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Contents

ISSUE 07

OCTOBER 2024

03
Welcome from the Editors

04
The Duty of Candour and Inquests
Robert Cohen

06
Achieving Racial Justice at Inquests: Important New Guide
Georgina Wolfe

08
Public Inquiries and their Recommendations: Prospects for Reform
Rob Harland

10
Making Effective Use of Admissions in Inquests: Reflections on *Tainton*
Amy Clarke

13
Considerations for Multiple IP Inquests
Jonathan Landau, Mark Thomas and Cicely Hayward

16
A Brief Review of Recent Developments in the Coroners' World
Alison Hewitt

17
***Parkin:* More Guidance on Article 2 Engagement**
Peter Taheri

20
A Review of Recent Cases
Alex Ustych and Barney Branston

Welcome from the Editors

Alison Hewitt and Amy Clarke

We are so pleased to welcome you to this latest issue of Insight, 5 Essex Chambers' periodic review of matters of interest to those concerned with Inquests and Public Inquiries.

This edition coincides with chambers' Inquests and Public Inquiries conferences which are being held, this Autumn, in Manchester and London. The interest which has been shown in these events reflects the extent of the work currently being undertaken in these fields by independent and in-house practitioners. Increasingly, these are specialist areas of practice, and we do hope that the articles in this publication will add to your own knowledge and expertise.

The contents of this edition are wide-ranging. Robert Cohen has written about the expected introduction of a "duty of candour" for all public servants, whilst Rob Harland has addressed the interesting topic of what becomes of recommendations made by Public Inquiries, and whether reform is needed. We have a piece produced jointly by Jonathan Landau, Mark Thomas, and Cicely Hayward in which they consider issues arising in inquests involving multiple agencies, and give practical tips as to how to manage them. And there is an article by Georgina Wolfe which reviews the recently issued, "*Achieving Racial Justice at Inquests: A Practitioner's Guide*"; this Guide has been produced by the charity Justice, in association with Inquest, with endorsement from a former Chief Coroner, and all those who practise in the coroners' courts should be familiar with its contents. By way of review of recent cases, Peter Taheri has written a piece on the case of *Parkin,* the latest consideration by the High Court of Article 2 engagement in inquests, and Alex Ustych and Barney Branston have provided a concise and very useful update on nine other recent cases of interest. Finally, your editors have also contributed; Amy Clarke has written a reflection on *Tainton* admissions, concluding that they can be useful to those representing state bodies but are under-used, and there is a very brief summary from Alison Hewitt of recent developments in the coroners' world, including recently issued Chief Coroner Guidance.

We hope this edition of Insight will be of use and of interest.

The Duty of Candour and Inquests

Robert Cohen

"My Government will take steps to help rebuild trust and foster respect. Legislation will be brought forward to introduce a duty of candour for public servants…" – The King's Speech 2024.

The Government has committed itself to introduce a 'duty of candour' applicable to all public servants: the so called 'Hillsborough Law'. The creation of such an obligation also finds support in the reports into Mid-Staffordshire NHS Trust, and the Grenfell Tower disaster. It is also likely to be considered in the ongoing Thirlwall Inquiry into the events at the Countess of Chester Hospital.

For lawyers representing public bodies, corporate entities, or healthcare providers, understanding this duty is paramount to ethical compliance and effective legal practice.

What is the Duty of Candour?

The duty of candour, in its broadest sense, refers to an obligation of openness, honesty, and transparency when dealing with the public, regulatory bodies, or the courts.

There is already a duty of candour relating to the NHS. This appeared pursuant to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which placed a statutory duty on NHS bodies and healthcare providers in response to systemic failures. Under Regulation 20, healthcare organisations must disclose to patients or their families when a treatment or service has caused significant harm or death. This includes a requirement to notify the affected individuals, provide an apology, and offer a full account of what went wrong.

It is anticipated that the Hillsborough Law will result in similar obligations applicable more widely.

Existing obligations

Although the Hillsborough Law will create a new obligation, practitioners must not lose sight of the existing requirements. In addition to the NHS Duty of Candour, there are already many related obligations on authorities to present an accurate account of what has happened. These include:
– obligations of disclosure in any civil proceedings arising from an incident,
– a duty of candour in any judicial review of decisions relevant to such an incident, – a duty to give evidence to public inquiries operating within the framework of the Inquiries Act 2005, – a duty on civil servants under the Civil Service Code to handle information as openly as possible (and similar obligations arising from the Ministerial Code), – an obligation to provide relevant information to a coroner and – a statutory duty of candour pursuant to the Victims and Prisoners Act 2024.

Challenges for Legal Practitioners

While the duty of candour promotes transparency and accountability, it can present significant challenges for lawyers representing public bodies. There are several elements to this.

First, compliance with the duty requires a careful understanding of what constitutes "relevant information." In some cases, it may not be immediately clear which documents or reports need to be disclosed. Legal teams must work closely with their clients to ensure that all potentially relevant materials are identified and provided in a timely manner. To avoid failing to comply with the duty an early approach should be agreed with clients to ensure that documents are reviewed and correctly categorised.

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Second, a major incident is likely to result in multiple intertwined legal processes. Ensuring that aspects of those processes are not ignored is paramount. Providing information to, for instance, a regulator, but inadvertently neglecting to provide it to the relevant Coroner is a route to justified criticism.

Third, it is vital that victims and their families are at the centre of this process. There have been several recent occasions in which families have learned of mistakes at the eleventh hour (and indirectly) when internal documents have been shared with a Coroner. This is antithetical to the intent behind the duty. The expectation is that public bodies should liaise with those directly concerned at the earliest possible stage. However, this in turn can raise issues with regulators or the Coroner who may expect that they will be appraised of relevant information as soon as possible. It is vital that lawyers coordinate disclosures with their client to ensure that victims do not learn of mistakes by press reporting.

Fourth, witness preparation is vital. If an organisation has candidly outlined failures to a Coroner, it is likely that witnesses will be asked about those failures. Witnesses must be made aware of the information provided to the court to ensure that they are not unfairly surprised by questions that they had not anticipated.

Addressing all of these issues is likely to be significantly aided by ensuring that different facets of incident response are overseen by the same core group. Ensuring that litigation, inquests, communication with the victims, and regulatory response are within one individual or group's purview will ensure consistent and responsible communication.

Conclusion

For legal professionals, understanding and adhering to the duty of candour in inquests is vital. It requires a proactive and transparent approach to disclosure, an openness to admitting fault, and a commitment to maintaining the integrity of the judicial process. While challenging, compliance with the duty of candour ultimately serves to enhance public confidence in the legal system and the institutions involved. However, it also provides opportunities for criticism which must be carefully managed.

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Achieving Racial Justice at Inquests: Important New Guide

Georgina Wolfe

In February 2024, the charity Justice, in association with Inquest, published 'Achieving Racial Justice at Inquests: a Practitioner's Guide'.

This ambitious guide is the first of its kind and was produced in consultation with an advisory group featuring a range of experts, including academics, representatives of the bereaved, solicitors and barristers (including 5 Essex Chambers' Anne Studd KC and Alison Hewitt) from a wide range of backgrounds. This work was borne of concern from families and practitioners that, in some inquests, race and racism had played a part in the death but was not always on the coroner's agenda. This guide seeks to raise awareness of such issues and encourage a sensitivity as to what might underlie a situation so that coroners can ensure they are explored. Where race and racism have played a role in a death, such an approach is vital.

The guide is divided into five parts:

Part 1: Racism and Deaths in Custody explains how race and racism shape the experiences of Black and racialised people (the terms used throughout the report) within the immigration system, policing, the prison and mental health systems. It explains the role of racial stereotyping in deaths in custody.

