scope must be judged in the context of providing evidence to answer the four statutory questions only, adding that:

"Coroners are reminded that an inquest is not the right forum for addressing concerns about high-level government or public policy. The higher courts have repeatedly commented that a coroner's inquest is not usually the right forum for such issues of general policy to be resolved : see Scholes v SSHD [2006] HRLR 44 at [69]; R (Smith) v Oxfordshire Asst. Deputy Coroner [2011] 1 AC 1 at [81]. ... an inquest would not be a satisfactory means of deciding whether adequate general policies and arrangements were in place for provision of personal protective equipment to healthcare workers in the country or a part of it."

But note that Guidance No. 37 was amended on 1 July 2020, and although the first part of the above passage remains, the revised version states (at §§16 and 17):

"However, it is repeated that the scope of inquiry is a matter for the judgment of the coroners, not for hard and fast rules. When handling inquests in which questions such as the adequacy of personal protective equipment for staff are raised, coroners are reminded that the focus of their investigation should be on the cause(s) and circumstance(s) of the death in question. Coroners are entitled to look into any underlying causes of death, including failures of systems or procedures at any level, but the investigation should remain an inquiry about the particular death."

Tips at this stage: Those representing an IP in relation to any COVID-19 death or inquest would therefore be well-advised to:

- gather and preserve evidence (contemporaneous records, accounts from key witnesses) in relation any issue which may arise, whether or not it has yet been raised by the coroner (bearing in mind that a coroner may re-open an investigation after a 100A or B has been issued, without need of the permission of the Chief Coroner or High Court),
- be ready to make submissions on scope (*R (Speck) v HM Coroner for District of York* [2016] EWHC 6 (Admin) being a useful case for this purpose), and to press the coroner for a clear ruling as soon as sufficient disclosure and evidence gathering has taken place, and
- note re requirement for a jury : (i) even though COVID-19 is a notifiable disease, a jury is not required under s.7 of the CJA 2009 because of s.30 of the Coronavirus Act 2020, and (ii) if the deceased died of COVID-19 in custody, but the death was otherwise natural causes, an inquest is needed but a jury is not.

Inquests : Backlog and "Recovery"

The national "lockdown" measures resulted in the adjournment of very many inquest fixtures and consequential delay and backlog have been unavoidable. In Guidance Nos. 38 and 39 the Chief Coroner has set out his advice and expectations for "recovery", including that coroners "should now be moving towards routinely conducting hearings again".

There is encouragement of the use of video and audio links for partially remote hearings (PIRs and inquests). The coroner must be present in court and the press / public must have access to view proceedings (from some part of the court building) but, as long as the IPs' views have been obtained and taken into account, the coroner may order that others (IPs, legal representatives and witnesses) take part remotely. Many coroners are now conducting hearings in this way, even in relatively complex matters.

There is recognition though that, "save in the most exceptional and limited circumstances", a partially remote hearing is not appropriate for any jury inquest. Currently, many coroners are undertaking risk assessments and arranging additional accommodation, staff and equipment to enable larger hearings to take place with social distancing, and practitioners can expect to see the re-listing of jury inquests on the rise from the Autumn onwards, very possibly with little or no account being taken of participants' (especially lawyers') availability.

Alison Hewitt

Coronavirus pandemic: impact on coroners' investigations and inquests (continued)

Tips: Coroners are likely to be anxious to ensure that all hearings are as stream-lined and focussed as possible. IPs and their legal representatives may wish to:

- ensure they are “ready to go”, potentially at relatively short notice, on matters which were previously listed,
- address or re-visit the issue of scope to ensure it is tightly focussed on the key causative matters and issues are narrowed (see *Speck* above),
- prepare full witness statements addressing all issues and questions arising so as to enable them to be admitted in writing under r.23 of the Coroners (Inquests) Rules 2013, if at all possible, and
- if it would assist the client, ask for an oral witness to be called via video-link pursuant to r.17 of the 2013 Rules; the increased use of this provision is expressly encouraged, especially for key workers (see Guidance No.39, §15).

“If an inquest is held, it is for the coroner to decide upon its proper scope and this is a discretionary matter. However, it is foreseeable that this issue will be controversial in some inquests and may become a battleground between the competing interests of different interested persons; it would not be surprising if, in due course, some coroners' rulings on precisely where the lines of proper enquiry should be drawn are challenged in the High Court.”

¹ See Coronavirus Act 2020, s.18 and §4 of Schedule 13.

² Reg.3(1)(a)(ix).

³ Reg.3(1)(b).

⁴ A lower threshold even than “prima facie case” and requiring only grounds for surmise: see *R (Fullick) v HM Senior Coroner for Inner North London* [2015] EWHC 3522 (Admin) at §§34-37.

⁵ See *R (Touche) v Inner London North Coroner* [2001] EWCA Civ 383; [2001] QB 1206.

⁶ As defined in *R (Jamieson) v North Humberside and Scunthorpe Coroner* [1995] QB 1.

⁷ www.hse.gov.uk/news/riddor-reporting-coronavirus.htm

Jonathan Dixey

Coronavirus: public inquiries



Over 40,000 people in the United Kingdom have died having had a laboratory-confirmed COVID-19 test. Hundreds of thousands more have had the virus but survived. Everyone has been impacted and affected by the decisions taken by the Government, the NHS and others in an attempt to control the spread of the disease. As the weeks have passed, those calling for a public inquiry have increased in number and volume. It is now inevitable that some form of official investigation will take place. Set out below is a review of the legal framework within which this could happen.

