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5 ESSEX COURT

INSIGHT

INQUESTS AND INQUIRIES

IN THIS ISSUE

"5 Essex Court has developed an enviable team for inquests and public inquiries work"

Chambers UK

Welcome from the Editors

Alison Hewitt
& Jonathan Dixey

Welcome to this edition of *Insight: Inquests and Inquiries.*

The questions of what does and does not trigger the enhanced investigative duty under art.2 to arise in an inquest, and the consequences if it is engaged, continue to generate much argument, as well as challenges in the Administrative Court and beyond. In this edition of *Insight*, we have the benefit of three articles which review and consider a number of recent cases and which give further guidance on the thorny issues arising. Alison Hewitt considers *Morahan* and the Divisional Court's views on the limits of art.2; Cicely Hayward reviews a trio of cases, *Dove*, *Ginn* and *McQuillian*, which give further examples of situations in which the higher courts have been called upon to define the boundaries of art.2; and Jonathan Landau discusses the case of *Boyce* which considered the well-known *Rabone* indicia in the context of a death of a 15 year old who was under a local authority care order and was accommodated in a private care home.

The behaviour of lawyers appearing in inquests (and coroners who conduct those inquests) is often a topic of comment and debate and Peter Taheri discusses the *Competences for lawyers practising in the Coroners' Courts* as well as the *Nguyen* case. We also bring you an article by Robert Cohen which returns to the ongoing efforts by the Coroner investigating the 2015 Shoreham Airshow crash to obtain material from the Air Accident Investigation Branch.

Georgina Wolfe considers s.13 of the Coroners Act 1988 and a number of recent applications under that provision for a new inquest. As she explains, although most of the 1988 Act has now been repealed, s.13 remains as an important tool within the armoury of claimants, particularly in those cases where the passage of time means that judicial review is no longer an option.

Finally, Anne Studd QC provides an update on the COVID-19 Inquiry. As explained in her article, the Inquiry Chair, Baroness Hallett, has recently concluded her consultation on the draft Terms of Reference. Amendments to the draft Terms have been proposed and we await the Prime Minister's response.

More generally, although we have no specific legal developments in relation to Public Inquiries to report, we do note that it continues to be a busy time for inquiry practitioners:

In February 2022 the *Post Office Horizon IT Inquiry* began its hearings into the human impact caused by the Horizon IT system at the Post Office and the prosecutions which followed. The Inquiry has been sitting and taking evidence from around the United Kingdom.

The *Grenfell Tower Inquiry,* the *Undercover Policing Inquiry* and the *Infected Blood Inquiry* continue to hear evidence.

In the *Brook House Inquiry*, the Chair has heard closing statements and is in the process of drafting her report.

The Chair of the *Manchester Arena Inquiry* is preparing volumes 2 and 3 of his report.

We hope you will find this collection of articles of interest and use.

Alison Hewitt

R (Morahan) v HM Assistant Coroner for West London [2021] EWHC 1603 (Admin)

As has repeatedly been said by the High Court, the factual circumstances in which the investigative duty under art.2 ECHR may arise in coroners' courts are not fixed or set in stone. Consequently, the boundaries to art.2, as they are currently judged to be, are regularly challenged by judicial review of coroners' decisions and *R (Morahan) v HM Assistant Coroner for West London* [2021] EWHC 1603 (Admin) is a recent example of this. The Divisional Court judgment contains a comprehensive review of the relevant legal principles and recent authorities, as well as a number of clear conclusions as to the current state of the law. It makes useful reading for practitioners and coroners alike but a word of warning – the outcome is under appeal. It is due to be heard by the Court of Appeal in July 2022.

The Facts

The inquest into the death of Tanya Morahan has not yet been heard and so "the facts" remain to be established. The available written evidence suggests that, at the time of her death in 2018, and following a period of detention under the Mental Health Act, Tanya Morahan was a voluntary patient in a psychiatric rehabilitation unit and that she died from an accidental drug overdose when she was on leave in the community. In the days before her death, Tanya, who had a known history of drug use, left the unit with permission on two occasions. On the first, she returned later than had been agreed but her informal status was continued. Two days later, on 3 July 2018, she left the unit by agreement for a second time, and she went to her flat which she was tidying in preparation for her discharge. She again failed to return. At the rehabilitation unit's request, the police attended the flat for a welfare check but received no response. On 9 July, Tanya's body was found at her flat and post mortem evidence showed that she had died from an overdose of recreational drugs, probably at a time closer to the last time she was known to be alive than when she was found. On the evidence available, the overdose appears to have been accidental.

The Challenge

In submissions which developed over time, Tanya's family argued that the investigative duty under art.2 arose, first because the factual circumstances were such as to result in an automatic duty to conduct an enhanced inquest and, secondly, because there were arguable breaches of a substantive operational (*Osman*) art.2 duty owed by the Central and North West London NHS Foundation Trust, which was responsible for the rehabilitation unit. The family relied upon the three factors identified in *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2; [2012] 2 AC 72 (the voluntary assumption of responsibility, vulnerability and exceptionality of risk) and they asserted that there was a failure to take reasonable steps to avoid the real and immediate risk of death (from accidental overdose) of which the Trust was or ought to have been aware. The Coroner rejected the family's arguments and ruled that art.2 was not engaged (although the question would be kept under review) and her decision was challenged by means of judicial review.

The Divisional Court's View

The Divisional Court rejected the claim. The Court's judgment was delivered by Popplewell LJ who reviewed the key authorities, in particular *Rabone* (above), *Lopes de Sousa Fernandes v Portugal* (2018) 66 EHRR 28, *Fernandes de Oliveira v Portugal* (2019) 69 EHRR 8, and *R (Maguire) v HM Senior Coroner for Blackpool & Fylde* [2020] EWCA Civ 738; [2021] QB 409. At §122 Popplewell LJ summarised the key principles as follows:

1. *There is a duty on the state to investigate every death. This is part of its framework duty under article 2 by way of positive substantive obligation. This duty may be fulfilled simply by identifying the cause of death. It may require further investigation and some explanation from state entities, such as information and/or records from a GP or a hospital.*
2. *In certain circumstances there is also a distinct and additional enhanced duty of investigation which requires the scope of the investigation to have the minimum features summarised by Lord Phillips in Smith at paragraph 64. In this country the enhanced investigative duty is usually, but not always, to be fulfilled by a Middleton inquest.*
3. *The enhanced investigative duty is procedural and parasitic on a substantive duty. It cannot exist where there is no substantive duty.*
4. *The circumstances in which an enhanced investigative duty, as a procedural parasitic duty, arises are twofold:*

   (a) whenever there is an arguable breach of the state's substantive article 2 duties, whether the negative, systemic or positive operational duties; and

   (b) in certain categories of circumstances, automatically.