Part 2: Approaching a Case as a Practitioner covers recognising institutional and structural racism, biases and limitations and then turns to listening to bereaved families and encourages strategic approaches to addressing issues of race and racism. This part includes a checklist to help practitioners recognise and address their own biases and offers guidance on working sensitively with families.

Part 3: Raising Issues of Race and Racism offers advice on when to raise race or racism alongside an overview of Article 2 of the European Convention on Human Rights. It encourages practitioners to raise these matters early. There is advice on how to investigate these issues and details about preliminary investigations, such as those conducted by the IOPC.

Part 4: Evidencing Issues of Race and Racism turns to how to identify '*surrounding facts*' and evidence that race and racism played a part in the death, for example, through reports, statistical evidence and experts. This part contains a list of factors to consider in seeking to demonstrate that the race of the deceased played a role in their death.

Part 5: Guidance for Coroners advises coroners themselves on ensuring racial sensitivity at inquests, explaining why these matters should be investigated and how to investigate them during an inquest. There is advice on managing juries and drafting effective Prevention of Future Death ('PFD') reports.

Finally, there are four checklists appended to the guide, including a coroner's checklist for determining whether to investigate issues of race and racism and a list of possible disclosure requests relevant to the statistical context.

Wider Application

Although the guide focusses on deaths in state custody, its application – as the title perhaps suggests – is in fact wider. Much of its advice could apply in other spheres such as health and social care

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Achieving Racial Justice at Inquests: Important New Guide

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and non-custody police-connected inquests. The guide itself recognises as much, emphasising that '*there are state-related deaths outside this context that also raise significant issues of racism*' and giving the example of persistent disparities of maternal mortality rates for Black and racialised women. This is a guide that is relevant to all inquest practitioners and which is likely to be cited in inquests where an arguable issue of race or racism arises.

Representing Public Authorities

While this guidance is targeted at those representing the bereaved, it should not be overlooked by practitioners appearing for public authorities. On the contrary. If any concerns raised have a basis, it will be essential to work with the coroner to explore them. And, if there are problems stemming from questions of race, it is in everyone's interests to identify them early on and seek to rectify them.

When presented with an inquest that gives rise to these issues or faced with arguments that race or racism were factors in a death, representatives (and their clients) will need to think carefully about how to respond. Those faced with a defensive client will be able to use this guide, stamped with the authority of the former Chief Coroner, to encourage an open approach. In some cases, there may be legal arguments that could be deployed to deter such issues being explored but representatives for public authorities should think carefully before deploying them. Proper inquiries should never be blocked and public authorities should be proactive in seeking to identify – and remedy – their own shortcomings. Perhaps one of the lessons of the Horizon Inquiry is that even where there is no express duty of candour, public bodies should embrace fearless self-analysis and disclosure. It may be better to undertake early, forward-leading enquiries to identify and address any issues at the outset. It will always look much worse if, later, an enquiry is made which vindicates a family's concerns and demonstrates systemic problems.

Anyone representing public authorities will want to work out a sensible way to investigate valid concerns carefully while not entertaining flights of fancy. Public clients should seek to be on the front foot and identify if these issues could arise before the first Pre-Inquest Review. If necessary, offer a witness statement from a senior and suitably-qualified witness to explain and close down any concerns or to make admissions and set out changes that have been made. It will always be wiser to reassure a coroner that a suspicion is ill-founded, if that is the case. Importantly, pre-emptive steps may comfort bereaved families.

What Next?

There have been growing calls from families and their representatives for inquests to be a way of recording that something has taken place which was affected by race, even if not causative or contributory to the death. At the moment, it remains unlawful for coroners to make such wide findings. Is there a change on the horizon? In recent years we have seen major developments in coronial law – this is an area of practice where the sands are always shifting. If a coroner conducts an investigation into issues of race and racism and uncovers something important but outwith the jurisdiction for their Record of Inquest or a PFD report, it is arguably in society's interests that it be recorded and lessons learned. We can expect some creative new legal arguments to follow.

Conclusion

As the opening words by the former Chief Coroner His Honour Judge Mark Lucraft KC say, this guide equips practitioners and coroners with the tools '*to recognise, raise and investigate issues of race or racism when they arise, sensitively and without reticence*'. It is, he says, '*an invaluable resource, not only for promoting racial justice, but for improving fact finding, increasing racial awareness, and providing better representation to families*'. In fact, one hopes, it might also assist public bodies and those who represent them too.

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Public Inquiries and their Recommendations: Prospects for Reform

Rob Harland

On 16 September 2024 the House of Lords Statutory Inquiries Committee published an important report on the future of public inquiries: *"Public inquiries: Enhancing public trust"*.

In its opening paragraphs, the Committee recognised what any reader of any newspaper will know to be true: that public inquiries are the subject of criticism on the basis of their length and cost, and a perceived failure in delivering what they are expected to achieve. "*By combining elements of law and politics, public inquiries can appear to 'freeze' both*", the Committee remarked. A particular question that the Committee posed itself was how to ensure that an inquiry's recommendations are implemented. The Committee noted why this was important: "*had the recommendations from the inquiry into deaths at the Bristol Royal Infirmary in 2001 been implemented, then the patient deaths investigated by the Mid-Staffordshire Hospitals Inquiry in 2013 may have been less likely to occur. And we heard that if the changes recommended by the 2013 inquest into the Lakanal House fire had been made, then the Grenfell Tower fire might have been prevented*".

We have been here before. The House of Lords previously considered the Inquiries Act in March 2014, in its report "*The Inquiries Act 2005: post-legislative scrutiny*". In that report, the Committee also noted that there had been a failure to make sure that recommendations were implemented. And although they were writing a decade earlier, they gave the same example: "*The Bristol Royal Infirmary report preceded the failings at Mid Staffordshire NHS Trust… if the Bristol Royal Infirmary Inquiry recommendations had been implemented, Mid Staffs would never have happened*". They duly made recommendations so as to improve the situation (19 of which had been accepted by government). But the 2024 House of Lords report notes that of the 33 recommendations the Committee had made in 2014, only one could be identified as having been implemented in the following decade – and that one (the creation of a central Inquiries Unit, so as to ensure that experience gleaned from one inquiry is not lost when another is formed) was so little understood that one of the Committee's own expert witnesses was not aware of the new Unit. It may not only be inquiries which are poor at having their recommendations implemented.

In *Public inquiries: Enhancing public trust*, the Committee considered different methods for scrutinising the government's compliance with Inquiry recommendations. The first is oversight of compliance by the inquiry chair herself. But this runs into various difficulties. If the chair is a serving judge, then their judicial independence for other matters may be compromised if they take on a continuing role which involves scrutinising acts of the executive. For this reason, Sir Brian Leveson, when questioned by a Parliamentary Select Committee about whether, when and how his recommendations should be implemented, refused to answer (and in this, he had the support of the previous Lord Chief Justice, Lord Judge). Other chairs (for example, retired judges) have sought to follow up on their recommendations informally. But once they have reported and are *functus*, they and their secretariat move on to other jobs and they have no formal power to hold institutions to account. It is perhaps for this reason (as well as trying to ensure that the public see that they are acting swiftly in response to urgent safety issues) that chairs will now, increasingly, issue interim reports, so that progress in relation to any recommendations made can be monitored whilst the inquiry is still live. As an example, the Covid

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Inquiry is to monitor progress against the recommendations it has made in Module 1: the Chair has requested that the responsible institutions publish (within six months of the report) the steps they will take in response to the relevant recommendation and the timetable for doing so. If they do not do so, the Inquiry will write to the institution in question after 3, 6, 9 and 12 months (after 9 months it will register its 'disappointment' and after 12 months ask the institution to set out its reasons for not having responded). None of this has strong teeth, absent the institutions themselves wishing to comply (or media pressure compelling them to do so). Professor Alexis Jay expressed her disappointment and concern that she was not able to set up any group with the Home Office monitoring her recommendations in IICSA. Sir John Saunders has sought to establish public implementation monitoring following the Manchester Arena inquiry.

