Albion Chambers, Broad Street, Bristol BS1 1DR

Telephone 0117 927 2144
Fax 0117 926 2569
DX 7822 Bristol

Email clerks@albionchambers.co.uk

www.albionchambers.co.uk

Number 7 January 2018

Albion Chambers INQUEST TEAM NEWSLETTER

Death in custody

The Farmer Review

Inquest practitioners are well aware of one of the most serious effects of the crisis in our prisons, so often reported in the press. Numbers of deaths in custody have risen rapidly in the last few years – a predictable consequence of reduced staffing levels, lack of resources in the mental health care of inmates, and overcrowding. The Chief Coroner's Guidance Number 16A notes that the fact that the inquest will be concerned with a death 'in state detention' does not mean that it will necessarily be an Article 2 inquest. That does not sit entirely easily with decisions such as *R on the application of Joanna Letts v Lord Chancellor, Equality and Human Rights Commission Intervening* [2015] EWHC 402 (Admin) and *R (on the application of JL) (a patient) v Secretary of State for Justice* [2008] UKHL 68. Those cases identified deaths in custody as a category of death in which an Article 2 compliant investigation was 'automatically' required. Practitioners may feel that where prisons' systems are straining and breaking down, the scrutiny of those systems which coroners' courts provide is of greater importance than ever, and that there is a strong policy reason for the broad scope of enquiry which an Article 2 compliant investigation necessitates.

In preparing for inquests concerning deaths in custody, it is helpful to consider Lord Farmer's Review "Importance of strengthening prisoners' family ties to prevent reoffending and reduce intergenerational crime" published on 10 August 2017. Whilst the review, unlike the Harris review of 2015, was not considering specifically how to reduce prison deaths, the review makes a number of recommendations which would help to do so:

- Each prison should establish a clear, auditable and responsive 'gateway' communication system for families and significant others: a dedicated phone line that is listened to and acted upon.
- Families' concerns about mental and physical health should be systematically recorded and action taken.
- Families (and significant others) should be properly informed about and able to request the opening of an Assessment, Care in Custody and Teamwork (ACCT) document, and if an ACCT document is opened they should be kept appropriately updated of any intervention/action arising from this and, if not, they should be told in writing why not.

Commentators have, however, observed that these recommendations lack novelty, and in spite of what might be considered their obvious protective effect, have been rejected by the government in the past. Concerns about over-zealous or vexatious family members being the cause of additional bureaucracy for no useful purpose are understandable. Nevertheless, it is clear that communication within the prisons, including with family members, leaves much to be desired, and that opportunities to safeguard those at risk are missed as a result.

The Ministry of Justice's Coroner's Statistics Bulletin 2016 showed a 19% rise in cases of death in state detention, excluding DOLS cases. That is an alarming statistic, indicative of the extent of the crisis in prisons. The charity INQUEST has said of the Farmer Review, "We welcome the Ministry of Justice response that they are developing a strategy which will take forward recommendations from the review, but wish to reiterate the concerns raised in our recent letter to the Times and in response to the latest MOJ stats which continue to show a prison system very much in crisis". The issue is not whether lessons are learned. Sadly it is whether solutions are funded.

Anna Midgley

Witness anonymity at inquests

Not infrequently, a client at an inquest will ask whether their identity can be kept secret, or whether there can be an order made which restricts the reporting of the inquest. Invariably, we remind them of the fact that inquests are public proceedings, where reporting of any concerns is often actively encouraged by coroners rather than prohibited, and that any application for anonymity or reporting restrictions would undoubtedly fall on deaf ears.

Such a response does however beg the question - what are the circumstances in which such an application might actually succeed?

Two recent cases have looked at this issue, with different results. In *R (T) v HM Senior Coroner for West Yorkshire* [2017] EWCA Civ 318 the Court of Appeal refused an application for anonymity where the applicant relied on Articles 2,3,8 ECHR and the common law duty of fairness. In another case, *R (Hicks and oths) v HM Senior Coroner for Inner North London* [2016]

EWHC 1726 (Admin), an anonymity order based on Article 2 was upheld, and screens were granted to preserve the integrity of the order.