In the aftermath of large-scale disasters and other incidents of acute public concern, public inquiries are often established to investigate and make findings of fact on the circumstances which gave rise to the incident and to deliver recommendations for how the events could have been avoided or the worst effects mitigated. In recent years public inquiries have been established by government to examine, amongst others, the circumstances which gave rise to the Grenfell Tower fire in 2017, the use and regulation of undercover police officers, and the use by the NHS of infected blood. A growing number of public inquiries have examined 'policy' decisions, such as the Scottish Government's Edinburgh Trams project and the Northern Irish Executive's Renewable Heat Incentive policy (the report of which was published earlier this year).

Section 1(1) of the Inquiries Act 2005 provides that a public inquiry may be established where it appears to a Minister that "particular events have caused, or are capable of causing, public concern" or "there is public concern that particular events may have occurred". Although the exercise of this discretionary power and the decision about the form a public inquiry may take, are often informed by political considerations, any such decisions are subject to judicial scrutiny. Both the Litvinenko and Brook House Inquiries followed successful challenges of ministerial decisions not to establish public inquiries under the 2005 Act. A different outcome was reached in respect of calls for the establishment of a public inquiry into the deaths of 24 civilians killed by British soldiers

in colonial Malaya in 1948 (*R (Keyu) v Secretary of State for Foreign and Commonwealth Affairs* [2015] UKSC 69, [2016] AC 1335). In each of those cases, the crucial factor was the engagement (or not) of arts.2 and 3 of the ECHR.

It is well-established that where there are circumstances giving rise to an arguable breach of arts.2 or 3 of the ECHR, an effective official investigation must take place. Ordinarily clinical decisions will not engage art.2 (see Jason and Emma's article on *R (Maguire) v HM Senior Coroner for Blackpool and Fylde* [2020] EWCA Civ 738 which confirms the approach taken in *R (Parkinson) v HM Senior Coroner for Inner London South* [2018] EWHC 1501 (Admin); [2018] 4 WLR 106.). However, deaths or serious ill-treatment resulting from healthcare planning and policy, and strategic decision-making, can be viewed differently. In *Powell v United Kingdom* (App. No. 45305/99), the ECtHR observed:

"The Court accepts that it cannot be excluded that the acts and omissions of the authorities in the field of health care policy may in certain circumstances engage their responsibility under the positive limb of Article 2."

In *Asiye Genç v Turkey* (App. No. 24109/07) the ECtHR criticised the unsatisfactory quantity and condition of the neo-natal intensive care equipment, namely incubators, in the region's hospitals, which showed that "the State had not taken sufficient care to ensure the smooth organisation and correct

functioning of the public hospital service, and more generally of its system for health protection, and that the lack of places was not linked solely to an unforeseeable shortage of places arising from the rapid arrival of patients". The Court found that as a result of the lack of access to functioning incubators, a premature baby with a life threatening condition had made several futile return trips in an ambulance pending any appropriate treatment or an examination and was ultimately deprived of any access to appropriate emergency care. In finding a breach of art.2, the ECtHR concluded that the lack of neo-natal intensive care equipment was "analogous to a denial of medical care such as to put a person's life in danger". The subsequent failure by the Turkish authorities to investigate the death was a further breach of art.2. One can see how this principle may be adopted to argue that, in relation to the current crisis, art.2 may be engaged to require investigation of our preparations for a pandemic, the management of "lockdown", the availability of personal protective equipment, medical equipment (such as ventilators) and testing, and the public's access to treatment.

Where an investigative duty does arise, the investigation must be inter alia independent, effective, reasonably prompt, subject to sufficient public scrutiny and must involve the next of kin to an appropriate extent (*Jordan v United Kingdom* (2001) 37 EHRR 52). The form of that investigation is generally a matter for the State to decide. In most instances in the UK, where a death occurs and the art.2 investigation obligation arises, the duty is discharged through a coroner's inquest.

Jonathan Dixey

Coronavirus: public inquiries (continued)

However, as is explored in Alison's article above, it is still too early to know how many coronial investigations of COVID-19 deaths will take place and, in any event, there are a number of reasons why an inquest may be an inappropriate or ineffective means of discharging the art.2 investigative duty (if such a duty arises):

1. We know that not all Coronavirus-related deaths are being reported to coroners. It follows that those deaths and the reasons for them will not be investigated or explained by inquests. Nevertheless, the bereaved family may want to know whether their loved one's death could have been avoided if different PPE had been available or, for example, whether the virus was contracted from someone who was discharged back to their care home from hospital without a suitable test having first been conducted.
2. A coroner's inquest is limited to ascertaining the facts of how the deceased person in question died, and there is an obligation to make only sufficient enquiry for that purpose. It is unrealistic to expect coroners to examine in each inquest either the macro-level acts and omissions which may have contributed to the death in question or the wider background picture.
3. Finally, and perhaps most fundamentally, the Coronavirus pandemic has impacted the lives of all of us: not just those who have so sadly died as a result of contracting the virus. The handling of this crisis will have a profound, and perhaps life-long, effect upon everyone in this country. Doubtless, there are important lessons to learn about planning for and managing a pandemic which will be apparent only from a review of the bigger picture.

It does not follow that even if the art.2 investigative duty applies, a public inquiry pursuant to the Inquiries Act 2005 must take place. During Prime Minister's Questions on 15 July 2020, the Prime Minister committed to "an independent inquiry":

Sir Edward Davey (Kingston and Surbiton):

Under this Prime Minister, we have suffered one of the worst death rates in the world and Europe's worst death rate for health and care workers. Previously, he has refused my demand for an immediate independent inquiry, saying that it is too soon, even though, back in 2003, he voted for an independent inquiry into the Iraq war just months after that conflict had started. If he still rejects an immediate inquiry, will he instead commit in principle to a future public inquiry: yes or no?