The House of Lords Committee also rejected the use of independent implementation monitors, as are employed in Australia to inspect (sometimes physically) compliance with recommendations. Instead, they preferred the model of a new, joint, select committee of Parliament: the Public Inquiries Committee (and, failing that, the use of a sessional committee of the House of Lords) to monitor implementation of recommendations. This body would publish all recommendations and reports in one place, undertake its own research and correspondence to establish what recommendations have been implemented, and publish the results. It is perhaps ironic that, more than a century after the failures of the select committee system (because they can act to protect the interests of the party in power) led to the Marconi scandal, and resulted in the Tribunals of Inquiry (Evidence) Act 1921, and the creation of Public Inquiries, we may now be enlisting the help of parliamentary committees in the system once again.

Will such a body assist? It is in everyone's interest that well-founded recommendations from Inquiries be implemented swiftly. The difficulty however comes when trying to establish what amount to well-founded recommendations. Sometimes the recommendations may turn out not to be as good as first envisaged. An inquiry may be expert on its own subject matter, but hear relatively little evidence on reforms for the future, particularly if the inquiry places significant weight on a single expert witness and does not actively seek contrary views. As the House of Lords considered, when rejecting the proposal that inquiry chairs be given a formal role monitoring the implementation of their recommendations, the chair of an inquiry may not be best placed to take decisions which are the preserve of the executive – such as weighing up the potential cost of any reform as well as its benefits. Nor is it always sufficient to expect the government of the day to be able to say immediately which recommendations are good or bad: they may be under significant political pressure, when the inquiry report is published, to commit to implementing the recommendations in full.

One example of this may be the Grenfell Inquiry's Phase 1 Report, in response to which Boris Johnson MP, then Prime Minister, stated broadly in Parliament that they would "*accept in principle all the recommendations that Sir Martin makes for central Government*." In *Rennie v Secretary of State for the Home Department* [2023] EWHC 1794 (Admin) this commitment was said (along with a commitment made in sealing a consent order in another judicial review) to have founded a legitimate expectation that the Home Office would implement a scheme for Personal Emergency Evacuation Plans, notwithstanding the fact that (on the government's case) their own investigations and consultations had shown that the recommendation would be too impractical and costly, and with too little benefit, to implement in practice. On the facts, the government succeeded in *Rennie* – their consultation was lawful and had discharged the legitimate expectation on them and there could not be said to be any breach of Article 2 ECHR – but it illustrates how a government can run itself into difficulties.

The introduction of a monitoring body may well assist in keeping pressure on, and will be welcomed, but perhaps the best way to increase the chance that government will implement inquiry recommendations is to ensure that it is wholly engaged in the inquiry process and has full opportunity to set out any objections to the inquiry's proposals *before* the recommendations are made. In those circumstances they will be better placed to agree to implement recommendations, and more incentivised to do so.

Rob Harland acted in *Rennie v SSHD* on behalf of the Defendant and is currently representing the Cabinet Office (including Number 10) in the Covid Inquiry.

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Making Effective Use of Admissions in Inquests: Reflections on *Tainton*

Amy Clarke

Inquest practitioners will be very familiar with R *(Tainton)* v *HM Senior Coroner for Preston and West Lancashire* [2016] 4 WLR 157 and the two key matters addressed by the Court and Sir Brian Leveson in his judgment.

The first, namely the test for finding a causative link between "an event or conduct" and the death, is settled and universally applied. However, the Court's judgment on the second matter, which was the recording of admitted failings, has not resulted in a clear and settled approach. After nearly a decade, there is little consistency in practice in terms of what constitutes a *Tainton* admission, nor when and how *Tainton* admissions can be made and recorded. Further, subsequent authorities have failed to provide consistent or conclusive guidance. Nevertheless, *Tainton* admissions are a useful tool when representing a state body, and they remain underused.

Tainton **and Subsequent Authorities**

The case of *Tainton* itself concerned the death of a prisoner from natural causes. The inquest was subject to the procedural duty under Article 2 (a "*Middleton*" inquest). There had been a delay in the Deceased's diagnosis of cancer and issues arose as to whether that, and other clinical failings, had more than minimally contributed to his death. Both prior to and during the inquest the relevant NHS Trust admitted, formally and in writing, substandard medical care. Further, those individuals who were responsible for the errors and who gave evidence, made similar admissions in the course of their evidence. However, the Coroner judged (correctly) that the evidence was insufficient to establish a causative link between the admitted failings and the death and so he did not invite the jury to record those clinical failings on the Record of Inquest. The Court found that the Coroner had made an error of law. Sir Brian Leveson stated [at para. 74],

"Putting the point 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 5(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 them causative of the death."

The requirement for admissions to appear on the Record of Inquest has since evolved, and was challenged in *R (Carole Smith) v HM Assistant Coroner for North West Wales* [2020] EWHC 781 (Admin). In *Smith*, a Coroner sitting without a jury decided not to record admitted, non-causative failings on the Record of Inquest in an Article 2 inquest, even though such failings had been recognised and considered in the course of the Coroner's "judgment" in which he gave his reasons for the conclusion which was recorded. This decision was challenged by the Family of the Deceased and the High Court, consisting of Dingemans LJ, Griffiths J and the then Chief Coroner, fully endorsed the Coroner's approach. The Court did not reference the judgment in *Tainton*; whilst *Tainton* was cited in relation to causation, the Court did not address it at all on the issue of whether admitted failings ought to feature on the Record of Inquest in an Article 2 inquest. Instead, the Court held that it was sufficient for the Coroner to have recognised the admitted failings in the course of his "judgment" when he set out his findings of fact and reasoning for his conclusion.

Whilst it is not explicitly set out in *Smith*, the judgment allows for a distinction to be drawn between

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Making Effective Use of Admissions in Inquests: Reflections on *Tainton*

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inquests heard by a Coroner alone and those heard with a jury. In the former, Article 2 can be satisfied by reference to admitted failings in the course of a publicly-delivered judgment in which the findings are set out, as such judgment forms part of the public record; there is no need for the admissions to appear on the Record of Inquest also. In a case heard with a jury, however, the jury is not able to provide any additional rationale or commentary about their findings, and so admitted failings must be recorded on the Record of Inquest, even if non-causative, otherwise they would not be recorded anywhere and Article 2 would not be satisfied.

In *R (Ginn) v HM Senior Coroner for Inner London* [2022] EWHC 28 (Admin), which concerned another Article 2 inquest into a prison death, the Coroner declined to invite the jury to record admitted failings in relation to the prison's resuscitation efforts and this was challenged by the Family. However, the Coroner had addressed the issue of resuscitation failings in a Prevention of Future Deaths Report and, taking a similar approach to that in *Smith*, the High Court considered that such Report was part of the outcome of the inquest and was sufficient to satisfy the Article 2 procedural requirement.

What is a *Tainton* admission?

The judgment in *Tainton* does not provide a definition of what does and does not constitute an "admitted failing" such as to trigger the requirement for it to be recorded. Drawing together *Tainton* and *Ginn*, it seems that a true *Tainton* admission is one made by an agency or organisation at very senior or "corporate" level, made following proper consideration of all the relevant evidence and facts, and made knowingly for the purposes of the inquest. An admission made, formally, in these circumstances can be treated as an acknowledgement of a failing on behalf of the State. Further, a *Tainton* admission can only be made if the organisation in question does so voluntarily. Neither the Coroner, nor any other IP, can force or direct a formal admission to be made on behalf of an organisation, nor the terms on which it is made.