Alison Hewitt

R (Morahan) v HM Assistant Coroner for West London [2021] EWHC 1603 (Admin) (continued)

5. *The categories in which it has been identified as arising automatically include killings by state agents, suicides or attempted suicides and unlawful killings in custody, suicides of conscripts, and suicides of involuntary mental health detainees. These have been identified by a developing jurisprudence and these categories cannot be considered as closed.*
6. *The underlying rationale for the categories of cases which automatically give rise to the enhanced investigative duty is that all cases falling within the category will always, and without more, give rise to a legitimate suspicion of state responsibility in the form of a breach of the state's substantive article 2 duties. The justification for the automatic imposition of the duty is not the wider rationale identified in Amin and Middleton, associated with the framework duty, of learning lessons with a view to protecting against future deaths.*
7. *The touchstone for whether the circumstances of a death are such as to give rise to an automatic enhanced investigative duty is whether they fall into a category which necessarily gives rise, in every case falling within the category, to a legitimate ground to suspect state responsibility by way of breach of a substantive article 2 obligation.*
8. *In this context legitimate grounds for suspicion connotes the same threshold of arguability as has to be satisfied in cases where the enhanced investigative duty does not arise automatically.*
9. *In addressing whether a category of death automatically attracts the enhanced investigative duty, the type of death is important. Deaths from natural causes are not to be treated in the same way as suicides or unlawful killings. This follows from (6) and (7).*

To emphasise the point, at §123 he added:

> *"The issue in this case was framed as raising the question as to … when the enhanced investigative duty arises automatically in the absence of an arguable breach of a substantive obligation. My answer would be never. The automatic duty arises, in the categories of case to which it applies, only when and because every case in the category raises a sufficiently arguable case of breach of the state's substantive article 2 duties. In this respect the arguability threshold is no different from that which applies to non-automatic cases."*

When it came to applying these principles to "the facts" surrounding Tanya's death, the Court found that the operational duty did not arise because the factors identified in *Rabone* were not met; there was no real and immediate risk of death from a cause of which the Trust was or ought to have been aware, there was no assumption of responsibility, Tanya was not particularly vulnerable (in the sense relevant to the duty) and her risk was not exceptional. Further, even if the duty did arise, there was no arguable breach.

So far as the submission that there was an automatic enhanced investigative duty was concerned, the Court found that no automatic duty arose in the case of an accidental death of a voluntary psychiatric patient; first because voluntary psychiatric patients cannot be treated in the same way as an involuntary detainee for these purposes, as their circumstances can vary across a wide spectrum (from Ms Rabone, where the power to impose involuntary detention on her should have been exercised when she tried to leave the unit, to, at the other end of the spectrum, a patient like Tanya for whom there were no medical grounds for statutory detention) and it would require a fact-specific inquiry, in each case, to establish where on the scale the deceased person lay; and secondly because there was no justification for extending the automatic duty to cases of accidental death.

The Divisional Court emphasised the need to focus on the scope of the duty which may be owed as there may be an operational duty to protect against some dangers but not others. The art.2 operational duty identified and relied upon must be a duty to take reasonable steps to avoid the specific risk to life which is relevant in the circumstances of the death. In *Rabone* the duty arose where the risk of suicide was the reason for admission to hospital, but a psychiatric hospital will owe no duty to protect a voluntary or detained patient from the risk (for example) of accidental death from a road traffic collision whilst on unescorted leave.

The key point is that the investigative duty arises when, and only when, it is arguable that there has been a breach of a substantive art.2 obligation, whether the circumstances fall within a category giving rise to an automatic duty (where the circumstances will always give rise to a reasonable suspicion of breach) or not. The claim failed because the Divisional Court did not find that there was evidence of an arguable breach of a substantive duty.

Comment

As stated above, the Divisional Court has provided real clarity on the current state of the law in this area, which is of benefit to both coroners and practitioners. Whichever way it is decided, we can only hope that the law will remain equally clear following the hearing of the appeal.

Jonathan Landau

R (Boyce) v HM Senior Coroner for Teesside and Hartlepool [2022] EWHC 107 (Admin)

Article 2 remains a frequently litigated topic in judicial review cases. In recent years, cases such as *Parkinson*[1], *Maguire*[2] and *Morahan*[3] have placed brakes on the growth of art.2 inquests. In a narrow sense, the judgment in *R (Boyce) v HM Senior Coroner for Teesside and Hartlepool* [2022] EWHC 107 (Admin) continues that trend. But it also serves as a reminder of the need to consider whether failures are attributable to the state, and of the limited practical implications of a decision as to whether art.2 does or does not apply.

The Facts

Grace Peers was 15 years old when she took her own life. At the time she was under the care of Middlesbrough Borough Council ('MBC') by the virtue of a care order and was accommodated in a private care home.

The Coroner ruled that the inquest would not be an enhanced art.2 inquest. Her first ruling on the issue was that the operational duty did not apply as there was insufficient evidence of a real and immediate risk to Grace's life. That was not challenged at the final hearing.

As regards the systemic duty, the Coroner directed that expert evidence be obtained into a number of matters directed to the question of whether the care home had been appropriate accommodation for Grace.

Having obtained that evidence, the Coroner ruled that whilst there were issues with the systems and procedures operated by MBC and the care home, it was not arguable that there was a real and substantial chance that improved systems would have saved her life, given the level of care she in fact received. Consequently, the inquest would proceed as a *Jamieson* inquest, albeit she would reconsider the matter at the conclusion of the evidence. The Coroner also wrote as follows:

> *"I remind myself that a determination as to the applicability of Article 2 will not affect the scope of the inquest, just the conclusion. I am still likely to need to consider issues regarding procedures and systems when considering my duty under PFD."*

The Grounds

Grace's mother challenged the Coroner's ruling on the following grounds:

1. The degree of supervision and control of Grace equated to state detention such that art.2 applied automatically. The state had parental responsibility through the care order which engaged state responsibility for her. Police would have been called had she tried to leave, and she was not there of her own free will.
2. The Coroner erred in holding that art.2 was not engaged.
3. The Coroner's observation that there was no practical difference between art.2 and Jamieson inquests, in so far as scope is concerned, was wrong.

The Decision

As to those grounds, HHJ Belcher (sitting in the Administrative Court) held:

Ground One:

Grace's situation was not analogous to state detention. It was not a case like *Rabone v Pennine Care NHS Trust* [2012] UKSC 2; [2012] 2 AC 72 where the power to detain involuntarily, which the court held should have been exercised, meant that the difference between the voluntary and involuntary status was one of form, not substance. The evidence in the present case was that the care provider had no power of compulsion or detention. There was a real and obvious difference between a child in secure accommodation who had thereby been deprived of their liberty and a child who was free to come and go, notwithstanding that the police would be called if she left the home. The arrangements were not, to use Lady Hale's terminology in *P v Cheshire West and Chester Council* [2014] UKSC 19; [2014] AC 896, a "gilded cage".

