5 ESSEX COURT

INSIGHT

INQUESTS AND INQUIRIES

IN THIS ISSUE

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

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Welcome from the Editors

Samantha Leek QC
& Jonathan Dixey

Welcome to the first issue of *Insight: Inquests and Inquiries* - a new publication produced by 5 Essex Court. The newsletter is intended to provide updates on key legal developments and practical insights from barristers who regularly appear in the most significant inquests and public inquiries and who are recognised as leaders in their field.

In this inaugural issue, we explore some of the key differences between inquests and public inquiries; the principles which apply in inquests arising from deaths in care homes and hospitals where the deceased was subject to Deprivation of Liberty Safeguards (DoLS); applications to quash previous inquests; when post mortem examinations are necessary; and the relevance of admissions of non-causative failings in inquests. In addition, you will also find summaries of three recent important decisions, including the judgment in the *Adath Yisroel Burial Society* case which concerned the so-called 'cab rank rule' of the Senior Coroner for Inner North London.

In this and in future issues we will draw upon the vast experience and expertise of members of 5 Essex Court. It has been a particularly busy year for our barristers who have been instructed in most of the leading public inquiries including: the *Grenfell Tower Inquiry*; the *Independent Inquiry into Child Sexual Abuse*; the *Anthony Grainger Inquiry;* the *Renewable Heat Incentive Inquiry*; and the *Undercover Policing Inquiry*. Recent and ongoing high-profile inquests in which members of 5 Essex Court have appeared or are currently instructed include: the *London Bridge Attack*; *Westminster Terror Attack*; *Perepilichnyy*; *Deepcut*; *Birmingham Pub Bombings*; and *Poppi Worthington*.

We are particularly delighted to celebrate Alison Hewitt's appointment as the Senior Coroner for the City of London. Alison was sworn into her new role on 30 April by the Chief Coroner. She will sit at the City of London Coroner's Court on a part-time basis and will continue to practise from 5 Essex Court.

Further information on who we are and the work we undertake can be found on our website www.5essexcourt.co.uk.

We hope you find this newsletter interesting and welcome any feedback or suggestions. You can contact us at: inquestsandinquiries@5essexcourt.co.uk.

Please also join our newly set up LinkedIn group which aims to provide a forum for debate and sharing views on key issues relating to inquests and inquiries.

Jason Beer QC

Inquests and public inquiries: a (brief) comparison

Within 24 hours of the Grenfell Tower fire the Prime Minister announced that a judge-led public inquiry would examine the circumstances which gave rise to the disaster. That Inquiry, chaired by the former Court of Appeal judge, Sir Martin Moore-Bick, began its public hearings last month.

The decision to establish a public inquiry to investigate the causes of the fire, rather than allowing inquests to perform this function, was not without controversy: various online criticisms were made, including a petition to Parliament which alone attracted tens of thousands of signatures.

To those who are familiar with coronial proceedings, it is perhaps surprising that so many people would consider an inquest to be a preferable means of establishing the truth rather than a public inquiry. In this, the inaugural issue of *Insight: Inquests and Inquiries*, it is important to restate some (but by no means all) of the key differences between inquests and public inquiries.

There are of course many similarities between an inquest and an inquiry, including: both are often used as the means by which the State investigates the causes and circumstances of a death or deaths; both accord a bundle of participative rights to those most affected by the subject matter of the investigation, albeit the legal funding position of families in inquiries is more generous than that in inquests; and both are independent of Government (save that the Government has an important part to play in setting the terms of reference of an inquiry, whereas the matters to be investigated by an inquest are set by a combination of ss.5 and 10 of the Coroners and Justice Act 2009 ('the 2009 Act') and the a decision of the coroner as to scope). However, there are a number of significant differences:

- **Apportioning blame:** An inquest may not expressly apportion blame to an individual or organisation for a death. A public inquiry may do so. Although s.2 of the Inquiries Act 2005 ('the 2005 Act') prohibits a public inquiry from determining any question of civil or criminal liability, that prohibition does not prevent it from naming and criticising individuals and organisations.
- **Scope of the investigation:** If Art.2 of the European Convention on Human Rights is not engaged, then the scope of the inquest may be limited, both in terms of the issues which can properly be investigated, and the conclusions and determinations reached at the end of it. A public inquiry does not depend upon the engagement of Art.2 for the breadth and depth of the issues which may be investigated.
- **Intensity of focus on the future:** An inquest is primarily concerned with what happened in the past: how did this person, or these people, come to die? Whilst the making of a 'prevention of future death report' is an important part of an investigation under the 2009 Act, it is ancillary to its primary statutory purposes. Prevention of future deaths, the improvement of standards, and the learning of lessons are key functions of a public inquiry established under the 2005 Act. An inquiry can and often does receive evidence about issues relevant to recommendations even though the issues were not arguably causative of death.
- **Access to hearings/information:** Although the standards of openness between inquests and inquiries are comparable these days, an inquiry has available to it a wider range of powers in terms of public access to the hearings of the inquiry – for example, it has powers to require that its hearings be broadcast publicly. This is the case with the *Independent Inquiry into Child Sexual Abuse (IICSA)* and the *Grenfell Tower Inquiry*, both of which are broadcast live on dedicated websites.
- **Ability to hold closed hearings:** A public inquiry has powers to receive evidence in closed hearings, where all or some core participants are excluded and secret or sensitive evidence is received and taken into account by the chairman of the inquiry. That power is not available in inquests (*R (Secretary of State for the Home Department) v Assistant Deputy Coroner for Inner West London* [2011] 1 WLR 2564). It is for this reason that some deaths have been investigated through public inquiries under the 2005 Act, rather than as inquests (for example, the *Azelle Rodney Inquiry*, the *Litvinenko Inquiry* and the *Anthony Grainger Inquiry*).

> "A public inquiry does not depend upon the engagement of Art.2 [of the European Convention] for the breadth and depth of the issues which may be investigated."

There are many reasons why some people still favour inquests over inquiries:

- First, despite delays in completing complex inquests, they are still likely to be heard and completed quicker than an inquiry under the 2005 Act. Inquests can be conducted at a local authority scale of funding, whereas an inquiry staff and structure need to be built and funded from scratch. Although public inquiries can be more wide-ranging in their scope and will routinely enjoy the chairing of a senior judge, there is not an absolute right for the family to ask questions.
- Second, many inquests concerning controversial deaths will be heard by a jury. Family groups in particular see that as a valuable protection against the power of the State and more likely to result in a fearless investigation leading to a just outcome than would be the case with a public inquiry.
- Third, the very ability of an inquiry to receive evidence in closed hearings, and the inability of an inquest to do so, is seen by some as a reason for favouring inquests over inquiries.

Beatrice Collier

Care homes and hospitals: DoLS

Beatrice Collier provides a quick refresher on the position in relation to inquests into the deaths of people lacking capacity who have died in care homes and hospitals.

The Deprivation of Liberty Safeguards ('DoLS') (part of the Mental Capacity Act 2005) aim to protect people who lack mental capacity, but who – in order that they can be given care and treatment in a hospital or care home – have to be deprived of their liberty.

Under the Mental Capacity Act 2005 ('the MCA 2005') a person who lacks capacity and is in a hospital or care home for the purpose of being given treatment or care may be subjected to restrictions and / or detention which constitutes a deprivation of liberty. Actions taken by staff which amount to a deprivation of liberty may be permitted if there has been authorisation for the deprivation of liberty under the statutory scheme. Without authorisation those actions would amount to false imprisonment and a breach of Art.5(1) of the ECHR. The statutory scheme is set out in Schedule A1 to the MCA 2005, and it incorporates certain safeguards known as the Deprivation of Liberty Safeguards or 'DoLS'.

The *Cheshire West* case

The Supreme Court judgment of May 2014 in the case of *Cheshire West and Chester Council v P* [2014] UKSC 19 widened the definition of 'deprivation of liberty'. The Supreme Court held that the key feature is whether the person concerned is under continuous supervision and control and is not free to leave. The person's compliance or lack of objection, the quotidian nature of the placement, and the purpose behind it are irrelevant to this objective question: in Lady Hale's oft quoted words "*a gilded cage is still a cage*".