In contrast, admissions or concessions made by individual witnesses prior to or in the course of their evidence should not be treated as *Tainton* admissions. It is often argued on behalf of Families that concessions made by individuals in the course of their evidence, or in earlier interviews, ought to be treated as a *Tainton* admissions, and consequently recorded on the Record of Inquest. That it not correct and practitioners need to be alert to that approach.

Why and When Should an IP Consider Making a *Tainton* Admission ?

Why? There are a number of reasons why an organisation or state agency may consider it sensible and advantageous to make an admission of facts and failings. These will vary from case to case, and be case specific, but may include:

a) if accepting failures in clear terms is the right thing to do as a public authority, particularly in respect of conduct towards a bereaved Family;

b) if the admitted failings are clearly going to be established and admitting them can assist the Coroner in narrowing the contentious issues and the evidence which needs to be obtained and adduced to address those issues,

c) if they can assist the Coroner in narrowing the causative issues that must be left to a jury,

d) if the admissions will ensure that the failings are accurately described and recorded, and

e) because, in addition to the above, making the admissions may assist in shortening the length of the inquest, in reducing the number of witnesses from the organisation (who may themselves be vulnerable) who will need to give oral evidence, and in stemming or reducing the reputational harm to the organisation flowing from the failings themselves.

When? *Tainton* admissions can be made at any stage of the inquest process, and the decision is entirely in the hands of the organisation considering it, but the challenge is identifying the point at which it has become both appropriate and most effective to do so. The right time to make a formal admission will depend entirely on the facts of a case, the procedural history before the inquest, and the state of evidence. In a case where other proceedings have preceded the inquest, and there is clarity as to relevant failings in the light of the evidence, such as in a prosecution or in the course of regulatory proceedings, then *Tainton*

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Amy Clarke

admissions can be considered well in advance of the inquest; if they are made at the pre-inquest stage, they can help to narrow the scope of the inquest and/or the extent of the evidence which the Coroner needs to obtain. In other cases, it may become apparent during the preparation of the inquest that witnesses are going to accept deficiencies or flaws in their own conduct and that there are related failings at an organisational level which ought to be acknowledged before those witnesses give evidence. In still further cases, particularly those where the cause or causes of the death are yet to be established, or are the subject of expert evidence which will be explored at the inquest, it may not be possible to consider the position on admissions sensibly until all the evidence has been heard and once causation has properly crystallised.

How Should a *Tainton* Admission be Drafted and Adduced into Evidence ?

There is no standard formulation of a *Tainton* admission, but the foundation of it should be that it is precise, clear and carefully thought out. When drafting, it may well be necessary to place any admission in the context of the organisation's underlying duties and powers, to set out what (of relevance) was and was not done, and to be clear as to the extent and limits of the admitted failing. Written *Tainton* admissions are likely to require careful drafting and should not be produced "on the hoof".

If the admissions are broken down into different component parts, make sure that they are consistent with each other, and that they do not have an unintended impact on another aspect of the evidence. This is particularly important where there is likely to be a civil claim following the inquest.

If made in advance of the evidence, it is also vital that your witnesses are aware of the nature of any admission being made by the organisation, especially if it relates to their conduct. It is less than ideal if an organisation makes a corporate admission, only for its witness of fact to undermine it, and potentially themselves, when they give evidence. Good inquest preparation will involve conferences with witnesses, during which any admission relevant to a witness' conduct can be explained and discussed with them, to ensure that they have the opportunity to explain why they disagree with the admission, or factual premise underlying it, if they wish to do so.

It is also important to consider how the admission is to be adduced, a question which is ultimately for the Coroner but on which they will doubtless appreciate your input. At the least, a witness statement from an appropriate officer of the organisation may be needed to introduce the admission, and this may be read. The more extensive and wide-ranging the admissions, the more likely it will be that the Coroner will want a senior individual from the organisation to speak to the admission by giving oral evidence; if that is the case, that too will require careful preparation, to ensure that the witness is sufficiently senior and sufficiently well-informed in relation to the basis for the admissions. A close eye must be kept on any attempts by other IPs to go beyond the admissions when questioning that witness. It is also important to ensure that other witnesses from the organisation, who will be called as witnesses of primary facts, understand their status within the inquest, and are not encouraged or permitted to take on the role of the "corporate witness" by explaining or commenting on the formal *Tainton* admissions.

How does a *Tainton* Admission Feature on a Record of Inquest?

Admitted failures of the part of the State should be recorded in Box 3 of the Record of Inquest. As indicated above, in an Article 2 inquest a jury may record them even if the failing was not causative of the death. If that is the case, this too should be made clear on the face of the Record of Inquest.

Conclusion

Although the years since *Tainton* have not brought consistency as to the way in which *Tainton* admissions are approached and used, the circumstances in which they may be appropriate and helpful are wide-ranging. They can be an effective way to narrow the issues and the evidence in an inquest, and they can help in other ways when drafted with care, and deployed at the right time. In summary, they should not be forgotten as, potentially, a useful tool when representing a state agency or similar organisation.

> *"There is no standard formulation of a* Tainton *admission, but the foundation of it should be that it is precise, clear and carefully thought out. When drafting, it may well be necessary to place any admission in the context of the organisation's underlying duties and powers, to set out what (of relevance) was and was not done, and to be clear as to the extent and limits of the admitted failing. Written* Tainton *admissions are likely to require careful drafting and should not be produced "on the hoof"."*

Considerations for Multiple IP Inquests

Jonathan Landau,
Mark Thomas and
Cicely Hayward

Those practising in the field of inquests will know that, in addition to families, it is commonplace for multiple organisational Interested Persons ("IPs") to be involved in complex inquests. At 5 Essex Chambers' forthcoming Inquests and Public Inquiries conferences being held this autumn in Manchester and London, we will be considering a number of the issues that can arise in multi-agency inquests.

1. Are you in the right court?

It may seem obvious that there is to be an inquest, but in some cases the circumstances of the death or deaths will be investigated by way of a public inquiry. This is most likely to arise where the scale of public concern or breadth of issues requires it (for example the current Thirlwall Inquiry into the Lucy Letby cases) or where there has been a successful public interest immunity application in the inquest proceedings (for example Litvinyenko and Manchester Arena Inquiries). If this is a possibility, it is important to consider early and plan accordingly. Public inquiries will usually require more extensive disclosure and witness evidence. They will go on for longer, are usually live-streamed and are likely to attract more media attention. A decision to convene or not to convene a public inquiry can be influenced by the conduct of the inquest(s); if IPs (and particularly families) have confidence that the inquest process will deliver a transparent, independent and rigorous investigation there is less likely to be a need for a public inquiry.

2. Help the Coroner

Many Coroner areas have still not recovered from the demands and backlogs of Covid. Even those that have recovered still face the challenge of stretched resources. Salaried coroners are often very busy and fee-paid coroners usually have other employment. Multiple-IP cases often involve very large volumes of material, witnesses and issues. Help the Coroner by providing relevant disclosure and identifying key issues. The Government's announcement in the 2024 King's Speech regarding a duty of candour may mean that soon there will be an express duty to do so. It will also be sensible in many cases to provide separate bundles to the Coroner containing material that is likely to be relevant, and material that is being provided out of an abundance of caution. Offer to provide redacted versions if the Coroner is considering disclosure. Identify witnesses that are likely to be key even if they have been (initially) missed by the Coroner or family.

3. Understand the inquest from other IPs' perspectives.

Considering from an early stage what the risks and objectives are to other IPs, as well as your own client, will help to identify areas of common interest and potential conflicts that can then be managed. Some IPs will have limited resources or experience of inquests. Some may be concerned about the risk of prosecution or claims.