In any event, the care home was a private body and in *YL v Birmingham City Council* [2007] UKHL 27; [2008] 1 AC 95 the House of Lords held that private providers of care homes were not functional public authorities for the purpose of the Human Rights Act 1998, absent any statutory or coercive powers. Accordingly, even if Grace had been deprived of her liberty and/or detained at the care home, that would not be pursuant to any action by the state and so art.2 would not have been automatically engaged.

Ground Two:

On the evidence, it was not even arguable that Grace lost a substantial chance of surviving because of the systemic failings. Accordingly, the enhanced investigative duty based on an arguable breach of the systemic art.2 obligation did not apply.

Ground Three:

In practice, there is little difference in scope between the two types of inquest. The practical solution is for inquests to address the broad circumstances, especially if there is a possibility that art.2 may become relevant in the future.

Jonathan Landau

R (Boyce) v HM Senior Coroner for Teesside and Hartlepool [2022] EWHC 107 (Admin) (continued)

Comment

Article 2 and state detention

It is submitted that in the light of *Morahan*, the question as to whether the arrangements amounted to state detention is not determinative of whether art.2 applies automatically. Rather, the question is whether the circumstances fell into a category which necessarily gives rise, in every case falling within the category, to a legitimate ground to suspect state responsibility by way of breach of a substantive art.2 obligation. Implicitly, though, the judge held that it could not be said that there would always be grounds to suspect state responsibility for deaths in circumstances such as Grace's, precisely because of the degree of freedom she had as compared to those detained by the state.

State responsibility

As regards the *YL* point, practitioners should include the issue of state responsibility for any arguable breach in their checklist of matters to consider when preparing submissions on art.2. It is not a straightforward issue. For example, the case has been disapplied by statute in respect of care arranged by local authorities for adults (Care Act 2014, s.73) and does not apply to private healthcare providers exercising statutory powers of detention as functional public authorities (*R (A) v Partnerships in Care Ltd* [2002] EWHC 529 (Admin)).

Causation art.2 systemic duty

It was common ground in the case that the appropriate test for causation was whether the deceased lost a substantial chance of surviving because of the breach. That is a lower threshold than the tortious test which is to show, on the balance of probabilities, that the relevant failure caused the death. The point was not argued and the court did not have to decide it. That may be because it was the test the Coroner applied when deciding the matter in the first instance. As set out above, her initial ruling concluded "that it was not arguable that there was a real and substantial chance that improved systems and procedures would have saved Grace's life" (§8).

There is reason to doubt whether the lower threshold test for breach of art.2 which is used in civil claims should be applied in inquests. In *R (Wiggins) v HM Assistant Coroner for Nottinghamshire* [2015] EWHC 2841 (Admin), the Administrative Court held that whilst causation is not a necessary element for a claim for a breach of the art.2 operational duty, that represented a different thread of authority relating to claims and was not to be applied to inquests. Whilst that case concerned a challenge about directions to the jury on causation, the reasoning is clear and suggests that it would apply to the duty to investigate matters, and therefore that it would also apply to the question of whether an inquest must proceed on a *Middleton* or *Jamieson* basis.

In the context of determining the art.2 question in respect of the systemic duty, in most cases the outcome is likely to be the same whether the tortious or substantial loss of chance threshold is applied. If it is arguable that there was a substantial lost chance of survival, it is also, at a stage before the evidence is heard, likely to be 'arguable' that the death was probably caused by any arguable breach. That will not always be the case though, especially where there is expert evidence with a firm conclusion on causation.

The issue is of more significance when it comes to conclusions. It is submitted that the test for causation in that context remains as set out in *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin); [2016] 4 WLR 157, i.e. a more than minimal, trivial or negligible contribution to death, as affirmed in two further recent art.2 cases: *Chidlow*[4] and *Carole Smith*[5] . The line of authority on that goes at least as far back as 2001[6] and remains good law. Applying a lower standard would breach the well-established line of authorities starting with *Lewis*[7] that there is no duty to include possibly causative factors in the Record of Inquest. This analysis is consistent with the statutory purpose of an inquest. Whilst the *art.2 issue* is to be answered by the question of whether there was an arguable breach of the relevant duty, the *conclusion* requires factual answers as to how and in what circumstances the deceased came by his death; it is expressly not to make findings of civil liability, which is prohibited in all inquests, whether art.2 or *Jamieson* in type.

Difference between art.2 and *Jamieson* inquests regarding scope

It is difficult to see why this was a valid ground. It was not, and could not have been, a reason for finding that art.2 was not engaged and was a point of practice not law. In any event, whilst there may indeed be little *practical* difference as regards scope between the two types of inquest, plainly there is a *legal* difference. In non-art.2 cases, scope is a matter of discretion which would be challengeable only by way of conventional judicial review principles, whereas in art.2 cases the ECHR jurisprudence requires consideration of central issues. Nevertheless, the judge's suggestion that inquests should proceed on a wide basis, especially where art.2 may become engaged as the evidence develops, is likely to be relied on by those acting for the bereaved when advocating for a wide scope. As the judge found though, this is already the case in practice.

[1] *R (Parkinson) v HM Senior Coroner for Inner London South* [2018] EWHC 1501 (Admin); [2018] 4 WLR 106

[2] *R (Maguire) v HM Senior Coroner for Blackpool & Fylde* [2020] EWCA Civ 738; [2021] QB 409

[3] *R (Morahan) v HM Assistant Coroner for West London* [2021] EWHC 1603 (Admin); [2021] QB 1205

[4] *R (Chidlow) v HM Senior Coroner for Blackpool and Fylde* [2019] EWHC 581 (Admin)

[5] *R (Carole Smith) v HM Assistant Coroner for North West Wales* [2020] EWHC 781 (Admin)

[6] *R (Dawson) v HM Coroner for East Riding and Kingston upon Hull Coroners District* [2001] EWHC Admin 352; [2001] Inquest LR 233, per Jackson J at §§65–67

[7] *R (Lewis) v HM Coroner for Mid and North Division of County of Shropshire* [2009] EWCA Civ 1403; [2010] 1 WLR 1836

Cicely Hayward

The article 2 investigative obligation: more food for thought

There have been a number of cases recently (in addition to the important decision in *R (Morahan) v HM Assistant Coroner for West London* [2021] EWHC 1603 (Admin); [2021] QB 1205 which is covered by Alison Hewitt above) that give us (yet more, did you say?) food for thought on when the enhanced investigative duty arises, and, having arisen, what it requires.