The Prime Minister:

As I have told the House several times, I do not believe that now, in the middle of combating the pandemic as

we are, is the right moment to devote huge amounts of official time to an inquiry, but of course we will seek to learn the lessons of the pandemic in the future, and certainly we will have an independent inquiry into what happened.

Hansard HC vol.678, col.1513-4, 15 July 2020

In the recent past, a variety of non-statutory inquiries and investigations have been established to examine issues of great public concern. These include committees of Privy Counsellors (as in the case of the Iraq Inquiry chaired by retired civil servant Sir John Chilcot); non-statutory ad hoc inquiries (such as the Hutton Inquiry (into the death of the government scientist Dr David Kelly) and the Harris Review into self-inflicted deaths in custody); and far less frequently, Royal Commissions (such as the Royal Commission on Reform of the House of Lords, chaired by Lord Wakeham). However, as confirmed in *R (MA and BB) v Secretary of State for the Home Department* [2019] EWHC 1523 (Admin) – which led to the establishment of the Brook House Inquiry – a public inquiry under the Inquiries Act 2005 has a number of advantages over a non-statutory inquiry. These include:

1. The power to compel attendance of witnesses and the production of documents. In *Re Finucane's Application for Judicial Review* [2019] UKSC 7, the Supreme Court identified as a key shortcoming the lack of opportunity to compel the cooperation of witnesses in a non-statutory inquiry into the death of Patrick Finucane, a solicitor murdered by loyalist terrorists in Northern Ireland in 1989.
2. The requirement to hold public hearings. Under s.18 of the Inquiries Act 2005, subject to limited exceptions, the chair "must take such steps as he considers reasonable to secure that members of the public (including reporters) are able (a) to attend the inquiry or to see and hear a simultaneous transmission of proceedings at the inquiry; (b) to obtain or to view a record of evidence and documents given, produced or provided to the inquiry or inquiry panel". In practice, public inquiries now 'stream' their proceedings online and publish evidence adduced during the hearings through increasingly sophisticated websites.
3. An established mechanism to provide funding for representation for core participants which promotes effective engagement.

Jonathan Dixey

Coronavirus: public inquiries (continued)

As with the question of whether or not an inquiry should be established, crucial decisions about the terms of reference, the identity of the chair, and the time in which a report should be presented to Parliament, will be subject to judicial scrutiny, albeit the courts have thus far been reluctant to interfere in the selection and appointment of the chairs of inquiries. Challenges to the appointment of Sir John Mitting as chair of the *Undercover Policing Inquiry* and Sir Martin Moore-Bick as chair of the *Grenfell Tower Inquiry* were both rejected.

Article 2 requires investigations to be prompt and to proceed with “reasonable expedition”: this is particularly the case in deaths in a hospital setting. “This is because the knowledge of facts and possible errors committed in the course of medical care should be established promptly in order to be disseminated to the medical staff of the institution concerned so as to prevent the repetition of similar errors and thereby contribute to the safety of users of all health services” (*Byrzykowski v Poland* (App. No. 11562/05), §117). In relation to current events, the relevant ministerial decision-makers will therefore need to calibrate the scope and terms of reference (i.e. what the inquiry is intended to achieve) to the imperative of learning lessons in a suitable timeframe: if a ‘second peak’ does arrive, it would be helpful to have learnt from any errors in the handling of the first.

Any inquiry will also need to be manageable. Given the sheer number of people affected by the Coronavirus – both directly and indirectly – and the myriad issues arising, any public inquiry has the potential to be so large as to be unwieldy. As to the potential numbers: by comparison, in the *Infected Blood Inquiry*, which was established to examine inter alia “the circumstances in which men, women and children treated by [the NHS] were given infected blood and infected

blood products, in particular since 1970”, over 2,000 people have been appointed as core participants with eight charities representing the interests of those affected. According to the Haemophilia Society, over 4,500 people with haemophilia and other bleeding disorders were infected in the 1970s and 1980s. In the *Grenfell Tower Inquiry*, over 550 individuals have been appointed as core participants. A group of more than 40 survivors of the 2017 Manchester Arena bombing sought to challenge the ruling of the Chair of the *Manchester Arena Inquiry* refusing them core participant status. On 7 July 2020, their application for permission to seek judicial review was refused. The biggest early challenge facing the chair of a Coronavirus public inquiry is likely to be determining who is and is not, a core participant (as defined by r.5 of the *Inquiry Rules 2006*).

For those public inquiries that were already on foot at the time that COVID-19 arrived in the United Kingdom, work has not ceased. Remote hearings have taken place in the *Independent Inquiry into Child Sexual Abuse* and limited attendance hearings have resumed at the *Grenfell Tower Inquiry* (albeit prompting complaints about who now has access to the hearing room itself). Virtual hearings are scheduled in the *Undercover Policing Inquiry*. The chair of the *Brook House Inquiry* opened that inquiry by posting a [video on YouTube](#).

As we all adjust to the realities of working remotely and socially distancing ourselves, the *Inquiries Act 2005* and *Inquiry Rules 2006*, which offer substantial discretion to the chair in how the proceedings are conducted, means that those hearings which have been ‘paused’ should be able to recommence in the near future. It remains to be seen when any public inquiry into Coronavirus itself will commence.