Consider what evidence and expertise other IPs may have in relation to issues. Read their internal reports as soon as they are available and consider the impact their conclusions may have for your client. Hold early meetings with witnesses who will often have a good

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Considerations for Multiple IP Inquests

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understanding of other organisations through multi-agency work such as MAPPA or other frameworks of joint working.

Identify what information was shared between agencies, when, how it was acted upon and whether better information sharing would have resulted in different decisions. Consider whether any improvements are required for PFD issues (discussed further below).

4. Expert witnesses

In multi-agency cases there may be a number of investigation reports available before the inquest prepared either independently or by the organisations involved. Sometimes these reports are prepared by individuals who are sufficiently expert and independent that further expert evidence is not required for the inquest proceedings, but not always. Consider your client's position on expert evidence early, and communicate it to other IPs. Where it is likely that a Coroner will instruct experts, see if agreement can be reached between the IPs as to the identification of appropriate witnesses. Coroners usually find this helpful. It is, perhaps, inevitable that IPs – both institutional and family – will wish to secure evidence from experts that they perceive may be most favourable to their position. Facing up to that reality and attempting to seek common ground is particularly important and requires careful thought in advance of instructing experts, and sometimes a proportionate process to allow IPs to comment on the expert's instructions will be sensible.

5. Article 2 issues

It is generally accepted – following the case of *R (Sreedharan) v HM Coroner for Greater Manchester* [2013] EWCV Civ 181 at §23 – that once Article 2 is engaged in an inquest, it is engaged for all IPs. However, the case of *R (on the application of Gorani) v Her Majesty's Assistant Coroner for Inner West London* [2022] EWHC 1680 (Admin) provides some support for a submission that there may be cases, where, in the Coroner's discretion, different levels of scrutiny are applied to different issues in the inquest:

> "Inherent in [the Claimant's] submissions is the argument that once the coroner had declared that the inquest was to be "an Article 2 inquest", all aspects of the Article 2 jurisdiction were in play. I would reject that suggestion…
>
> … the fact that a coroner declares that an inquest will serve to meet the state's obligation to investigate the death, and that s5(2) of the 2009 Act applies, does not trigger an obligation on the coroner to investigate every aspect of the case to the standards of Article 2. The obligation imposed by s5(2) requires an investigation "where necessary" to ensure compliance with the Convention. A coroner's ruling as to the particular issues in respect of which Article 2 requires investigation delimits the scope of the Article 2 inquiry."

It is well established that a decision that the Article 2 procedural obligation is engaged does not impact the scope of the investigation carried out by a Coroner or the breadth of inquiry at the inquest itself (see e.g. *R (Morahan) v West London Assistant Coroner* [2022] EWCA Civ 410 at §8), so issues that are identified as being in the proper scope of the inquest will be investigated and the extent of the investigation will not be affected by a decision that the Article 2 procedural obligation is engaged by the action or inaction of one or more of the IPs. However, *Gorani* confirms that Coroners retain a broad discretion as to what is in the proper scope of the inquest, and they are not required to investigate every aspect of the case.

Whilst in practice, adherence to this by Coroners varies, it is an important consideration when making submissions on Article 2 cases, particularly when the key issues in the case relate to other IPs.

6. Take a Global View on Causation

As set out above, inquests often consider the interaction between various IPs, particularly regarding sharing information. This is particularly important in relation to causation. Whilst at first blush a client's position may be that it did all it could within its powers or with the information it had, that may become untenable if it did not share information that others could have acted on, or that there were deficiencies in the process of obtaining information from other IPs. Again, this may be relevant to PFD issues.

7. Dangers of cut-throat approaches

A cut-throat approach should have no role in inquisitorial proceedings. However, it is important that inquests elicit the key evidence relevant to the issues identified as being in scope. Sometimes there will be conflicts of evidence between IPs' witnesses that need to be resolved, and sometimes there will be genuine concerns by one IP about the performance or conduct of another IP's witnesses, that impacted on their own ability to take appropriate action. This has to be handled

> *"A cut-throat approach should have no role in inquisitorial proceedings. … As ever, preparation is the key. Start by identifying the client's goals and approach the inquest from that perspective. Usually that will be by putting the client's best foot forward as well as identifying remedial action rather than attacking other IPs. Where there is no option but to raise an issue with another IP, consider giving notice to their representative …."*

Considerations for Multiple IP Inquests

Jonathan Landau, Mark Thomas and Cicely Hayward

carefully. If the evidence is not fully aired clients may feel their decisions and actions have not been fairly explored in their proper context, and if there are future civil proceedings it can be useful to turn to the transcripts of the evidence given in the coronial proceedings to weigh and apportion liability risk. Equally, in many multi-agency cases, particularly those involving public bodies, IPs will need to continue to work collaboratively long after the inquest has concluded, and indeed may wish to consider how they can improve their joint working, so it is important not to sow unnecessary discord. And of course finger pointing and slopey shoulders will do nothing to alleviate a Coroner's concerns about multi-agency failings.

As ever, preparation is the key. Start by identifying the client's goals and approach the inquest from that perspective. Usually that will be by putting the client's best foot forward as well as identifying remedial action rather than attacking other IPs. Where there is no option but to raise an issue with another IP, consider giving notice to their representative and always remember the proceedings are inquisitorial and respect and courtesy will go a long way.

8. Duty to the Court

Both SRA and BSB ethical frameworks stress the duty of lawyers to the court. As mentioned above, there may shortly be a statutory duty of candour in inquests. The Government has also signed up to the Hillsborough Charter committing to placing the public interest over reputation, avoiding defending the indefensible and ensuring that public can hold it to account. The Competences for Lawyers Practising in the Coroners' Courts also includes the following:

> "Are you aware of any issues that should be raised with the court, or with other interested persons if legally represented, in advance of the inquest? Dealing with any issues relating to your client(s) or witnesses early on may help to ensure that the process runs smoothly."

Sometimes Coroners may miss issues that relate to IPs. Consider how to approach this. In the first instance, it may be best to raise this with the IP's representative. If they decline to raise the issue with the Coroner, it may be necessary to explain that you have a duty to do so.

9. Co-operation on PFD matters.

It is trite but important to recognise that PFDs are intended to prevent future deaths. All IPs would wish to further that objective as soon and effectively as possible. Where deaths involve multiple agencies, effectiveness may require dialogue to ensure that remedial action is system-wide and workable between agencies. Consider asking families and the Coroner at an early stage what concerns they have. Certainly, consider the early submissions of families' representatives which will usually raise key issues. Identify a witness or witnesses of suitable seniority to provide PFD evidence and, if appropriate, ask them to consider speaking to counterparts in other organisations about issues which there is joint responsibility for (which, for PFD evidence, as long as the fact of any such discussions is transparent, will usually be fine) .

10. Civil claims

The conclusions of an inquest are not admissible in civil proceedings and IPs should not try to conduct inquests as mini trials. However, the prospect of subsequent civil proceedings should not be ignored. An inquest will usually give prospective parties in related civil litigation a reasonable understanding of the strength of the evidence on the key liability issues and it will mean there is a transcript of evidence that can (by agreement or court order) be utilised at trial (sometimes in place of further written or oral evidence). This can be really valuable in complex multi-agency cases because the financial and sometimes emotional burden on witnesses of giving the same evidence twice is huge.