The short answer which emerges from the case law is that for applications to succeed under Article 2 ECHR there must be a 'real and immediate' risk to life, and anonymity (and screens where necessary) must be a necessary and proportionate way of addressing the risk.

A summary of the relevant principles from the case law is as follows:

- The Article 2 threshold is high and the criterion of a 'real and immediate risk' should be one that is not easily satisfied – *Re Officer L* [2007] UKHL 36;
- A real risk is one that is objectively verified and an immediate risk is one which is present and continuing – *Re W's Application* [2004] NIQB 67;
- Once Article 2 is engaged, the coroner is the 'public body' who must determine what protective measures would afford a necessary and proportionate response to the risk – *Re Patrick Pearse Jordan* [2016] NICoroner 1;
- Anonymity orders are not synonymous with screens, and the protective measures employed may involve screening the witnesses to a limited extent - *Re Patrick Pearse Jordan* [2016] NICoroner 1;
- Orders which supplement an anonymity order, such as an order for screens, may be necessary to avoid the anonymity order becoming frustrated – *R (Hicks and oths) v HM Senior Coroner for Inner North London* [2016] EWHC 1726 (Admin)
- Where the evidence falls short of engaging Article 2, the coroner may still make other arrangements, such as the use of screens, practical arrangements to prevent an individual being photographed in the environs of the court, and preventing certain questions being asked – *R (T) v HM Senior Coroner for West Yorkshire* [2017] EWCA Civ 318

In the case of T, the applicant was a 19-year-old woman who had presented to the Accident and Emergency department of her local hospital with a shoebox containing the body of her dead baby, who had been born several days before. The applicant had tried to hide her pregnancy from her family, who she knew would not approve. When interviewed by the police about the baby's death, she initially said conception was the result of her being raped, before subsequently admitting a consensual sexual relationship which she had sought to keep secret from her family.

The applicant filed evidence from her family, her GP, and an expert in honour-based abuse. In summary, the evidence suggested the applicant had received some threatening messages, and there was the possibility of her being deported to Pakistan and subjected to a forced marriage. It was submitted on her behalf that the evidence constituted:

- A real and immediate risk to life under Article 2; alternatively
- A real and immediate risk of inhuman and degrading treatment under Article 3; alternatively
- A balancing act between the Article 8 right to private life and the Article 10 right to freedom of expression, which the applicant argued favoured anonymity; alternatively
- An infringement of the common law duty of fairness.

What undermined the applicant's arguments was the fact that at an earlier PIR, the press had reported the applicant's name and the initial details of the investigation, without the applicant coming to any harm. That information was still available on the internet, and it was difficult to see how a failure to grant anonymity would result in any greater risk than the applicant currently faced. In any event, the court reasoned that the risk of harm to the applicant could be dealt with by appropriate protection from state agents.

The case is interesting, I suggest, for two reasons. First, it goes beyond the limited Article 2 arguments that are typically run in these cases, putting forward arguments under Articles 3 and 8. Second, it is relatively rare in anonymity cases for the applicant to be anyone other than a police officer. As an aside, it is also useful as a demonstration of the 'high threshold' required before the state's Article 2 operational duty is engaged.

In the case of *Hicks and others*, there was clear evidence that the police officers who had been involved in pursuing the deceased immediately prior to his death would be the subject of a real and immediate risk to their lives if their identities became know. Evidence was presented to the coroner which suggested the risk of significant harm to the officers was 'probable', and that risk included a risk to life. Two arrests had already been made as a result of relevant threats.

On appeal, the decision to grant anonymity was not challenged; the family instead seeking to challenge the method by which the coroner sought to maintain the integrity of the anonymity order. Due to the court building's inability to provide screens, the coroner had directed that the family and other members of the public would hear the officers' evidence from a different room, listening though an audio link. Fortunately, the High Court managed to resolve the issue with the courts estate, and made a court available at the RCJ with facilities to screen witnesses during their evidence.