“Any inquiry will also need to be manageable. Given the sheer number of people affected by the Coronavirus – both directly and indirectly – and the myriad issues arising, any public inquiry has the potential to be so large as to be unwieldy... The biggest early challenge facing the chair of a Coronavirus public inquiry is likely to be determining who is and is not, a core participant (as defined by r.5 of the *Inquiry Rules 2006*).”

Jason Beer QC & Emma Price

Inquests, care home residents and medical negligence:

When does s.5(2) of the Coroners and Justice Act 2009 apply?



In June 2020 the Court of Appeal handed down its judgment in *R (Maguire) v HM Senior Coroner for Blackpool and Fylde* [2020] EWCA Civ 738 and in doing so clarified whether the state's investigative duty under art.2 ECHR arose following the death of a vulnerable care home resident whose liberty was restricted under a Deprivation of Liberty Safeguards ('DoLS') authorisation. In concluding that the duty may arise, but only in limited circumstances, the Court provided valuable and much-needed guidance on when s.5(2) of the CJA applies.

Jacqueline Maguire ('JM') was 52 when she died in hospital on 22 February 2017 of: (i) perforated gastric ulcer and peritonitis; and (ii) pneumonia. She had Down's Syndrome, learning disabilities and behavioural difficulties, as well as some physical limitations. She had lived for more than 20 years in a residential care home. Her placement was paid for and supervised by the Blackpool Council and was subject to a standard authorisation granted by the council pursuant to the DoLS set out in Schedule A1 to the Mental Capacity Act 2005.

JM became ill over the two days before her death. A range of criticisms were levelled at the care home, paramedics and an out-of-hours GP in respect of delay in JM being admitted to hospital.

The inquest and judicial review proceedings

Proceedings for judicial review brought by JM's mother sought to challenge two decisions made by HM Senior Coroner for Blackpool and Fylde after all the evidence had been heard in the inquest, namely that: (i) art.2 was not engaged; and (ii) a conclusion of neglect should not be left to the jury. On 15 May 2019 the Divisional Court (Irwin LJ, Farbey J and HHJ Lucraft QC (the Chief Coroner, sitting as a Judge of the High Court)) dismissed the claim for judicial review *R (Maguire) v HM Senior Coroner for Blackpool & Fylde* [2019] EWHC 1232 (Admin).

The grounds of appeal

JM's mother appealed to the Court of Appeal against the Divisional Court's decision insofar as it related to the engagement of art.2, on the following grounds:

1. The Divisional Court erred in concluding that the procedural obligation under art.2 did not apply. By parity of reasoning with the case of *Rabone v Pennine Care NHS Trust* [2012] UKSC 2; [2012] 2 AC 72, the circumstances of JM's care dictated that the procedural obligation applied. It was not a medical case of the sort considered in the case of *R (Parkinson) v HM Senior Coroner for Inner London South* [2018] EWHC 1501 (Admin); [2018] 4 WLR 106.
2. If Parkinson applied, the Divisional Court was wrong to

conclude that the failure to have in place a system for admitting JM to hospital on the evening of 21 February 2017 did not amount to a systemic failure.

3. The Divisional Court erred in failing to take account of the wider context of premature deaths of people with learning disabilities.

The Court of Appeal's discussion and conclusions

The judgment analyses the extensive ECtHR and domestic jurisprudence on the extent of the positive obligations imposed by art.2 in the context of a person subject to a DoLS authorisation who may have died following errors in medical care and treatment.

At §22, the Court restated the approach adopted by the ECtHR in *Lopes de Sousa Fernandez v Portugal* (2018) 66 EHRR 28 in cases involving alleged medical negligence. In such cases, the state's positive obligations are regulatory, "including necessary measures to ensure implementation, including supervision and enforcement". It would only be in "very exceptional circumstances" that a state may be responsible under the substantive limb of art.2.

On the question of medical deaths in custody, the Court of Appeal considered *R (Tyrell) v HM Coroner for County Durham and Darlington* [2016] EWHC 1892 (Admin), Lord Burnett observing (at §51) in relation to his own judgment in *Tyrell*:

"The Osman operational duty on prison authorities extends to medical care provided within custodial institutions in the way discussed in *Tyrell* and in securing outside medical treatment in a timely way when it is needed. The approach to alleged medical negligence or mishap by outside medical professionals, to which a prisoner had been appropriately referred, would be no different from the ordinary approach in such cases. If the facts in *Tyrell* had included a suggestion that the NHS hospital had treated the cancer negligently, the operational duty would not have arisen save to the extent that the cumulative tests now found in *Lopes de Sousa* were satisfied."

Jason Beer QC & Emma Price

Inquests, care home residents and medical negligence:

When does s.5(2) of the Coroners and Justice Act 2009 apply? (continued)

The Court of Appeal did not accept the Appellant's underlying argument that the undeniable vulnerability of an individual in JM's position, coupled with the fact of a DoLS authorisation dictates that she was owed an art.2 operational duty. Instead, the Court stressed the importance of focussing "on the scope of any such duty and why it might be owed" (§71). The Divisional Court "was right to identify the unifying feature of the application of the operational obligation or duty to protect life as one of state responsibility" (§72).

The question whether an operational duty under art.2 was owed to JM was "not an abstract one which delivers a "yes" or "no" answer in all circumstances" (§96). The operational duty is owed to vulnerable people under the care of the state for some purposes but the authorities "do not support a conclusion that for all purposes an operational duty is owed to those in a vulnerable position in care homes, which then spawns the distinct procedural obligation (with all its components) in the event of a death which follows either alleged failures or inadequate interventions by medical professionals" (§97).