Where there are multiple IPs who may in due course be co-defendants a common issue is how to settle a claim where the defendants have different litigation strategies, apportionment assessments or quantum assessments. Sometimes one IP will have made a formal admission prior to the inquest proceedings and therefore argue they should not be liable for the inquest costs (some of which are usually recoverable in subsequent civil proceedings on the basis that the inquest made a trial unnecessary – see e.g. *Lynch v Chief Constable of Warwickshire Police [2014] 11 WLUK 442*). As always, the first step is communication. See what common ground can be reached. If more time would help, ask for it. If clear sight of the damages and costs exposure would make a difference, ask the Claimants to provide provisional schedules (on a without prejudice basis if that is their preference). If common ground with co-defendants is impossible, clients should see if they can reach their own terms with the deceased's family with appropriate apportionment of both damages and costs. Finally, don't forget that how an IP has conducted an inquest can have a big impact on the civil proceedings – both the "tone" and the financial bottom line.

"Finally, don't forget that how an IP has conducted an inquest can have a big impact on the civil proceedings – both the "tone" and the financial bottom line."

A Brief Review of Recent Developments in the Coroners' World

Alison Hewitt

Earlier this year, on the 25th May, there was a change of judicial leadership in the coroners' world in that HH Judge Thomas Teague KC retired as Chief Coroner of England and Wales and was replaced by HH Judge Alexia Durran. Judge Durran, whose judicial home is at the Old Bailey, was formerly one of the two Deputy Chief Coroners and so enters the role with experience of coronial law and practice. The appointment is, initially at least, for a three-year term.

The final Guidance issued to coroners by Judge Teague before his retirement came out in March 2024, in the form of "*Guidance No.46: Obtaining Information Regarding Social Media Use*" which addresses a coroner's options when it comes to obtaining evidence relating to the use of social media, should such information fall within the scope of an investigation. The use of Notices under Schedule 5 to the Coroners and Justice Act 2009, whether issued directly to social media providers, or to the Office of Communications ("Ofcom"), is addressed. Further, there is guidance as to Ofcom's powers under s. 101 of the Online Safety Act 2023, which is of relevance when a coroner is investigating the death of a child, and Ofcom's powers under s. 163 of the 2023 Act, which is of relevance to any death investigation.

Since her recent appointment in May, the new Chief Coroner has also been busy in relation to Chief Coroner Guidance. In June 2024, there was an updated version of "*Guidance No. 45: Stillbirth, and Live Birth following Termination of Pregnancy*", followed in September 2024 by the lengthy "*Guidance No. 47: The Death Certification Reforms*". The latter addresses the extensive changes – of significance to coroners but probably of minimal interest to most practitioners – which came into force on the 9th September 2024. The simply-stated principle underlying the reformed system is that where a death is natural and did not occur in detention, scrutiny should be provided by the medical examiner and not the coroner, and there should be a clear delineation between "*medical*" and "*judicial*" certification of death. The changes are brought about by the *Medical Certificate of Cause of Death Regulations 2024* and, whilst they change the terminology and forms used by coroners in relation to death certification, they do not alter what deaths must be reported to a coroner, as set out in the *Notification of Deaths Regulations 2019.*

Further, Judge Durran has already been working for some time, with others, on an updated "*Bench Book*" for Coroners. This is expected to be a significant additional resource and one with which practitioners will want to become familiar following its release (the date for which is still to be announced).

Finally, it is worth noting that an "*Independent Review of Forensic Pathology*" was published last month by the Government. The work was commissioned in 2022 by the then Home Secretary following recommendations in Bishop James Jones' 2017 report *'The patronising disposition of unaccountable power: A report to ensure the pain and suffering of the Hillsborough families is not repeated'*. The Review, which was written by Glenn Taylor who, sadly, died shortly after its completion, notes significant improvements in forensic pathology services, and the "*quality and depth*" of post mortem reports, in the intervening period since Hillsborough, but sets out six key recommendations for further reforms, including a renewed call for a National Autopsy Service. It notes the dwindling availability of forensic pathologists, a matter which should be of real concern not only to coroners, but also to all those involved in death investigation and the wider justice system.

"The use of Notices under Schedule 5 to the Coroners and Justice Act 2009, whether issued directly to social media providers, or to the Office of Communications ("Ofcom"), is addressed. Further, there is guidance as to Ofcom's powers under s. 101 of the Online Safety Act 2023, which is of relevance when a coroner is investigating the death of a child, and Ofcom's powers under s. 163 of the 2023 Act, which is of relevance to any death investigation."

Parkin: More Guidance on Article 2 Engagement

Peter Taheri

The judgment of Mrs Justice Collins Rice in R *(Parkin) v HM Assistant Coroner for Inner London (East)* [2024] EWHC 744 (Admin) is worthy of review by practitioners representing institutional IPs in Inquests. It provides a further instructive example – readily comparable to circumstances that we find arise frequently in practice – of why it cannot be assumed that an inquest involving the death of a vulnerable individual will engage article 2.

Parkin does not change the threshold for engagement, but it serves as an important reminder that you must first analyse whether there was a relevant duty at all, before considering whether there is evidence of an arguable breach of duty. The High Court reiterated that the key to assessing whether there is an operational article 2 duty will be the application of the *Rabone* indicia [*Rabone v Pennine Care NHS Trust* [2012] 2 AC 72].

Rabone summarised

Parkin provides a helpful summary of Lord Dyson JSC's three *indicia* in *Rabone*:

Firstly, *"'… an assumption of responsibility by the state for the individual's welfare and safety (including by the exercise of control)'. The exercise of control is the paradigm example of the operational duty arising. Where a state body has assumed complete control, for example by detaining, imprisoning or conscripting an individual, it is 'subject to positive obligations to protect the lives of those in their care'".* (paragraph 23)

Secondly, *"'the vulnerability of the victim is a relevant consideration': In circumstances of sufficient vulnerability, the ECtHR has been prepared to find a breach of the operational duty even where there has been no assumption of control by the state"* (paragraph 24).

Thirdly, *"the nature of the risk to life is relevant: … Is it an 'ordinary' risk of the kind that individuals in the relevant category should reasonably be expected to take or is it an exceptional risk? Thus in* <u>*Stoyanovi v Bulgaria*</u> *(Application No.42980/04 (unreported) given 9 November 2010), the ECtHR rejected an application made by the family of a soldier who died during a parachute exercise."* (paragraph 25)

Application of _Rabone_ in _Parkin_

In *Parkin* the Deceased, Mrs Wolff, died at home from smoke inhalation when her sofa caught fire. She lived alone, and was a hoarder, and had reluctantly accepted support with her personal hygiene and medication compliance, but she had capacity and had rebuffed multi-agency involvement. The Coroner, as quoted by the High Court in paragraph 29, set out circumstances, familiar from various scenarios encountered frequently in practice, where the deceased had mental capacity, interacted with the state, but has made unwise choices:

> *"Citizens who are free to do so, are free to live their lives without restraint or interference from the state. By the same token, the state is not subject to additional scrutiny if it has not incurred obligations or taken on itself the particular responsibilities which the curtailment of rights and freedoms, or the failure reasonably to intervene, involves. … the bare fact that such institutions may have interacted with the citizen does not thereby determine whether Article 2 is engaged. … The evidence is that she lived in her own home. She had declined additional intervention by the state. Her mental capacity had been assessed and she was*

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Parkin: More Guidance on Article 2 Engagement

Peter Taheri

> *deemed to have capacity. She was therefore entitled to exercise choice. She had the right to take unwise or inappropriate decisions. The state does not take on added duties or responsibilities in such circumstances."*

The High Court agreed with this approach.