The case is interesting because it shows how effective it can be to take some quite 'bolshy' social media posts and put them in front of a coroner as evidence of a real and immediate risk to life. One of the posts quoted in the High Court's judgment (in fact the only post) was a suggestion that 'the guns are going to come out on the estate'. It is easy to imagine how such a statement could have been tweeted from a teenager's bedroom with little or no prospect of it being acted upon, yet it forms the basis for satisfying the high threshold for Article 2.

In summary, therefore, if your client is seeking an order for anonymity, consider carefully the evidence that might get you over the hurdle for a 'real and immediate risk', before considering why any other type of protective measure is not appropriate for your client. It is not an easy task.

Alexander West

R (Maguire) v Assistant Coroner West Yorkshire

[2017] EWHC 2039 (Admin) 14 August 2017

Ann Maguire, a teacher, was murdered in her classroom by a 15-year-old pupil. C pleaded guilty to her murder and was sentenced. The inquest is to be resumed. However, the issue of whether some of the school's pupils should be called to give evidence at the inquest has been contentious. In the wake of the death, those pupils reported to the police how C had behaved in a threatening way and, in particular, his morbid interest in Mrs Maguire prior to events. A pupil had reported this behaviour to a teacher after the murder. Others did not report the behaviour.

The Claimants want these pupils, interviewed by the police, called to give evidence so that the inquest could hear as to the pupils' understanding of the school rules relating to weapons on school premises, informing those in authority, and, for those who had taken no action, to explain why. The Claimants wanted the

inquest to look at how children might be encouraged to share concerns with adults.

The application was opposed by some of the interested parties, concerned about the affect on pupils who might be called to give evidence and affected by the events themselves.

The Assistant Coroner determined that the scope of the inquest should include examination of the policies and procedures prevailing at the school for matters to be reported in confidence by pupils to staff members, and how these were communicated to the pupils. He declined to call the 'interviewed pupils' in order to explore this issue.

The Claimants sought judicial review submitting that the Coroner's decision was irrational, unfair and failed to take into account relevant matters. They contended that in weighing benefit and risk the Coroner had struck the balance wrongly and so removed the only evidence which could be given on an issue which the Coroner had identified as being in scope.

Mr Justice Holroyde did not agree, but noted that the distress of a young witness was not necessarily a reason why that witness cannot or should not give oral evidence. The issue for the judge was not where the balance should be struck, but whether the Coroner's conclusion as to where the balance lay was one which was not reasonably open to him. He concluded that the Assistant Coroner's decision was correct.

The Judge found that the interviewed pupils had already volunteered their reasons for acting or failing to act, and none of that reasoning suggested that pupils did not know they could speak to a teacher or thought their report would not be treated seriously. The Coroner had properly taken into account that this relevant information could be extracted from the transcripts of the interviews and put before a jury. He had also correctly taken account of the risk of re-traumatising a witness and the impact of the passage of time since the events upon recollections of their own reasoning.

Comment

The judge considered what evidence the pupils could or might give and concluded that the benefit of calling their evidence would be limited and needed to be set against the risks to them. The decision that the investigation did not require oral evidence to be heard from them, when their earlier police interviews were available, was a conclusion reasonably open to the Assistant Coroner against the backdrop of the foreseeable risk of inflicting psychological harm.

Giles Nelson

Albion Chambers Inquest Team

Team Clerk
Nick Jeanes

Kate Brunner QC
Call 1997 QC 2015
Team Leader, Recorder
Upper Tribunal Judge

Stephen Mooney
Call 1987

Fiona Elder
Call 1988

Paul Cook
Call 1992
Recorder

Jason Taylor
Call 1995

Kirsty Real
Call 1996

Richard Shepherd
Call 2001

Anna Midgley
Call 2005
Team Leader

Simon Emslie
Call 2007

Alexander West
Call 2011