The consequence of the judgment was that more people were now judged to be deprived of their liberty, and therefore to require authorisation and the application of DoLS - thus ensuring a rigorous procedure of assessment, independent of the hospital or home, of whether the deprivation of liberty was in the individual's best interests.

The use of DoLS in hospitals and care homes following the *Cheshire West* case increased exponentially, with the Care Quality Commission and the Department of Health anticipating the applications for authorisation for DoLS to rise to over 100,000 per year.

DoLS and inquests

Prior to April 2017 it used to be the case that an inquest was required if the person subject to a DoLS authorisation had died (whether in hospital or in a care home, and whatever the circumstances). This was because s.1(2)(c) of the CJA 2009 provides that a Coroner must conduct an investigation into a person's death if the deceased died whilst in custody "or otherwise in state detention".

The definition of "state detention" is contained in s.48(2) of the 2009 Act:

> "a person is in state detention if he or she is compulsorily detained by a public authority within the meaning of section 6 of the Human Rights Act 1998".

It was generally considered that a person who has been deprived of their liberty under a DoLS authorisation in hospital or a care home was in state detention.

But in April 2017 the CJA 2009 was amended by the insertion of s.48(2A) which provides that:

> "...a person is not in state detention at any time when he or she is deprived of liberty under section [...] 4(5) [...] of the Mental Capacity Act 2005".

Section 4(5) refers to an authorised deprivation of liberty in order that the person concerned can receive care–as already described. Accordingly, for the last year there has been no automatic requirement on "state detention" grounds for a coroner's investigation into deaths of those people who die in care homes or in hospitals whilst subject to a deprivation of liberty authorised under the MCA 2005.

Chief Coroner's Guidance

The Chief Coroner has issued guidance on this topic: *Chief Coroner's Guidance No.16A Deprivation of Liberty Safeguards – 3rd April 2017 onwards* which provides the background as well as a full and helpful explanation of the operation of DoLS authorisations and a summary of the impact of the *Ferreira* case concerning a death in intensive care: (*R (Ferreira)* v *HM Senior Coroner for Inner South London* [2017] EWCA Civ 31).

Of course a person who dies while subject to restrictions amounting to "state detention" in a hospital or care home, but without there having been a deprivation of liberty that has been authorised under the MCA 2005, will still have to be the subject of an investigation and inquest pursuant to s.1(2)(c) of the CJA 2009.

> "...what it means to be deprived of liberty must be the same for everyone, whether or not they have physical or mental disabilities. If it would be a deprivation of my liberty to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision, and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person. The fact that my living arrangements are comfortable, and indeed make my life as enjoyable as it could possibly be, should make no difference. A gilded cage is still a cage." Lady Hale in *Cheshire West*, para 44

Robert Cohen

A question of causation

Robert Cohen examines the decision in *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin).

The limited questions to be answered in the course of an inquest are familiar and require no additional comment. However, despite these limits there is a clear trend for coroners to be asked to consider issues in a wider compass. Those regularly acting for public bodies or healthcare providers in inquests will not be surprised if bereaved families seek wider findings; those acting for families will recognise the potential benefits of such an approach.

How is a coroner to address an invitation to consider possible wider failings, even if those failings are not likely to have been causative of the death?

The law until 2016

In *R (Lewis) v HM Coroner for the Mid and North Division of Shropshire* [2009] EWCA Civ 1403; [2010] 1 WLR 1836 the Court of Appeal considered the inquest into the death of a young offender who had been found hanging in his cell. The Coroner had not asked the jury to reach findings on the actions of officers who had found the deceased, and this was the subject of a judicial review. In the Court of Appeal it was suggested on behalf of the deceased's family "that in order for the jury's verdict to be required on it, a fact or circumstance does not have to have been a **probable cause** of or contributor to the death, so long as it is **capable** of having had such a bearing".