Following *Parkinson*, many coroners and practitioners have tried to reconcile the approach in that case with *Rabone*:

"74. The argument advanced before the coroner, the Divisional Court and us was largely structured around a binary question: is this a *Rabone* case or a *Parkinson* case? That, however, is not the approach of the Strasbourg Court. The fact that an operational duty to protect life exists does not lead to the conclusion that for all purposes the death of a person owed that duty is to be judged by article 2 standards."

JM's circumstances were not analogous to a psychiatric patient who is in hospital to guard against the risk of suicide: she was resident in a care home because she was unable to look after herself and it was not possible for her to live with her family; she was not there for medical treatment; and if she needed medical treatment it was sought, in the usual way, from the NHS (§101).

The points made by the Appellant under Ground 3 did not alter the position. (For a discussion of how statistics may be relevant in inquest proceedings, see Francesca's article below on *R (Carole Smith) v HM Assistant Coroner for North West Wales* [2020] EWHC 781 (Admin)).

As for Ground 2 of the Appeal, the Court was "unable to accept that the criticisms of the paramedics or out of hours GP come close to satisfying the first exception identified by the Strasbourg Court, namely that the patient's life was knowingly put in danger by a denial of access to life-saving emergency treatment" and did not consider that JM's case raised "systemic or structural dysfunction in [medical] services" which resulted in her being denied life-saving treatment (§105).

In the light of the Court of Appeal's conclusions, the coroner was right to conclude that, on the evidence adduced at the inquest, there was no basis for believing that JM's death was the result of a breach of the operational duty of the state to protect life.

Jason, Emma and Sarah Burton of DLA Piper discussed *Maguire* in one of 5 Essex Court's 'Sofa Series' webinars. You can watch again on [YouTube](#).

Implications

The headline to take away from the Court of Appeal's decision is that an art.2 operational duty is owed to vulnerable people under the care of the state for some, but not all, purposes. In medical cases, the fact that a person is vulnerable and his or her liberty is restricted by a DoLS authorisation does not alter the principles to be applied, and it will only be in "very exceptional circumstances" that there will be state responsibility under the substantive limb of art.2. This means that for the majority of these cases, the procedural obligation to hold an art.2 compliant inquest will not be triggered.

The decision is likely to be a very significant one for coroners and practitioners in coronial, mental health and healthcare law: NHS Figures suggest that about 200,000 applications are made for DoLS per year, about half of which are granted. This is especially so in the light of the significant number of deaths of care home residents in the course of the COVID-19 pandemic.

Also notable is the importance attached by the Court of Appeal to determining the scope of any potential positive obligation under art.2 and why such an obligation might be owed: "in law, context is everything".

Amy Clarke

Revisiting *Rabone*: *Lee*



The claimant in *R (Lee) v HM Assistant Coroner for the City of Sunderland* [2019] EWHC 3227 (Admin) successfully challenged the Coroner's ruling on the engagement of art.2 ECHR, securing the clearest indication yet that in relation to deaths of patients receiving treatment or care for mental health problems, the *Rabone* principles (*Rabone v Pennine Care NHS Trust* [2012] UKSC 2; [2012] 2 AC 72) will extend to the provision of healthcare in the community, as well as in the hospital setting.

Background

Melissa Lee had a history of significant mental health problems and had been diagnosed as suffering from Emotionally Unstable Personality Disorder ("EUPD"). She had overdosed a number of times and had engaged in other harmful behaviour. Melissa was admitted to a psychiatric ward in 2012 on an informal basis and from December 2012 onwards was managed in the community. That regime included various care plans and by 2015, a specific crisis plan. Melissa's care plan was overseen by a multi-disciplinary team of health and social care services and specifically recorded the frequency of self-harm and overdosing.

Between 2012 and 2016 Melissa overdosed on a number of occasions and was admitted to hospital as both a voluntary patient and on a compulsory basis under the Mental Health Act 1983. In February 2016, Melissa's treating psychiatrist formally confirmed the diagnosis of EUPD and prescribed medication. A full assessment of Melissa's needs was carried out on the 8th March 2016 and five days later Melissa overdosed again. She was treated at A&E, but discharged herself and returned home. A further assessment was carried out by the crisis team the day after she was discharged and it was determined that Melissa was at moderate risk of self-harm, and did not require hospital admission. Melissa overdosed again on 17th March and was admitted to A&E. She discharged herself that evening and was sadly found dead the next morning at home. Melissa had consumed a quantity of drugs that had caused her death.

The challenge

Melissa's mother had sought to argue that there had been arguable breaches of both the operational and systemic duties under art.2. The Assistant Coroner ruled that neither aspects of the art.2 duties were engaged. The substantive challenge brought by Mrs Lee was that the Coroner's findings had been superficial; Melissa's vulnerability and the level of risk she posed had not been properly considered, and too much weight had been placed on the level of control that had been assumed by the Trust. Mrs Lee also argued that there had been failures and/or inadequacies in care planning and discharge planning that could amount to a breach of the systemic duty under art.2.

The court's conclusions

The Administrative Court held that the claim should succeed in respect of the operational duty point, and that the issue should be remitted back to the Coroner to determine. She was not successful on the systemic duty argument.

The Coroner had correctly acknowledged that the three-fold analysis set out in *Rabone* applied, namely that the real and immediate risk to a person's life, the extent of their vulnerability, and the degree of control assumed by the State for their safety, must all be considered. In this case however, the Coroner appeared to have focussed only on the control question and therefore had not adequately addressed the full picture.

Reflections

The significance of this case is that it is the first reported challenge to a coroner's decision which has the potential effect of extending the operational duty under art.2 beyond the hospital setting. Since *Rabone*, many Trusts have taken the view that in some cases relating to patients treated in the community, they will not challenge a finding that art.2 is engaged. *Lee* essentially endorses that position, where the facts of a particular case merit it.