Dove

In *R (Dove) v Assistant Coroner for Teesside and Hartlepool* [2021] EWHC 2511 the Divisional Court rejected the submission that the Department for Work and Pensions' ("badly flawed") decision to withdraw Employment Support Allowance ("ESA") from the deceased shortly before she died, gave rise to an arguable breach of the art.2 operational duty. The deceased had received ESA (or its predecessor) for a significant period of time, in part because of her severe mental health problems which included a history of suicide attempts. She committed suicide two weeks after her ESA was stopped. It was the applicant's belief that had her daughter's ESA payments not been stopped, she would not have ended her life when she did.

The applicant failed to convince the Divisional Court that the three indicia of the existence of the art.2 operational duty as set out by Lord Dyson JSC in *Rabone* – (i) the assumption of responsibility by the state for the individual's safety and welfare, (ii) the vulnerability of the victim, and (iii) the nature of the risk and whether it is exceptional – were met in this case. Indeed, in a helpful reminder that even the low threshold required to find an arguable breach of one of the substantive art.2 duties is a matter of law, Farbey J did not consider in these circumstances it was "*even open to this court to hold that such a duty exists, even arguably*". The key points from the decision were:

1. The DWP, charged with allocating public funds by way of welfare benefits, had not assumed responsibility for preventing suicide of those who received the funds (even knowing, as they did, of the risk in this case). In observations that might equally apply to other state bodies and institutions who conduct welfare checks in various capacities, Farbey J held that the fact that DWP's guidance to staff stipulated that a safeguarding visit should be undertaken in circumstances relevant to the deceased's case, did not import an assumption of responsibility:

   "In my judgment, the language of safeguarding [in the guidance] conveys in a practical way the actions that the Department's officials should take. It is not a reason for this court to adopt an approach to state responsibility that would…amount to a significant extension of domestic and ECtHR jurisprudence."

2. In common with the Court of Appeal in *R (Maguire) v HM Senior Coroner for Blackpool & Fylde* [2020] EWCA Civ 738; [2021] QB 409, the court held that even significant vulnerability was not sufficient for the purposes of establishing the operational duty; *"the unifying feature of the application of the operational duty is state responsibility… there is no general obligation to prevent suicide in the absence of the assumption of responsibility"*.

Practitioners will note that Farbey J was (unsurprisingly) dismissive of the applicant's reliance on rulings and conclusions in other inquests in which issues with the administration of state benefits had been held to engage the art.2 investigative obligation. Rulings of a coroner are neither binding nor persuasive in the High Court or, for that matter, in other coroners' courts.

Ginn

In *R (Ginn) v HM Senior Coroner for Inner London* [2022] EWHC 28 (Admin) there was no question that the art.2 enhanced investigative duty was engaged because the deceased had taken his own life in custody. The issue was whether that duty had been discharged by the inquest. Steyn J held that it had not, because the jury had not been directed to determine whether the central issues raised in the inquest caused or contributed to Mr Ginn's death.

The main issue in the case was the adequacy of the Coroner's oral directions to the jury:

> *"[The Coroner] did not identify the central issues, direct the jury that they must consider them or direct the jury that they must include in the narrative any such matters that they determined caused or contributed to Mr Ginn's death. On the contrary, the directions would have given the jury the clear impression that there was no need for them to make any determination in respect of any of the central issues canvassed in evidence."*

Steyn J accepted that the Coroner's decision not to give the jury written directions as well as oral directions was not of itself a public law error, but did consider that, consistent with the guidance given to coroners, it would have been advisable to give written directions in this case: "*one should never be too quick to assume that written directions would be superfluous*". The judge noted that even if the basic circumstances of the case were fairly straightforward, the issues of law relevant to the jury's task (approaching causation and formulating a narrative) were anything but straightforward for the jury.

Cicely Hayward

The article 2 investigative obligation: more food for thought (continued)

The Claimant also challenged the Coroner's decision not to direct the jury to include admitted failures in the Record of Inquest, relying on the decision in *Tainton*. Steyn J's conclusions on this issue were:

1. In respect of a failure that had been the subject of a formal admission in respect of the resuscitation attempt on the deceased, it was sufficient that this was addressed in the Prevention of Future Deaths Report. The fact that it was not on the Record of Inquest did not cause any unfairness to the family and did not result in a failure to comply with art.2. This conclusion makes clear what was probably implicit from the observations in *R (Worthington) v HM Senior Corner for Cumbria* [2018] EWHC 3386 at §47 and *R (Carole Smith) v HM Assistant Coroner for North West Wales* [2020] EWHC 781 (Admin) at §77, that drawing too fine a distinction as to which part of the public record a particular finding is reflected in, is unlikely to find much favour in the High Court.
2. In respect of various other failures that had been accepted by witnesses in evidence but were not the subject of a formal admission by the Ministry of Justice, there was "*a distinction between the kind of formal admission made by the Trust in Tainton and the agglomeration of evidence… relied on in this case*" and the Coroner was not required to direct the jury to record them as admitted failures if they were not found to be causative.

The decision in *Ginn* may mean that in the future coroners are more likely to set out for the jury, in clear (and perhaps written) terms, what the central issues are in the case, so early identification of those issues and how they might be formulated for the jury will be even more important for practitioners. It should also ensure Records of Inquest are less likely to be populated with the numerous nervous concessions of so many witnesses who give oral evidence.

McQuillan

The conjoined appeals in the case of *Re McQuillan's Application for Judicial Review* [2021] UKSC 55; [2022] 2 WLR 49 concerned the circumstances in which there is an obligation on the state to investigate a death or allegation of torture in breach of arts.2 and 3 of the ECHR, when the triggering event (i.e. the death / torture) pre-dates the commencement of the Human Rights Act 1998 on 2 October 2000. The question arose in the context of criminal rather than coronial investigations, but the issue is potentially relevant to inquest practitioners dealing with historic cases.

The Supreme Court explained and applied the Grand Chamber's decision in *Janowiec v Russia* (2014) 58 EHRR 30 to domestic law. In summary:

(i) There must be a "**genuine connection**" with the triggering event (i.e. the death or art.3 breach) which comprises two criteria, namely (i) a reasonably short time between the death and the commencement of the HRA on 2 October 2000, not in excess of 10 years; and (ii) the major part of the investigation must have been carried out, or ought to have been carried out, after the commencement of the HRA, or

(ii) The "**Convention values**" test must be satisfied; this arises in extraordinary situations where the "genuine connection" criteria are not met but where the need to ensure that the guarantees and the underlying values of the Convention are protected (this would be for cases such as war crimes, genocide and crimes against humanity).