Whilst the Court was sympathetic to this submission, its full effect was rejected on the basis that the language in the Coroners Act 1988 and the Coroners Rules 1984 could not support such an approach. Instead the Court concluded that a coroner had a power **but not a duty** to leave a possible rather than a probable cause to the jury.

Following this decision *Lewis* came to be regularly cited by all parties in inquests, often in support of radically different propositions. Bereaved families usually relied upon the disquiet expressed by the Court, and the possibility of leaving such a finding to a jury; institutions tended to observe that there was no basis to depart from the Court's fundamental reasoning that non-causative factors did not have to be considered.

The decision in Tainton

These issues came to a head in *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin); [2016] 4 WLR 157. The deceased (Mr O'Neil) was a prisoner who died following a delayed diagnosis of cancer. The Prison and Probation Ombudsman was critical of the failure to provide appropriate medical treatment. The NHS Trust admitted that they had been negligent but denied causation. They asserted that even if they had acted more promptly Mr O'Neil would still have died. On this basis the Coroner refused to leave to the jury the issue of whether the Trust's negligence had significantly hastened Mr O'Neil's death.

Mr O'Neil's bereaved mother challenged the Coroner's decision. She argued that to achieve compliance with Art.2 of the ECHR the Coroner ought to have "directed the jury to determine whether Mr O'Neill's death was hastened as a result of the admitted delays in his treatment; whether the medical attention he received was inadequate or amounted to neglect; whether there were systemic failings within the Trust's health care provision at HMP Preston; and how the hastening of deaths, in similar circumstances, could be prevented in the future".

The Court agreed with the Coroner that it was inappropriate for the jury to be asked to consider the trust's failings but held:

> "[W]e consider that the coroner should have directed the jury to include in the Record of Inquest a brief narrative of the admitted shortcomings of the healthcare staff... In light of the fact that the coroner withdrew the issue of causation from the jury, such a statement would have to have been supplemented by an explanation that it could not be concluded that these shortcomings significantly shortened Mr O'Neill's life... Putting it another way, in an inquest such as this, where the possibility of a violation of the deceased's right to life cannot be wholly excluded, section 5(1)(b) and (2) of the 2009 Act should require the inclusion in the Record of Inquest of any admitted failings forming part of the circumstances in which the deceased came by his death, which are given in evidence before the coroner, even if, on the balance of probabilities, the jury cannot properly find causative of the death."

The way forward

The Court made clear that its decision was fact sensitive. However, it has resulted in increased disputes as to the proper ambit of conclusions in cases in which there might have been a wide array of failings.

Ultimately these disputes have no clear answer: the decision in *Lewis* is binding, but the observations in *Tainton* are persuasive. Experience suggests that in resolving this tension coroners have adopted a pragmatic approach. The possibility of allowing a brief narrative recording failings has been used as a tool to ensure that obvious failures are not ignored in the course of conclusions, even if those failures are not really causative.

It follows that the decision in *Tainton* has been taken to add a string to coroners' bows. Those acting in inquests need to be adept at identifying additional issues that may be the subject of *Tainton* motivated conclusions. It is vital to ensure that non-causative matters are not neglected in the course of preparing for inquests.

John Goss

Starting all over again – applications under s.13 of the Coroners Act 1988

John Goss considers the power to quash the conclusions of previous inquests.

Unlike in most legal proceedings, there is no appeal once an inquest has concluded. Judicial review may be possible, but the time limit is short, the tests for review relatively strict and remedies discretionary. One might be forgiven for thinking that, after the inquest's conclusions have been handed down, that is that. However, s.13 of the Coroners Act 1988 ('the 1988 Act') provides a lesser-known statutory power for the High Court to quash an inquest and order a fresh one. Section 13 has been used in several high-profile cases in recent years, including the Hillsborough Inquests, the various inquests into the deaths of soldiers at Deepcut Barracks, the inquests into the deaths of Daniel Whitworth and Gabriel Kovari (two of the victims of serial killer Stephen Port) and the inquest into the death of Poppi Worthington.