The key points to take away from *Lee* are:

1. The real and immediate risk test can (and should) be applied to patients being treated in the community.
2. The question of how immediate such a risk needs to be has still not been defined and the expansion of the *Rabone* principles could lead to further challenge about that point when read in the context of a sustained history of self-injurious behaviour and suicide attempts.
3. Coroners will increasingly have to make findings about the extent of an individual's risk and their particular vulnerabilities. This is inevitably complicated in respect of all mental health conditions, but EUPD can be a particularly challenging condition to manage and predict.
4. Whether or not art.2 is engaged will still be fact specific and should not be assumed.

Francesca Whitelaw

Causation in coronial law



“I pass with relief from the tossing sea of Cause and Theory to the firm ground of Result and Fact.” – Winston Churchill

What is the threshold for and the standard of proof for causation of death to be applied at an inquest, and what role do statistics have to play in establishing causation? These were issues before the Divisional Court (Dingemans LJ, Griffiths J and the Chief Coroner of England and Wales, HHJ Lucraft QC) in the recent decision of *R (Carole Smith) v HM Assistant Coroner for North West Wales [2020] EWHC 781 (Admin)*.

The inquest

The proceedings arose from the inquest into the death of 27-year old Leah Smith who was found hanging from a bannister at her home address on 28 April 2017. In March 2017 Leah had suffered a sudden onset of paranoid delusions and was referred to community mental health. On 17 April 2017 Leah took an overdose of co-codamol in the context of paranoid delusional thinking and was admitted to hospital. She was discharged on 19 April 2017 and was seen at home. She was being prescribed risperidone (an anti-psychotic). On 25 April 2017 Leah was seen, for the first and only time, face-to-face by a psychiatrist, Dr Mehr, in consultation. Dr Mehr noted his impression that Leah was suffering from a first episode of psychosis; he prescribed mirtazapine (an anti-depressant) and olanzapine (an anti-psychotic) and indicated that she should be reviewed if required by the home treatment team. Leah was seen and given her medication on 26 April 2017. On 28 April 2017 she hanged herself. She was taken to hospital but died on 2 May 2017.

The Coroner conducting the inquest determined that a duty to investigate was engaged by art.2. She instructed an expert Consultant Forensic Psychiatrist, Dr Maganty, who, in a pre-inquest report, made various criticisms of the care

Leah had received, materially concluding that “Considering...the...failure of provision of basic medical care, in my opinion, on the balance of probabilities, the death of Miss Leah Smith was not only predictable but was entirely preventable...”

Dr Maganty gave evidence at the inquest. Under questioning from the Coroner he explained that his view that the death was predictable and preventable was based upon the 5-year mortality rate of those who have been treated for first episode psychosis, who do not have illicit substance use and who have a supportive family (conditions which applied to Leah), as being less than 0.1%. He accepted however that patients do still commit suicide whilst being medicated for such a condition. He made other concessions, including that there were never grounds to detain Leah in hospital; he made no criticisms of a particular practitioner; the Home Treatment Team had access to a consultant psychiatrist; he himself had not seen Leah and could not therefore determine the cause of his diagnosis of “severe depressive episode with psychosis”; and that whilst Leah’s condition was treatable, there is a difference between treatment and cure.

The court also heard evidence from Dr Mehr who had seen Leah face to face 3 days before she hanged herself. He indicated that she had “denied any thoughts of deliberate self-harm, suicide or harming others”; there was no reason to admit her to hospital; he reached a working diagnosis of “first episode psychosis and depression” (consistent with Dr Maganty’s opinion); and had assessed her as being at low risk which did not mean no risk, but one which could be managed by the Home Treatment Team. He set a very low threshold for follow up.

The Coroner’s findings

At the end of the inquest, the Coroner, sitting alone, delivered her decision in two parts: her “Reasons”, which were a carefully structured and reasoned narrative and consideration of the issues; and the Record of Inquest (‘ROI’). The ROI recorded the medical cause of death (multi-organ failure and self-suspension) which was uncontroversial. Part 3 of the ROI answered the question of “How, when and where, and in what circumstances the deceased came by her death” in the following terms:

“On 28/4/17 the deceased was found hanging by the neck from a bannister at her home address. She was taken to hospital where she was placed on life support. Test revealed no brain activity was evident and she sadly passed away on 2/5/17. The deceased had a short history of mental health issues with an attempted overdose a week prior to her death. She was receiving anti-psychotic medication and was under the care of the Mental Health Services at the time of her death.”

Part 4 of the ROI, the conclusion of the Coroner as to death, stated:

“The deceased hung herself with a ligature on 28/4/17. This act caused her death. At the time she took this action it is likely she was suffering from an episode of psychosis of unknown origin.”

Francesca Whitelaw

Causation in coronial law (continued)

The challenge to the Coroner's findings

The first and second grounds of challenge were that the Coroner had erred in law (1) as to the threshold for causation of death and (2) as to the standard of proof for causation of death. The Divisional Court cited and applied *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin); [2016] 4 WLR 157 in explaining that (1) and (2) were separate concepts, but that "Putting these two concepts together, the question is whether, on the balance of probabilities, the conduct in question more than minimally, negligibly or trivially contributed to death".

The Court considered that whilst there were passages in the Coroner's Reasons where she used such phrases as "There is no certainty in this case" and "words such as, 'reasonably confident, if, on balance of probabilities, do not provide any certainty', it was "not fair or correct" to pick out isolated phrases and that the Reasons as a whole had to be considered. The Coroner ultimately settled on the correct formulation of the question she had to answer and answered it:

"I am not satisfied on the balance of probabilities that if all of these things had happened, when they should have happened, that it could be said it was more likely than not that Leah's death on 2 May could have been prevented."