Assumption of responsibility or state control

Collins Rice J found no assumption of responsibility or state control:

> *"It is not every risk to life – even in the case of … an NHS patient – which gives rise to an operational duty on the state to prevent it. And it is clear that Mrs Wolff's circumstances were not the 'paradigm' for the operational duty arising. She was not a person over whom the state exercised 'control'. She was not in the custody of the state. She was a private citizen who died in her own home…" (paragraph 48)*

The significance placed on the fact that the deceased's sad death was within her own home will resonate with practitioners. The distinction with *Rabone* is important: in *Rabone*, the deceased was a voluntary patient in hospital that could and should have been detained under Mental Health Act powers if she were to choose to leave – and so someone for whom the difference with a detained patient was a distinction of form but not of substance. The power of the state to detain if necessary was not present in *Parkin*: *"It had been professionally established, including relatively recently, that there were no Mental Health Act powers"* to detain Mrs Wolff, nor was there any other apparent basis in law for exercising control over her. (paragraphs 49-50).

Collins Rice J emphasised that *"Helping and supporting an individual, even in the discharge of legal duties, does not routinely give rise to an operational duty. Something more is needed. And it cannot just be a real and present risk to life because that is necessary but not sufficient for the duty to arise."* The bar for assumption of control by the state is not a low one: *"it is not every case in which health and social care professionals draw up care plans for individuals, or patients spend time in hospital, that the Art.2 duty arises."* (paragraph 52)

'Vulnerability'

Contrary to the tendency of some lawyers to argue that the 'vulnerability' *indicium* applies wherever a professional at some point has recognised that the deceased was in some way vulnerable, *Parkin* importantly reminds us that "*not every degree of vulnerability will be relevant*". Collins Rice J agreed with the Coroner that Mrs Wolff was not <u>sufficiently</u> vulnerable to justify inferring a state duty in respect of the risk to her life:

> "*She was not identified as vulnerable on account of her mental health. She did not … lack competence to make her own decisions about her lifestyle. … Mrs Wolff was an adult of confirmed competence and psychiatrically sound mind… Baroness Hale JSC in Rabone (at [100]-[101]) underlined that there is no general duty of the state to protect an individual from deliberate self-harm, even where the authorities know or ought to know that it entails a real and immediate risk of death. The authorities are unanimous that the autonomy of properly autonomous individuals must in the end be respected."* (paragraphs 56-58)

The 'nature of the risk'

Similarly, in considering whether the 'nature of the risk' was an 'exceptional' one, Collins Rice J considered whether the risk in question was *"other than an ordinary risk of the kind that individuals, rather than the state, are reasonably expected to deal with. And even if an (autonomous) individual is known not to be accustomed to acting reasonably in such matters, again I was shown no authority to suggest the imposition of an Art.2 duty on the state as a result"* (paragraph 61). In other words, a person with capacity, and not sufficiently mentally unwell to justify state detention or control, being known to make unwise choices, need not engage the operational duty.

The practical result that there is no general duty on the state to protect from an immediate risk of deliberate self-harm known to the state, absent a sufficient level of vulnerability, incapacity or mental illness, may seem surprising. However, it reflects the sad reality that people without mental illness can self-harm and even complete suicide. The limits on the proper expectation on the state to intervene are limits based on the constitutional principle of respect for individual liberty.

Do we even get to the next stage?

If there is no duty, then there can be no breach. Often legal argument on article 2 starts with breach – for example,

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Parkin: More Guidance on Article 2 Engagement

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with representatives of institutional IPs arguing there was not even arguably anything more that their client could have done to avert a risk to life. Yet, where the operational duty can be shown not to arise (and there is no arguable systems duty – a different question beyond the scope of this piece), questions over breach do not necessarily need to be considered by the Coroner.

Parkin on breach

Even in relation to arguable breach, paragraphs 27 to 28 of *Parkin* helpfully remind us that the bar is high:

> *"As to the scope of the positive obligation, 'this will depend on whether the authorities should have foreseen a real and immediate risk and what more they could be expected to do' … The duty 'must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities, including in respect of the operational choices which must be made in terms of priorities and resources'".*

We are reminded that the question is whether the operational duty has been discharged reasonably. This involves *"consideration of the circumstances of the case, the ease or difficulty of taking precautions and the resources available. … In this case, it also required a consideration of respect for the personal autonomy of [the deceased]."*

Whereas *Rabone* marked a milestone in the development of the article 2 case law indicating a willingness on the part of courts to find engagement in situations close to the borderline, *Parkin* is a contribution this year, further to other recent authorities such as *Maguire* and *Morahan,* to the courts emphasising where the limits of article 2 engagement in inquests should be found.

> ***We are reminded that the question is whether the operational duty has been discharged reasonably. This involves:*** **"consideration of the circumstances of the case, the ease or difficulty of taking precautions and the resources available … In this case, it also required a consideration of respect for the personal autonomy of [the deceased]."**

A Review of Recent Cases

Alex Ustych and
Barney Branston

Scope of coronial investigation

***R. (on the application of Mid and West Wales Fire and Rescue Service) v HM Assistant Coroner for Carmarthenshire and Pembrokeshire* [2023] EWHC 1669 (Admin)**

The Assistant Coroner had not acted unlawfully by treating the findings of the Marine Accident Investigation Branch into the death of a firefighter (following the collision of two fire service boats) as being conclusive as to the cause of the accident. The judicial review turned on the status of the Divisional Court's comments in *R. (on the application of Secretary of State for Transport) v HM Senior Coroner for Norfolk* [2016] EWHC 2279 (Admin) on the same subject. Those comments were that where there was this type of report, the coroner was to regard the investigation's findings as conclusive as to the cause of the accident, absent credible evidence that the investigation was incomplete, flawed or deficient. The claimant fire service was unable to persuade Eyre J that those comments were *obiter* or that the *Jamieson* duty overrode the approach in *Norfolk.* A coroner can thus proceed on the basis that there had already been an investigation by the body best placed to reach a conclusion, which should only be duplicated by the coroner's investigation if there is credible evidence that the earlier investigation had been deficient.

***Re Dalton's Application for Judicial Review* [2023] UKSC 36**

How far back (before the Human Rights Act 1998 came into force in October 2020) could a death be before the obligation to investigate it under the HRA was no longer triggered? The Supreme Court found that the 1998 Act did not impose any procedural obligation to investigate deaths which had occurred more than 12 years before it came into force in October 2000, absent exceptional circumstances. The decision of the Attorney General for Northern Ireland not to order a further inquest into the death of a man, who died in 1988 when he unknowingly (while concerned about his neighbour) detonated a bomb which had been placed in his neighbour's house by the IRA with the intention of killing members of the security forces, was not incompatible with the state's procedural obligation to investigate deaths that had occurred in circumstances which potentially engaged the state's responsibility under Article 2.

Seven Justices presided over this appeal and were unanimous in their ruling, but sometimes divided in their reasoning, including on whether there should be a strict 10-year limit on backwards reach (before October 2020) or if it should be more flexible.

Unlawful killing

***R. (on the application of Bryan) v HM Coroner for Buckinghamshire* [2024] EWHC 26 (Admin)**

The concept of presumption of sanity as it applied in the context of criminal proceedings should not be applied to a deceased person involved in an inquest, as it would be unfair to do so. The question for the coroner would be whether the issue of insanity had been properly raised. If there was sufficient evidence of insanity for it not to be withdrawn from consideration, then the question would be whether the correct conclusion on the balance of probabilities was that the person in question was not insane. If it was more likely than not that the person was insane at the time of committing the act that had led to the death in question, a conclusion of unlawful killing would be unsafe and should not be reached.

This legal issue arose in the tragic context of a mother who jumped in front of a train while holding her three-year-old daughter. The coroner returned a short-form conclusion of suicide in relation to the mother and a narrative-only conclusion in relation to the child. The coroner found that (a) he was not satisfied that the mother was not insane at the time of the act, and (b) he was satisfied that she was likely to have been insane at the time of the act. There was clear evidence that the mother was subject to an episodic psychosis. The child's aunt argued that the coroner erred in adopting a presumption of insanity in relation to the mother and that anything other than a short-form conclusion that the child was unlawfully killed was irrational. Both challenges failed.