Section 13 gives the High Court power to quash a previous inquest's conclusions and order a new inquest, where by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise, it is necessary or desirable in the interests of justice for another investigation to be held. An application can only be made with the approval of (or by) the Attorney General, which acts as a filter against hopeless applications. It can also be made only where an inquest 'has been held', which means concluded (*Flower v HM Coroner for Devon* [2015] EWHC 3666 (Admin); [2016] 1 WLR 2221). Where an inquest has been adjourned and not resumed (often after criminal proceedings), s.13 cannot be used to revive it, although the Coroner has a residual discretion to resume the proceedings (as has recently occurred in the *Birmingham Pub Bombings Inquests*).

The High Court set out the principles to be applied in s.13 applications when it quashed the original Hillsborough inquests (*Attorney General v HM Coroner of South Yorkshire (West) & anor* [2012] EWHC 3783 (Admin)). In short, a fresh inquest will normally be both desirable and necessary in the interests of justice when new evidence has emerged that may reasonably lead to the conclusion that the substantial truth about how an individual met his/her death was not revealed at the first inquest. That is particularly so where a different conclusion is likely. But even where the court does not anticipate a different conclusion, it may still be desirable for the full extent of the evidence to be publicly revealed. The passage of time is a factor, but not a decisive one.

Section 13 is not primarily a power to use following procedural failings, unless the process adopted at the original inquest has caused justice to be diverted or led to an insufficient inquiry. Judicial review would usually be more appropriate in such circumstances.

More commonly, the issues will relate to new evidence. That evidence must have been unavailable at the time of the original inquest, have been admissible if it had been available, and be credible and relevant to a significant issue in the investigation. A clear recent example is the inquest into the deaths of two of the victims of serial killer Stephen Port, which both recorded open conclusions. Once Port had been convicted of their murder – a fact which would have been admissible in the inquest had it been known the time – it was clear that the inquests' conclusions ought to be revisited.

Similarly, in the Poppi Worthington case, the original inquest had been seriously hampered by concurrent Family Court proceedings. No evidence was called and the answers to 'how, when and where the deceased came by her death' were left open. It was ripe to be quashed. In both cases, the applicant in the s.13 proceedings was the Coroner her- or himself.

A more striking use of the power is to revisit inquests which concluded many years previously. In some cases, this is a result of new forensic techniques, particularly where these enable the identification of previously unidentifiable remains (*Re HM Senior Coroner for North West Wales* [2017] EWHC 2557 (Admin)). In others, newly available expert evidence has cast doubt on the correctness of the inquest's conclusions or reasoning – although where competing views have been weighed up and a firm view reached, it is not sufficient that a different coroner might take a different view.

The most high profile cases often follow longstanding campaigns by relatives of the deceased, as seen in the fresh inquests into the deaths at Hillsborough and Deepcut. It is not limited to such high-profile cases. Recently, the open verdict from the 1998 inquest touching the death of Onese Power following a police pursuit was quashed. The High Court held that there had been insufficient inquiry into the accounts of the officers concerned, and that newly available expert evidence might cast further light on the circumstances of the death. In all of these cases, the result is an extensive – and expensive – fresh inquest, required because, for whatever reason, the process failed the first time around.

The lesson to be drawn from these disparate cases is a simple and salutary one: make sure that an inquest does not leave stones unturned, or key questions answered unsatisfactorily, or you may have to start all over again – even many years later.

> "...a fresh inquest will normally be both desirable and necessary in the interests of justice when new evidence has emerged that may reasonably lead to the conclusion that the substantial truth about how an individual met his/her death was not revealed at the first inquest. That is particularly so where a different conclusion is likely."

Alison Hewitt

When are post mortems necessary?

A Coroner has a power, but not a duty, to request a post mortem examination if it is necessary to enable him/her to decide whether the death is one into which he must conduct an investigation (s.14 of the CJA 2009). In fact, autopsies are requested in about a third of reported deaths. In the future this may be affected by the promised introduction of the Medical Examiner scheme in April 2019 although it is not yet fully understood in what way or to what extent.