The Supreme Court also considered a number of issues pertaining to the need for an art.2 investigation to be independent, and confirmed the approach of Kerr LCJ (as he then was) *In re Kelly's application for judicial review* [2004] NIQB 72; a challenge to the effectiveness of an investigation conducted pursuant to art.2 should generally await the outcome of the investigation. The domestic test for apparent bias set out in *Porter v Magill* [2001] UKHL 67; [2002] 2 AC 357 (whether a fair minded and informed independent observer, having considered the facts, would conclude there was a real possibility that the tribunal was biased) should not be read across to considerations of the independence of an art.2 investigation.

"The unifying feature of the application of the operational duty is state responsibility…there is no general obligation to prevent suicide in the absence of the assumption of responsibility."

Anne Studd QC

What shape could the Covid Inquiry take?

The draft terms of reference for the COVID-19 Inquiry were published on 10 March 2022. These are wide-ranging and cover the central, devolved and local public health decision-making, including how and when decisions were made, how the NHS and wider health and social care system responded, and the economic response. The Inquiry Chair, Baroness Hallett, held a four-week public consultation which closed on 7 April 2022. During this time, she and the Inquiry team met with over 150 bereaved families and many representatives from interested groups. They sought views on the following:

- Do the Inquiry's draft Terms of Reference cover all the areas that you think should be addressed by the Inquiry?
- Which issues or topics do you think the Inquiry should look at first?
- Do you think the Inquiry should set a planned end-date for its public hearings, so as to help ensure timely findings and recommendations?
- How should the Inquiry be designed and run to ensure that bereaved people, or those who have suffered harm or hardship as a result of the pandemic, have their voices heard?

Over 20,000 individuals and organisations responded to the consultation.

On 12 May 2022, the Chair wrote to the Prime Minister setting out her recommended Terms of Reference. As explained more fully within the Inquiry's *Terms of Reference Consultation Summary Report*, the key changes to the draft Terms of Reference are:

- The Terms of Reference should be expanded to include a focus on children and young people, the mental health and wellbeing of the UK population, and collaboration between regional, devolved and national government, and the voluntary and community sector.
- The Terms of Reference should be reframed to put "possible inequalities", i.e. the unequal impact of the pandemic, at the forefront of the investigation.
- Other changes are recommended to "sharpen our focus". These include care in the home, regulatory control, support for victims of domestic abuse, and first contact with the NHS, including 111 and 999 services.

In order to get the Inquiry started in 2022, it is possible that the hearings will commence with the experiences of Bereaved Families and others who suffered hardship or loss as a result of the pandemic. In the *Post Office Horizon IT Inquiry* they have taken those witnesses first in order to commence the process and allow further time to collect the additional material required. That may be the position adopted here.

In her update following the closure of the consultation, Baroness Hallett talked about the families she and her team met with Long Covid survivors, and representatives from a number of sectors including equalities, health, social care, post-16 education, children, the justice system, charities, faith leaders, the scientific community, frontline and key workers, local government, travel and tourism, business, the arts, heritage organisations, sports, and the leisure industry.

The consultation may result in greater emphasis being given to the period before 23 March 2020 and the science and decision making that led to the first lockdown. When one recalls the criticism in relation to closing borders (or not), earlier implementation of social distancing, imposing a period of lock down earlier (or not), the inaccurate data from the first few hundred (FF1), and the pre-lockdown planning for a slow growing pandemic, it seems likely that this period should take on a greater role than seems to be currently envisaged; on 10 March 2020 official figures suggested there had been a total of 913 cases, but experts now estimate there were 75,000. That section could probably be dealt with as a separate module and again may enable the Inquiry to get started within a reasonable time.

It is likely that the Chair will try and limit the number of core participants given the wide-ranging ambit of the inquiry. While the consultation period may have ended, there is still time for those organisations wishing to have a "voice" to contact their trade or professional organisation to ensure that they are heard in relation to the Inquiry itself. It is likely, though, to be difficult, save exceptionally, for a single organisation to obtain Core Participant status. There is also a significant expense in 'going it alone'.

Saara Idelbi, in her recent blog post, provides thought provoking questions to consider when planning your organisation's strategy for the Inquiry.

What happens next?

As at the time of writing, the Prime Minister has yet to respond to the Chair's report, although it is anticipated that the proposed changes will be accepted. Once the Terms of Reference are finalised, the Inquiry can begin its work formally and the evidence gathering will commence.

A final poignant touch from the Chair comes in the form of a Listening Project to be launched in the Autumn. As the Chair explained in her 8 April 2022 update:

> *"Many of the bereaved have told me about the loss of their loved ones, their grief and the effect on their mental health. Through the Listening Project the Inquiry will seek to understand more about how the pandemic has affected people, in a less formal setting than a public hearing."*

This mirrors the procedure adopted by the *Independent Inquiry into Child Sexual Abuse* and will run alongside the Inquiry to make sure that as full a picture as possible is obtained and can inform the final report.

Editors' comment: You can keep up to date with the very latest developments in the COVID-19 Inquiry, by accessing 5 Essex Court's COVID-19 Public Inquiry Hub.

Robert Cohen

Protected evidence and inquests: conflict or cooperation?

Robert Cohen discusses the recent case of *HM Senior Coroner for West Sussex v Chief Constable of Sussex Police and others* [2022] EWHC 215 (QB) which considered the disclosure to a coroner of cockpit recordings.

Background

On 22 August 2015 a Hawker Hunter aircraft crashed into the A27 near Shoreham. Eleven people died. HM Senior Coroner for West Sussex has a responsibility to conduct inquests into the deaths. Separately there was an investigation by the Air Accident Investigation Branch ('AAIB'), as is required by statute.

There was also a police investigation into the crash. At the culmination of that investigation the pilot of the Hawker Hunter was charged with 11 counts of gross negligence manslaughter. He was tried (before Edis J and a jury) at the Central Criminal Court between January and March 2019. An issue raised at the trial on behalf of the pilot was whether he had suffered some form of cognitive impairment which had led him to fly the aircraft in the way that he did. Expert evidence on that matter was before the jury by way of reports and oral evidence. The pilot was acquitted on all counts on 8 March 2019.

Under international, EU, and domestic law, cockpit recordings have a very high degree of protection from disclosure for purposes other than safety investigations. This is to ensure that evidence can be presented to the AAIB which is candid and un-defensive. The need to ensure safety and prevent future accidents is paramount. It has been suggested that this gives rise to a tension: Can an effective inquest be conducted when some of the evidence is protected from disclosure, even to the coroner?