In reaching its conclusion on causation, the Divisional Court also cited and applied *R (Chidlow) v HM Senior Coroner for Blackpool and Fylde* [2019] EWHC 581 (Admin) which itself cited the Tainton formulation of the threshold and standard of proof for causation, but also Clerk & Lindsell on Torts (22nd edition, 2017) on the role of statistics in making findings about causation in individual cases:

"Care has to be exercised when relying on statistics as a means of establishing causation. The court must look at the claimant's individual circumstances rather than at the general statistics."

In *Chidlow*, the Court held that general medical statistical evidence alone was unlikely to be sufficient for causation. For example, even where there was relevant statistical evidence of a survival rate of over 50% without the relevant act or omission, in the absence of further evidence supporting the proposition, a jury could not safely conclude that the deceased probably would have fallen into the category of survivors. Being a figure in a statistic does not of itself prove causation.

The Divisional Court in *Carole Smith* found that the Coroner had applied this analysis appropriately to the facts when she concluded that she could not say, on the balance of probabilities, that the fact that Leah did not see a consultant psychiatrist in person until 25 April 2017 had any evidential causative effect on the actions that she undertook on 28 April 2017 which resulted in her death. Dr Maganty's use of statistics was couched in too general terms to be applied to establish what caused or contributed to the death in Leah's individual case.

The Court also highlighted that it was important to distinguish between cases concerned with what ought to be left to a jury and cases concerning what verdict or conclusion is open to the Coroner sitting alone, once seized of the question. In *Chidlow*, the Coroner had failed to recognise that establishing a medical cause of death was not essential to being able to form an opinion as to the effect of delayed treatment and for that reason had erroneously declined to leave to the jury the question of whether an admitted delay in an ambulance attending the deceased contributed to the death. The Coroner in the present case was sitting alone and was reaching her own finding of fact (the jury question, if there had been a question), which was that Dr Maganty's evidence concerning statistics did not have any evidential causative effect.

The Divisional Court went on to dismiss the Claimant's third ground of challenge, holding that it was not irrational for the Coroner to reject Dr Maganty's conclusion that, on the balance of probabilities, the death was predictable and preventable. The Coroner was not bound to accept Dr Maganty's evidence even if it stood alone (which it did not). In deciding that Dr Maganty's evidence on causation "appeared to be little more than an assertion", with an admitted degree of "hindsight bias", the Divisional Court perhaps considered it to be adrift on the tossing sea of cause and theory, whereas the Coroner's Reasons and the ROI ultimately represented the firmer ground of result and fact.

"Care has to be exercised when relying on statistics as a means of establishing causation. The court must look at the claimant's individual circumstances rather than at the general statistics."

Francesca Whitelaw

Causation in coronial law (continued)

Key Messages for Practitioners

- The key question for causation of death remains “whether, on the balance of probabilities [**standard of proof**], the conduct in question more than minimally, negligibly or trivially contributed to the death [**threshold**]”. (*Carole Smith* applying *Tainton*).
- Care has to be exercised when relying on statistics as a means of establishing causation. Being a figure in a statistic does not itself prove causation. The Court must look at the individual circumstances and for other evidence to support any statistics relied upon (*Carole Smith* applying *Chidlow*).
- If statistics are to be used to support arguments of causation, then they ought not to be general or isolated statistics, but, where appropriate, those taken from a range of studies, specifically related to the features of the individual case and, ideally, supported by other evidence (such as medical evidence, which might include clinical experience, an analysis of specific features of the deceased’s condition at material times, and/or a review of all other available medical evidence).

Editorial Comment:

Another striking feature of the ruling in *Smith* is that the Divisional Court made it plain that a coroner sitting alone may recognise relevant failings in the care provided to the deceased in Reasons delivered in open court, but may also decide not to record those failings on the face of the Record of Inquest, without breaching the procedural requirements of art.2 or otherwise acting unlawfully. In an approach which echoed that of the Court in *R (Worthington) v HM Senior Coroner for the County of Cumbria* [2018] EWHC 3386 (Admin), the Divisional Court treated the coroner’s Reasons as part of the public record. Is this contradictory of the judgment of Sir Brian Leveson P in *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin); [2016] 4 WLR 157, which ruled that in certain circumstances admitted state failings must be included on the face of the Record of Inquest? It seems not given that, in *Tainton*, the findings relating to the death were made by a jury which, unlike a coroner sitting alone, could not give Reasons or record any matters other than on the Record of Inquest itself.

“...general statistical evidence alone is, however, unlikely to be sufficient. For example, even where the rate is over 50%, a raw survival rate for the group into which (without the relevant event or omission) the deceased is said to fall is unlikely to be sufficient because, without evidence supporting the proposition derived from the population data, a jury could not safely conclude that he or she would have fallen into the category of survivors. As Croom-Johnson LJ put it, being a figure in a statistic does not of itself prove causation.”

John Goss

Counting the costs: inquests, costs and damages



In general, inquests are not concerned with money. Not only are high-level questions of resources usually ruled out of scope, but the coroner or jury may not frame a determination in such a way as to appear to determine any question of civil liability, and there are no costs-shifting provisions at the inquest itself. But financial issues can arise in three distinct ways: first, when challenging a coroner's decision in the High Court; second, when the costs of representation at an inquest are claimed as part of the costs in a separate civil claim; and third, where the conduct of a public authority causes or contributes to a breach of art.2 ECHR.