Post mortem examinations ('PMs') can be conducted by any "suitable" registered medical practitioner although the vast majority are undertaken by pathologists based in local hospitals. Coroners may also specify the kind of examination to be made, for example by means of a fully or partially invasive examination of the body or a CT or MRI scan. If there is a suspicion of criminality, or the deceased died whilst detained by the State, a "special" PM, by a Home Office accredited Forensic Pathologist, will usually be organised. This will involve a more comprehensive level of examination and will be more thoroughly documented (including photography). If the deceased was a baby or child, a Paediatric Pathologist should conduct or be involved in the autopsy. Currently, the shortage of specialist pathologists, and the growing reluctance of hospital pathologists to undertake routine PMs for the statutory fee, are of concern.

It is for the coroner to decide whether an autopsy should be held. If he/she concludes that a PM is not needed then his/her decision will probably not be challengeable by judicial review unless the absence of an examination constitutes insufficient enquiry.

If the coroner concludes that a PM is required, the permission of the deceased's family is not needed. However, rights under Art.9 of the ECHR may arise and it is now clear that coroners must take account of them. In *R (Rotsztein) v HM Senior Coroner for Inner North London* [2015] EWHC 2764 (Admin) the Administrative Court gave guidance as to the approach coroners must take when considering whether to direct an invasive or non-invasive procedure in cases where the family has expressed religious objections to the use of an invasive autopsy.

Coroners may also consider whether to request or permit a second (or further) PM. In 1985 the Home Office encouraged coroners to arrange a second autopsy in cases of suspected homicide and to keep the resulting report, unseen, for future use by anyone charged with causing the death. But coroners are not obliged to do so and increasingly do not. They are, though, obliged to consider any request for a second PM by a person or organisation with Interested Person status in the inquest.

Any medical practitioner who conducts an autopsy at the coroner's request must report the result to him/her as soon as is practicable and in the form required by the coroner (which will almost always be a written report). Any Interested Person is entitled to receive a copy of a PM report. The report will contain both factual and opinion evidence. The pathologist will set out what was seen and found in the course of the external and internal examination of the body (or from any scan of the body) and will record the outcome of any further testing conducted by himself or other specialists, including histology, toxicology, radiology, bacteriology, virology and metabolic studies. He/she will then go on to state his opinion as to the likely medical cause of death, based primarily upon the PM findings, but sometimes also taking account of the circumstances of the death. The medical conditions or events leading directly to the death are recorded, sequentially, under Ia to Ic and any underlying relevant conditions may be included under II.

In many cases the PM will reveal a clear and uncontroversial medical cause of death, but sometimes the findings are open to interpretation and forming an opinion can become as much an art as a science. Experienced Consultant Pathologists can disagree strongly as to their interpretation of the agreed findings and their opinion as to the cause of death. In the recent inquest into the death of *Poppi Worthington* (before HM Senior Coroner for Cumbria) five Consultant Pathologists gave significantly differing opinions as to the proper interpretation of what was seen on examination and concerning the 13 month old's cause of death.

It goes without saying that Interested Persons are entitled to instruct their own expert to consider what was found by the PM examination (including by viewing, for example, photographs and histological slides) and to provide a written report of their opinion. A coroner must consider, on its merits, any application for such further expert evidence to be admitted at the inquest.

"In many cases the PM will reveal a clear and uncontroversial medical cause of death, but sometimes the findings are open to interpretation and forming an opinion can become as much an art as a science."

Aaron Moss

Scope of an inquest: two recent decisions

When witnesses are not required: *R (Maguire and others) v Assistant Coroner for West Yorkshire (Eastern Area) and Others* [2018] EWCA Civ 6

The family of a teacher murdered by her pupil appealed against the Coroner's decision not to call the nine fellow pupils who saw the assailant on the morning of the attack. The appeal was initially dismissed by the Divisional Court and subsequently the second appeal dismissed by the Court of Appeal. The Coroner's reasons were rational.