Legal principles

The disclosure of material recovered in the course of AAIB investigations is governed by Retained EU Regulation No 996/2010 ("the EU Regulations") and the Civil Aviation (Investigation of Air Accidents and Incidents) Regulations 2018 ("the 2018 Regulations"). The EU Regulations continue to apply in the United Kingdom as Retained EU law under the European Union (Withdrawal) Act 2018. Article 14(1) of the EU Regulations provides that (emphasis added):

The following records shall not be made available or used for purposes other than safety investigation:

a. *all statements taken from persons by the safety investigation authority in the course of the safety investigation;*

b. *records revealing the identity of persons who have given evidence in the context of the safety investigation;*

c. *information collected by the safety investigation authority which is of a particularly sensitive and personal nature, including information concerning the health of individuals;*

d. *material subsequently produced during the course of the investigation such as notes, drafts, opinions written by the investigators, opinions expressed in the analysis of information, including flight recorder information;*

e. *information and evidence provided by investigators from other Member States or third countries in accordance with the international standards and recommended practices, where so requested by their safety investigation authority;*

f. *drafts of preliminary or final reports or interim statements;*

g. *cockpit voice and image recordings and their transcripts, as well as voice recordings inside air traffic control units, ensuring also that* information not relevant to the safety *investigation, particularly information with a bearing on personal privacy, shall be appropriately protected, without prejudice to paragraph 3.*

This prohibition is reflected in domestic law. By reg.25 of the 2018 Regulations (emphasis added):

1. *Subject to paragraphs (3) and (4), any relevant person who knowingly contravenes any of the prohibitions in paragraphs 1 or 2 of Article 14 of Regulation 996/2010 also contravenes these Regulations.*

2. *In paragraph (1) "relevant person" means—*

   (a) an Inspector;

   (b) any other officer of the Secretary of State; or

   (c) any person to whom any relevant record has been made available by such an Inspector or other officer.

3. *Paragraph (1) does not apply to information which is included in a final safety investigation report.*

4. *Paragraph (1) does not apply where a relevant person makes a relevant record available to another person ("person A") in the following circumstances—*

   (a) in a case where person A is a party to or otherwise entitled to appear at judicial proceedings and the relevant court has ordered that that record must be made available to person A for the purposes of those proceedings; or

   (b) in any other case, where the relevant court has ordered that that record must be made available to person A for other specified purposes.

Robert Cohen

Protected evidence and inquests: conflict or cooperation? (continued)

5. *The relevant court must not make an order under paragraph (4) unless it is satisfied that the benefits of the disclosure of the record concerned outweigh the adverse domestic and international impact which the disclosure might have on the safety investigation to which the record relates or any future safety investigation.*

The coroner's application

In 2016 the Chief Constable of Sussex Police had applied to the High Court for disclosure of material gathered in the course of the AAIB investigation. The police wished to use that material for the purposes of the criminal investigation. The High Court refused to grant the police access to any of this material, save for one item, the Go-Pro camera footage of the flight, recorded within the cockpit by the pilot, using his own camera: see [2016] EWHC 2280 (QB).

The Go-Pro footage was used in the course of the criminal trial. It was set up as a split screen montage by the police and was shown to the jury in open court during the trial.

After the pilot's acquittal, in June 2019, the AAIB reviewed their original investigation and considered the theory that the aircraft was flown in the manner that it was because the pilot had suffered a cognitive impairment during the looping manoeuvre. A supplementary review report was published on 19 December 2019. This concluded: "there was no new and significant evidence of cognitive impairment" and that "the findings of the (2017) AAIB investigation remain valid". The AAIB accordingly declined to re-open their investigation.

After the conclusion of the criminal trial the Senior Coroner reopened her investigation. As part of that investigation, she applied to the Court for an Order for disclosure of: (i) the Go-Pro camera footage recorded by the pilot (including both the original footage and the split screen montage created for the criminal trial); (ii) expert reports produced at his trial which addressed the issue of cognitive impairment; and (iii) the transcripts of evidence given during the criminal trial.

The coroner's stated purpose for this application was to assess whether there was credible evidence that the AAIB investigation into the air crash was incomplete, flawed or deficient. She indicated that if she concluded that it was, then she would seek to further investigate the matters within the AAIB's reports.

The AAIB resisted the application for disclosure on a number of grounds. It asserted that there was no public interest in the re-examination of a matter which it had already considered. It noted that there was no credible evidence to question the AAIB's examination. It also argued that disclosure would have a significant potential adverse impact on future safety investigations. The British Air Line Pilots Association served evidence which strongly supported the AAIB in its opposition to disclosure.

The bereaved families supported the application. As well as endorsing the Coroner's approach generally, they argued that the Go-Pro footage was not protected at all on the basis that the footage was made by the pilot for his own personal purposes rather than under any legal obligation. This was a surprising submission. For the court to accept it they would have to conclude that the High Court was wrong in the analysis it had conducted in 2016 and that a further case (*BBC v Secretary of State for Transport* [2019] EWHC 135 (QB); [2019] 4 WLR 23) was wrongly decided.

The court's decision

The court concluded (at §42) that all the material was protected material in accordance with the previous decisions cited above. The court considered the balance between benefit and harm associated with allowing the Coroner's application. The court accepted (at §114) that:

> *"…one of the main benefits of the current culture of co-operation with AAIB investigations within the worldwide aviation community is that the AAIB generally receives prompt and direct access to the relevant witnesses and evidence. There is a justified concern that wider disclosure of protected materials would mean that witnesses would refer to, or be advised to refer to, their employer organisation (for example manufacturers, operators, regulators) before dealing with the AAIB. Employer organisations would be likely to refer the matter to their legal advisers with a view to the consideration of how evidence given at this time might have an effect on future litigation. This would slow down the progress of a safety investigation and could ultimately affect or delay the development and formulation of any safety recommendations. Again, there is evidence that there have been investigations in which this has occurred…"*

The court also noted that there was evidence that experts instructed by the AAIB had become much more reticent in situations where it appears to them that their evidence to the safety investigation might be used in other ways.

Finally, the court accepted the AAIB's evidence that cockpit recording devices are not obligatory in all aircraft. The court agreed that disclosure of the footage, as anticipated by the Coroner, would increase reticence in the aviation community and discourage voluntary installation of such devices.

On the other side of the scales, the Court was dismissive of the argument that there was significant benefit associated with disclosure. In an earlier decision (*R (Secretary of State for Transport) v Senior Coroner for Norfolk* [2016] EWHC

Robert Cohen

Protected evidence and inquests: conflict or cooperation? (continued)

2279 (Admin)) Lord Thomas CJ had concluded that an AAIB investigation report was admissible evidence in an inquest. He had deprecated the re-investigation of matters that had already been the subject of an expert and independent inquiry. In the light of that approach, the gateway for disclosure is the existence of credible evidence that the AAIB's investigation was incomplete, flawed or deficient. In this case the court observed (at §126) that:

> *"It is clear why such a strict requirement is imposed: anything less would open the door to wasteful and duplicative reinvestigation by coroners. "Credible evidence" is the condition precedent or gateway - it is an important control mechanism."*

The court continued (at §128):

> *"We reject the Coroner's submission that the prohibition in Norfolk on her reinvestigating matters already investigated by the AAIB does not preclude her seeking protected material and expert opinion to determine whether she has credible evidence that the AAIB's investigation was incomplete, flawed or deficient.*
>
> *That would re-write the Norfolk test and make it weak to an extent that would seriously undermine its purpose, which is avoiding duplication of investigation by a non-expert body."*

The court proceeded to conclude that there was no credible evidence that the AAIB's report was "incomplete, flawed or deficient". On that basis they held that the condition precedent for disclosure was not fulfilled and they dismissed the Coroner's application.