Costs in the High Court

Two recent cases illustrate the general principles applied when an interested person ('IP') challenges decisions by a coroner in the High Court by way of judicial review. In *R (Adath Yisroel Burial Society) v HM Senior Coroner for Inner London* [2018] EWHC 1286 (Admin), a coroner who had implemented a policy that was found to be unlawful was ordered to pay the successful claimants' costs. The Administrative Court applied *R (Davies) v Birmingham Deputy Coroner* [2004] EWCA Civ 207; [2004] 1 WLR 2739, which held that costs against a coroner would be the exception, not the rule. They would be ordered only in three situations:

1. Where there was a 'flagrant instance of improper behaviour', including unreasonably failing to sign a consent order disposing of proceedings.
2. Where a coroner resisted an application in such a way that they became an active party to the litigation. If a coroner simply appeared neutrally to assist the court 'on questions of jurisdiction, procedure, specialist case law and such like', then the High Court would normally not make any order for costs.
3. As a matter of discretion, an order might be made against a coroner where fairness required it.

reconsider her policy even after the Chief Coroner had intervened to argue against its lawfulness. That was an important factor in relation to the third situation, especially where one of the claimants was a charity. Additionally, the Court considered that the coroner had ceased to be neutral when she filed addendum detailed grounds (without permission – it is perhaps worth noting that this coroner, for reasons which are unclear, was acting in person) that advocated for the correctness of her policy. In the circumstances, she was ordered to pay the claimants' costs from the point she abandoned neutrality.

In *R (Worthington) v HM Senior Coroner for the County of Cumbria* [2018] EWHC 3386 (Admin), the same case law was applied but in decidedly the other direction. Here, an IP sought judicial review of the inclusion of particular factual findings on the face of the Record of Inquest. The claim was dismissed. The coroner sought his costs, despite an earlier suggestion that he took a neutral stance. *Davies* was applied again, and the coroner awarded his costs on the basis that having not been neutral in practice, he would have been liable to pay the claimant's costs if the claim had succeeded. There was no prejudice to the claimant, who would not have run his case any differently without the assertion of neutrality by the coroner. But the Administrative Court did issue something of a warning to coroners who seek to have it both ways: if a coroner wishes to have the protection from costs conferred by a neutral stance, then a neutral stance needs to be adopted and maintained as a matter of fact.

While explaining context and reasoning is consistent with neutrality, the court will look to the 'tenor' of the position taken by the coroner in the High Court proceedings to assess whether it was genuinely neutral overall.

Costs of representation as costs in a civil claim

It has long been the case that the costs of legal representation at an inquest can be claimed, subject to some limitations, as costs 'incidental to' a subsequent civil claim arising out of the death. In *Fullick v Commissioner of Police of the Metropolis* [2019] EWHC 1941 (QB), the principles were reviewed and applied in a reported case for the first time since the extensive modification of the Civil Procedure Rules relating to costs in 2013. At the inquest, a jury had held that inadequate police policies, procedures and training had contributed to a death at a police station. A subsequent civil claim was settled for £18,000 plus costs. The costs claimed included substantial costs in relation to pre-inquest hearings and the inquest itself. It was accepted that those costs were in theory recoverable, so long as they were relevant to the civil claim, reasonably and necessarily incurred, and proportionate.

On the facts, evidence as to the cause of death and actions and procedures of the police were relevant to the civil claim, particularly as the claim sought damages for breach of art.2. The wider public interest in the claim, as well as the fact that the outcome of the inquest meant that the civil claim was resolved shortly afterwards, were

John Goss

Counting the costs: inquests, costs and damages (continued)

heavily in the claimants' favour in terms of proportionality. The court reiterated that the onerous exercise of "identifying and evaluating the relevance and utility to the civil claim of participating in the inquest" was still necessary, and that a stage by stage approach was required. Where an inquest spends time on matters which are not relevant to the civil claim, it is unlikely that the costs of representation at that part of the inquest will be recoverable in that claim. A detailed note covering what matters were canvassed and when is, therefore, likely to be helpful.

Damages for breach of the ECHR

Finally, a recent case from Northern Ireland (*Jordan v Police Service of Northern Ireland* [2019] NICA 61) deals with damages arising from breaches of the ECHR. In the latest stage of the long-running saga of the inquest into the death of Pearse Jordan in 1992, Mr Jordan's parents brought a claim against the Police Service of Northern Ireland for breach of art.2 based on delay to the inquest proceedings. The Court of Appeal (Northern Ireland) upheld the trial judge's decision on liability and ordered £5,000 in damages in respect of 14 months' culpable delay arising from disclosure failures.

The NICA made clear that public authorities ought not to be held responsible for non-culpable delay, which would

generally include litigation to establish the extent of their legal obligations. But where public authority IPs are culpable for a delay that caused or contributed to a breach of art.2, then damages could be required to give just satisfaction. It should be noted that damages in respect of a judicial act done in good faith cannot be awarded for an art.2 breach (s.9 of the Human Rights Act 1998), as confirmed by the recent case of *Mazhar v Lord Chancellor* [2019] EWCA Civ 1558; [2020] 2 WLR 541.

As a result, liability for damages on this basis is limited to public authority IPs, and does not extend to coroners.

Conclusion

While costs and damages are not the foremost matter to consider when involved in an inquest, as shown above they can become highly relevant in a variety of different ways. An understanding of when and how these financial considerations might arise is useful for coroners and IPs alike, not least as keeping a weather eye on the issue may prevent or reduce any monetary risks further down the line.

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