Mrs Maguire was a Spanish teacher at the school, which has 950 students across four year groups. A 15-year old student, WC, murdered Mrs Maguire in 2014. A small number of pupils were aware that WC had a knife on him that morning and he had told some of them of his hatred of Mrs Maguire and his desire to kill her. Each of these pupils underwent a police 'Achieving Best Evidence' interview, the video recordings of which were to be played in evidence in the inquest. The evidence of the children exposed two common themes: (1) almost all did not take WC's threats seriously and (2) many recognised that had they taken action in the light of what they knew, Mrs Maguire's death would have been prevented.

In ruling on scope, the Coroner considered that the immediate circumstances of the murder had already been fully investigated in connection with the criminal proceedings. The resumption of the inquest was broadly justified to investigate the rules and policies that the school had in place relating to bringing knives into school and how pupils should react when aware. The Coroner determined not to investigate "what did students understand about not evaluating themselves the risk represented by any individual, and whether those risks were genuine?" since it was outside scope.

The Vice Principal of the sixth form college at which the nine pupils now studied provided a statement explaining the substantial harm that would be caused to them should they give evidence. Mrs Maguire's sisters shared this view, but other family members did not. The Coroner ruled that the risk of harm outweighed the value of any evidence they might give.

The Court of Appeal agreed. It held that the evidence of the pupils was only within scope "to a limited extent". In fact, the school had no relevant rules or policies in place and accordingly the pupils would be unable to speak to the way in which these were enforced. The only relevant evidence which might be given was the individual child's thinking in connection with the decisions he or she made that morning. That was not within scope. The decision not to call these witnesses was plainly rational. In coming to that decision, the Coroner was entitled to rely on the evidence of risk of harm before him. Although it had not been considered by the Coroner, the underlying harm would not have been avoided by the use of procedural safeguards such as video link evidence and screens.

Identification of perpetrators: *R (Hambleton and others) v Coroner for the Birmingham Inquests (1974) and Others* [2018] EWHC 56 (Admin)

In judicial review proceedings arising out of the resumed inquests into the deaths from the 1974 Birmingham bombings, ten Claimants (family members of the deceased) challenged the ruling of Sir Peter Thornton QC (the former Chief Coroner) that the investigation into the identity of the suspected perpetrators (the so-called "perpetrator issue") would not fall within the scope of the inquest.

The Coroner had previously ruled that the inquests would comply with the procedural requirements of Art.2 of the ECHR and would be held with a jury. In determining that the perpetrator issue was outside scope, the Coroner said:

> "In considering the exercise of my discretion on the question of scope I have therefore taken into account both the distinction between the roles of inquests and criminal proceedings and the statutory prohibitions in section 10(2) and paragraph 8(5) of Schedule 1. I have also looked at the particular circumstances of the instant case."

Section 10(2) of the CJA 2009 provides that a determination in an inquest "may not be framed in such a way as to appear to determine any question of criminal liability of the part of a named person, or civil liability." Paragraph 8(5) of Schedule 1 to the CJA 2009 provides that such a determination "may not be inconsistent with the outcome of the proceedings in respect of the charge by reason of which the investigation was suspended" or "any proceedings that… had to be concluded before the investigation could be resumed."

Among other factors, the Coroner said that although a jury may conclude that the deceased were unlawfully killed it may not say by whom. To permit the issue to be within scope would be seen to be taking on the role of a 'proxy criminal trial', the inquest process did not have the resources of a police force and such an investigation would be disproportionate to answering the four statutory questions.

The Divisional Court held that the Coroner did not pose the correct question in asking whether the factual issue of the identity of the bombers was sufficiently closely connected to the deaths to form part of the circumstances of the deaths. The Coroner's decision on the perpetrator issue was quashed and remitted to him in light of the judgment. Although inquests should not become proxy criminal trials without the protections afforded to the defendants, there may be inquests in which the identity of those involved in violent deaths may properly be within the scope of the inquest. A jury is entitled to explore facts bearing on criminal and civil liability, even if it cannot reach conclusions in such terms. The Coroner was entitled to consider proportionality and practicality, but had attached too much weight to the latter.

The Court further held that the procedural requirements of Art.2 did not require the Coroner to investigate the identity of the perpetrators of the Birmingham bombings. A state's obligation is to enforce the criminal law so far as reasonably possible, and such a duty could be properly discharged by the police despite the failures in their original investigation.