Lessons for the future

The suggestion of conflict between inquests and regulatory investigation loomed large in some of the reporting of this decision. However, a full reading of the court's decision demonstrates that this is not correct. More properly, the recognition by the court that there should not be re-investigation of decisions by regulators is rooted in a desire for cooperation and comity. The court does not wish for coroners to reopen investigations by scrutinising underlying material unless absolutely necessary.

"There is a justified concern that wider disclosure of protected materials would mean that witnesses would refer to, or be advised to refer to, their employer organisation (for example manufacturers, operators, regulators) before dealing with the AAIB. Employer organisations would be likely to refer the matter to their legal advisers with a view to the consideration of how evidence given at this time might have an effect on future litigation. This would slow down the progress of a safety investigation and could ultimately affect or delay the development and formulation of any safety recommendations. "

Peter Taheri

Guidance on conduct at inquests: practitioners and coroners

Inquest practitioners will be familiar with oft-cited concerns over standards of practice among lawyers in coroners' courts, including concerns about an overly adversarial approach, and a perceived lack of empathy, sensitivity and respect for bereaved families, by some practitioners. In an effort to ensure all are aware of the ground rules, the regulators – the Bar Standards Board, the Solicitors Regulation Authority, and CILEx Regulation – jointly have published new guidance on expected conduct for lawyers in inquests: ***Competences for lawyers practising in the Coroners' Courts***. These 'competences' spell out the "targeted expectations" and – to put it more supportively, as does the Chief Coroner's foreword – "'bespoke" guidance for those acting in coroners' courts. The High Court has recently seen fit to provide words of advice to a Coroner also.

Practitioner conduct

The regulators' websites provide the carrot of more details and other resources to assist learning and CPD in this regard. There is a hint of a stick in that coroners are encouraged "to address practice that falls short of these competences either during the hearing itself or through raising their concerns with the relevant regulator". The impact of the new guidelines will be evaluated by the regulators together with the Chief and Deputy Chief Coroners, practitioners, the MoJ, and bereaved families.

The 'Competences' themselves are condensed into a single-page, divided into four sections.

Firstly, '**Procedure**': This emphasises the need to keep one's understanding of coronial law and procedure up to date and the importance of assisting the coroner with the disclosure of all relevant facts (or, to put it plainly, not partaking in cover-ups, while respecting one's duty to one's client).

Secondly, '**Dealing with vulnerability**': Unsurprisingly, the first headline point here is that one must recognise that the bereaved family is properly at the heart of the inquest. The family may be vulnerable in the inquest because they are unfamiliar with the inquest process, because they may be unrepresented while other interested persons are represented, or because they do not understand how the inquest process differs from other proceedings in which they may have been involved, such as an ombudsman's process or criminal proceedings. There is also welcome recognition that practitioners should appreciate that other interested persons or witnesses may also be vulnerable, with the specific example given (in the further guidance) of a member of the emergency services who may have been affected by witnessing someone's death.

It is made clear that practitioners are expected to ensure that their clients understand the inquest process and have their expectations managed sensitively. As the Chief Coroner put it:

> *"All lawyers who practise in coroners' courts should appreciate – and should explain to their clients – that an inquest is not a means of apportioning blame, let alone a form of litigation, but a sharply focused and necessarily limited investigation into four questions: who the deceased was, and when, where and by what means the deceased came by his or her death."*

Practitioners are required to adapt to the needs of vulnerable people and the third, and arguably most important, section of the 'Competences' expands on this, focusing on '**Communication and engagement**'. Here the need for plain English, and concise and clear communication, is stressed; rather than bamboozling bereaved families with cold and confusing legalese, "demonstrating empathy as appropriate" is advised. Recognition is required of the inquisitorial and fact-finding nature of an inquest, with practitioners expected to question in a way appropriate in that context. While "firm and robust" questioning may sometimes be necessary, an "aggressive and hostile" style is not permissible. In case anyone needed reminding always to be respectful and professional, both in and out of court, that is in the document too. Of course, the vulnerability and communication topics interlink: practitioners are guided to adapt questions for different witnesses, for example by not asking the same sort of questions of vulnerable or grieving witnesses as one might ask a pathologist. While challenges to the evidence may be necessary, this should be proportionate and should weigh vulnerabilities in the balance.

Finally, the fourth and last section – '**Awareness of key organisations**' – reminds practitioners to be aware of organisations offering support to family members and witnesses, such as the Coroners' Courts Support Service or the charity INQUEST, and to work with them or to signpost or make referrals to them as appropriate.

Coronial conduct

Recent events make clear that it is not just practitioners whose conduct is

Peter Taheri

Guidance on conduct at inquests: practitioners and coroners (continued)

under the microscope. *Nguyen v HM Assistant Coroner for Inner West London* [2021] EWHC 3354 (Admin) provides an informative illustration of where the line of appropriate conduct lies for the presiding coroner. In *Nguyen*, the High Court was concerned with an assertion of bias. The Court did order a new inquest, albeit not on the ground of apparent bias, but the claimant's submissions and the Court's response are salutary.

Professor Leslie Thomas QC, on behalf of the claimant, argued that too many of the Coroner's questions were not in fact questions at all, but amounted to speeches, and too many were "particularly robust" and crossed the line from probing into advocacy. It was submitted that the Coroner's examination of one witness was unfair and unduly pressurising, and that the Coroner's view of the merits of the issues was too often betrayed; it was also argued that the Coroner was reluctant to call into question clinicians' clinical judgments and had a closed mind to competing views. Finally, the Coroner was criticised for delivering an ex tempore judgment immediately at the conclusion of the evidence, without taking a break to reflect, and then failing to refer to the last witness' evidence.

It is not unusual to encounter coroners with firm "provisional views" on the issues arising in an inquest, and so it is interesting to note the way in which, specifically, the High Court did criticise the Coroner. It was said that, "some of the questions were too assertive, amounted to the setting out of propositions rather than questions and /or involved several questions and not one, making it difficult for the witness to answer." One remark by the Coroner which revealed a provisional view was considered "unwise" and another, about a matter being "quite shocking really", was considered "close to being intemperate". Despite this criticism, ultimately, it was decided that a firm provisional view is not apparent bias, although this case was "quite close to the line". Further, the Court held that delivering findings and a conclusion immediately after the last witness' evidence, did not raise any particular concern: "Whether she needed time to reflect and assemble her notes was a matter for her."