Procedural issues

***Ben Leeson, William Anthony Leeson v Donald McPherson* [2023] EWHC 2502 (Ch)**

The High Court provided useful guidance on disclosing information/

A Review of Recent Cases

Alex Ustych and Barney Branston

documents from civil proceedings into an inquest arising from the same death. This was the second set of civil proceedings arising from the death of Paula Leeson, who drowned in an indoor swimming pool in remote holiday accommodation in Denmark while on holiday with her husband, Mr. McPherson, who stood to gain some £3.5 million in insurance payouts and assets. Mr. McPherson was acquitted of Mrs. Leeson's murder. The coroner resumed the inquest following the criminal trial, but his decision to restrict the temporal scope of the inquest to the events immediately before the death was successfully judicially reviewed (on the basis it would have excluded circumstantial evidence relevant to how Mrs. Leeson died) in 2023 ([2023] EWHC 62 (Admin)).

The claimants brought civil proceedings in the Chancery Division, claiming that Mr. McPherson unlawfully killed Mrs. Leeson—if that finding is made on the balance of probabilities, it would deny Mr. McPherson various financial benefits. Within the civil claim, the parties were directed to agree a Schedule of Agreed Facts; that Schedule made extensive reference to documents disclosed during the civil proceedings. The Schedule also contained some admissions by Mr. McPherson. The claimants then sought permission (needed due to the restrictions in CPR 31.22 on the collateral use of documents from civil proceedings, which includes information within those documents) to provide that Schedule (and the information from disclosed documents it contained) to the Coroner.

The Court found that public policy considerations restricting collateral use were significantly outweighed by the public interest in furthering an effective inquest. Paragraph 64 of the judgment contains a useful list of factors that may be applicable to such applications.

***R. (on the application of Maguire) v HM Senior Coroner for Blackpool and Fylde* [2023] UKSC 20**

The Supreme Court provided a useful distillation of the procedural and substantives duties under Article 2 ECHR, reaffirming the specific matters which must be found in order to establish an arguable breach of the substantive duties. Jackie Maguire was in a care home subject to a standard DoLS authorisation (due to lacking capacity to make relevant decisions). She suffered a fit but refused to go to hospital when paramedics attended. An out-of-hours GP advised that her condition was not so serious as to override her wishes. She collapsed again the following day and died in hospital. The key issue in the judicial review was whether Article 2 required an "expanded" (answering the question 'in what circumstances?') or standard ('by what means?') conclusion for the purposes of s. 5 (2) of the Coroners and Justice Act 2009.

The Supreme Court went through the procedural and substantive duties in Article 2, highlighting that the systems (substantive) duty required the State to put in place systems which were capable of being operated in a way that ensured a proper standard of care. But criticism of individuals' failures in implementing that system is not the same as evidence of deficiencies in the system. The Court discouraged 'reverse engineering' the Article 2 systems duty by formulating obligations based on what went wrong; the duty should be assessed based on what system it was reasonable for an organisation to have ahead of an incident. A systems duty breach in healthcare cases is exceptional and a report from a regulator (such as the Care Quality Commission) suggesting compliance with guidelines is potent evidence against such an allegation.

The Article 2 operational duty in a care home context does not apply to all aspects of physical health but requires the care home to stand in for the resident's family (e.g. securing access to healthcare available to the general population). Actual or constructive knowledge of the nature/degree of risk to that person's life is the focus of the assessment.

Neither the systems nor operational duty were arguably breached in this case, either by the care home or the healthcare provider.

Quashing/new inquest

***R. (on the application of Hunter) v HM Assistant Coroner for County Durham and Darlington* [2024] EWHC 1275 (Admin)**

The parents of Roisin Hunter-Bennett ('Roisin'), a woman who died from suicide (the short-form conclusion which the coroner recorded, uncontroversially) sought judicial review of the coroner's formulation of the circumstances of her death set out in Box 3 of the Record of Inquest. Specifically, they took issue with the attribution of Roisin's low mood to the "ending of a relationship and the pressure of balancing work and studying for examinations". They contended that Box 3 should instead have attributed the low mood "to an emotionally abusive relationship". There was evidence that, following the end of that relationship, Roisin continued to receive abusive messages from her ex-partner, including on the day before she hanged herself.

This evidence was reflected in the coroner's formal findings of fact, concluding that the abusive relationship was more than minimally contributory to the mental state that led to her death. However, this finding was not then distilled into the Box 3 findings. The coroner conceded, pre-action, that the emotionally abusive feature of the relationship should have therefore been recorded in Box 3. The claim was only necessary as the coroner was *functus officio* so that High Court intervention was required to amend the Record of Inquest, which was found to be in the interests of justice in this case. No costs against the defendant appear to have been awarded.

***Re Assistant Coroner for Inner London* [2024] EWHC 1085 (Admin).**

MPS officers found the body of a 43 year old lady at her

A Review of Recent Cases

Alex Ustych and Barney Branston

home address when answering concerns for her safety. At postmortem, the toxicologist found levels of blood alcohol of 194/100ml and postmortem levels of GHB of 37 ug/ml, noting that naturally occurring levels of GHB are usually “below 50 ug/ml”. The pathologist misread that part of the toxicologist’s report as usually “below 30 ug/ml” and duly recorded that the death was “1(a) mixed alcohol and GHB toxicity.” On subsequent review the pathologist noted the mistake and also that the level of blood alcohol was below that usually associated with death; the cause of death was amended to ‘unascertained’. However, this ‘fresh evidence’ was sufficient for the court to quash the determination and findings and order a fresh investigation and inquest. A further factor noted by the court was the negative impact that the recorded conclusion had had on the deceased’s family and the need to avoid unnecessary stigma to the memory of the deceased (citing R v Inner South London Coroner, ex p Kendall [1988] 1 WLR 1186 at 1191-1192 per Simon Brown J).

***R (on the application of HM Senior Coroner for Sefton, Knowsley and St Helens) v Michael Kay & Ors* [2024] EWHC 1366 (Admin)**

It was in the interests of justice, pursuant to the Coroners Act 1988 s.13, for a fresh inquest to be held into the death of an individual where bronchopneumonia and mixed drug toxicity had been recorded as the cause of death but medical evidence detailing suicide notes, intentional overdoses and depression, had not been put before the coroner at the original inquest. Such notes were from seven weeks prior to her death and the deceased’s parents opposed a fresh inquest in a ‘dignified and thoughtful letter’. Her husband had not responded. Despite her parents’ opposition and it being three and half years since the death, the court quashed the original inquest and ordered a fresh inquest before a different coroner.

***R (on the application of HM Senior Coroner for the County of the East Riding of Yorkshire and the City of Hull) v HM Assistant Coroner for the County of the East Riding of Yorkshire and the City of Hull* [2024] EWHC 2007 (Admin)**

The court granted an order quashing an inquest into the death of a man who had disappeared aged 80, where the assistant coroner recorded an open conclusion, following the finding of remains which were conclusively determined to be those of the deceased. The court ordered a fresh inquest into the death. Mr Conboy had disappeared from home on 20 April 2009 and a missing persons enquiry revealed no trace. In November 2018 the Chief Coroner authorised an investigation into his death under s1(5) of the Act and an inquest held on 5 February 2019 concluded that on the balance of probabilities he had died on 20 April 2009, whereabouts and circumstances unknown, and recorded an Open conclusion in Box 4. Nearly four years later a dog walker discovered skeletal remains, DNA sampling of which showed them to have been Mr Conboy. The court identified the various factors to consider in an application to quash and in the light of such evidence that might lead to a conclusion other than Open, described as ‘the conclusion of last resort’, duly did so.

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