This decision is being appealed.

Jeremy Johnson QC and Robert Cohen act for the Chief Constable of West Midlands in the substantive inquests.

Amy Clarke

A 'cab rank rule' and respect for religious beliefs

R (Adath Yisroel Burial Society and Ita Cymerman) v HM Senior Coroner for Inner North London [2018] EWHC 969 (Admin).

The Claimants sought judicial review of the Coroner's policy of refusing to prioritise burials on the basis of the religion of the deceased. The Coroner's policy was held to have been discriminatory, unlawful and irrational.

The Coroner's policy read as follows, *"No death will be prioritised in any way over any other because of the religion of the deceased or family, either by the Coroner's officers or by the Coroner"*. The Coroner had previously described the policy as applying the cab rank rule, and as being akin to an equality protocol. She had maintained that the policy reflected her best attempts to consider the rights of all those within her jurisdiction. In formulating the policy, she had also considered Arts.8, 9 and 14 of the ECHR and the Equality Act 2010 ('the EA 2010'). In addition, she had relied on the Chief Coroner's guidance issued in May 2014, which provides as follows:

> "It is important to state that all Coroners in England and Wales are obliged to act within the scope of the current law which must be applied equally and consistently for all. The law does not allow the Coroner to give priority to any one person over another. Nevertheless, Coroners are always sensitive to the needs of certain faith groups. They are committed to providing as complete a service to the public (including release of bodies for early burial) as they are able to within the limits of available resources."

The issue of the blanket application of the policy had been a point of contention between the First Claimant and the Coroner for some time. Leaders within the Jewish and Muslim communities had expressed in clear terms how a lack of flexibility within the policy could cause real harm. In particular, it was argued that if the policy were to be applied rigidly families would be forced to break with the principles of their deeply held religious beliefs, which would cause additional anguish at a time of grief and vulnerability.

The Claimants argued that the policy unlawfully fettered the Coroner's discretion, amounted to breaches of Arts.9 and 14 of the ECHR, indirect discrimination contrary to s.19 of the EA 2010 and breach of the public sector equality duty under s.149 of the EA 2010. The Chief Coroner supported the Claimants' arguments, save that he did not accept that the policy amounted to a breach of s.149.

The Court allowed the application for judicial review. The core of the decision was that the policy was over-rigid, resulting in irrationality, discrimination and breaches of the ECHR. In particular, the court held that the policy did amount to an unlawful fettering of the Coroner's discretion as to when and how to exercise her statutory powers, and for how long she ought to retain custody of a body. The policy was held to be over-rigid and would preclude her from taking any account of the individual circumstances of a case. Furthermore, the policy specifically excludes religious beliefs as a consideration. Such a position was incapable of rational justification and was discriminatory.

In respect of Art.9 of the ECHR, the Court held that the fundamental difficulty with the policy was that it did not strike any balance, let alone a fair one, between a number of competing interests within the Coroner's jurisdiction. The Court also held that the policy violated the principle of equal treatment under Art.14 of the ECHR: uniformity is not the same thing as equality. In addition, the court held that the policy was indirectly discriminatory, contrary to s.19 of the EA 2010.

This case highlights an issue that appears at first glance to be specific to this particular Coroner, in this particular area. However, there are some points of more general application that can be drawn, as follows:

- A uniform approach to a particular issue or request may create unfairness and inequality, even where the intention is to provide a level playing field. Coroners must approach decision making in a considered and balanced manner;
- Policies and procedures should not be prescriptive to the point of total inflexibility. Policies ought to reflect, on the face of it, a willingness to be flexible, and;
- The demands of a busy coronial area within the context of limited public resources are unlikely to justify decision making that could result in inequality.

In response to the Court's decision, on 17 May 2018 the Chief Coroner, HHJ Mark Lucraft QC, issued *Guidance No.28: Report of Death to the Coroner: Decision Making and Expedited Decisions*. This new guidance can be found on the Chief Coroner's website.

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