Nevertheless, readers may well conclude that lawyers and coroners alike are now required to pay particular care over their conduct and, in particular, how robustly they ask questions and communicate in Inquests.

Editors' comment:

The *Competences for lawyers practising in the Coroners' Courts* can be found online here.

In addition to the *Competencies* themselves, the three regulators have each produced guidance material which can be found through their individual websites:

For solicitors, see the SRA's website here.

For CILEX advocates, see the CILEX's website here.

For barristers, see the BSB's website here.

The websites include video messages from the Chief Coroner, bereaved family members, and those who work within the coronial system.

The guidance promotes a careful and courteous approach which, we anticipate, most of our readers already adopt. However, those practitioners who do not fully meet the standards set out within the *Competencies* may find that coroners, increasingly, use the document as a further tool to ensure fairness and clarity, especially for the bereaved, and a proportionate focus on the four statutory questions.

"All lawyers who practise in coroners' courts should appreciate – and should explain to their clients – that an inquest is not a means of apportioning blame, let alone a form of litigation, but a sharply focused and necessarily limited investigation into four questions: who the deceased was, and when, where and by what means the deceased came by his or her death."

Georgina Wolfe

Section 13: lucky for some

Alone in the barren wasteland of the mostly-repealed Coroners Act 1988, section 13 stands tall. It was not usurped by the right of appeal to the Chief Coroner proposed in the Coroners and Justice Bill (which did not make it into the Act). Nor is it rendered redundant by our old friend, judicial review. Section 13's broad legal test and lack of time limit make it an attractive option for claimants.

Section 13 allows the High Court to order an investigation into a death and, where an inquest has already been held, to quash any conclusion, or determination or finding made at that inquest and order a fresh investigation. It applies where the High Court is satisfied either (a) that a coroner refuses or neglects to hold an inquest or an investigation which ought to be held or (b) where an inquest or an investigation has been held, that it is necessary or desirable in the interests of justice that an investigation or another investigation should be held. Section 13(1)(b) offers a non-exhaustive list of circumstances which might cause a court to conclude that a new investigation is necessary or desirable: "by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise."

Section 13 does not dirty its hands with such common concerns as time limits. An application can be made at any time. There is just the small matter of obtaining the consent (fiat) of the Attorney General to cross the threshold of the High Court. One might think this is a prohibitively high bar but fortunately, Suella Braverman QC spent the last year avoiding lockdown parties and diligently granting fiats, so there are plenty of recent section 13 cases around.

Earl v Senior Coroner for East Sussex [2021] EWHC 3468 (Admin) provides a startling example of the effects of this lack of time limit. The court granted the parents' application to quash an inquisition following the death of their daughter. Jessie Earl went missing in 1980. Her skeletal remains were found in 1989, alongside her tightly-knotted bra. The Coroner recorded an open verdict, finding that the medical cause of death was unascertainable. Jessie's parents strongly disagreed. In 2000, a cold case investigation suggested that Jessie had been murdered and found a serious error in the original police investigation which had not treated the death as homicide. It also observed that there were shortcomings in the Coroner's conclusion. The cold case investigation identified further lines of inquiry, including finding that Jessie's remains were available for analysis. The Attorney General granted Jessie's parents a fiat in November 2020. The court found that the words 'or otherwise' in section 13(1)(b) were capable of capturing situations such as an unreasonable verdict or the results of a new police investigation. It held that there was an insufficiency of inquiry, the open verdict was not reasonable under public law principles, and a new inquest was independently justified because two Senior Investigating Officers expressed the firm view that Jessie had been murdered. In concluding that there was an "overwhelming" case for a new inquest, the court did not comment on whether it was necessary, or desirable, or both.

To obtain an order for a new inquest based on new evidence, the s.13(1)(b) test is similar to that in *Ladd v Marshall* [1954] 1 WLR 1489, except without the requirement that the new evidence could not have been obtained at the first hearing. All that needs to be shown is that the new evidence might have made a material difference and it is necessary or desirable in the interests of justice to hold a new investigation. In the matter of the *Re Inquest into the Death of Michael Richard Vaughan* [2020] EWHC 3670 (Admin), Michael Vaughan had been receiving mental health treatment when he died after overdosing on paracetamol. He left a suicide note, a copy of which was retained by the mental health team leader and in his medical records, but it was not passed to the police or Coroner. At the inquest, the Coroner returned a conclusion of misadventure. Mr Vaughan's brother asked for the inquest to be reopened. Following various delays, a new coroner obtained a fiat and applied to the court for an order pursuant to s.13 quashing the inquest and requesting a fresh one. The Divisional Court granted the application. Although unpersuaded that a fresh inquest was necessary within the meaning of s.13 (the court pointed to delays for which the Coroner's office was responsible), the court decided that it was desirable, principally because it was the brother's wish but also because of the likelihood of a different conclusion.

In *Mays v HM Senior Coroner for Kingston upon Hull and the East Riding of Yorkshire* [2021] EWHC 3604 (Admin), the court ordered a fresh art.2 inquest where new evidence had come to light. The deceased (S) suffered from serious mental health difficulties and had made several attempts to take her own life. A community psychiatric nurse (CPN) took her to an NHS assessment unit, but she was sent home following an assessment by the gatekeeping nursing team. She took her own life that evening. The "sympathetic and thorough" Senior Coroner found that the failure to admit S to an acute inpatient psychiatric bed constituted neglect which had a direct causal relationship to her death. After the inquest, fresh evidence came to light revealing a conversation shortly after the assessment where the CPN was reassured by a consultant psychiatrist who knew S. The court found that this was relevant and potentially highly material to the inquest issues which

Georgina Wolfe

Section 13: lucky for some (continued)

potentially represented another opportunity to provide the appropriate care and assistance that S required. While perhaps unlikely to substantially alter the ultimate conclusions, the court held that a fresh inquest was likely to lead to additional findings of fact and was necessary and desirable.

Finally, *Nguyen v HM Assistant Coroner for Inner West London* [2021] EWHC 3354 (Admin) (which is also covered by Peter Taheri in his article). There, the court granted a s.13 application finding that new experts' reports obtained by the deceased child's parents constituted new evidence which was credible and relevant to an important issue and it was desirable in the interests of justice for a further investigation to be held.

Section 13 remains a useful tool for those seeking a fresh inquest. As can be seen from this recent case law, this is especially so for claimants who are out of time to seek judicial review or who have uncovered additional evidence.

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