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Number 6 April 2016

Albion Chambers INQUEST TEAM NEWSLETTER

Reining in the scope of inquests

The boundaries of the fact-finding process of an inquest are frequently a highly contentious matter, and there has been a lack of certainty in recent years over how coroners should set an inquest's scope. In Article 2 inquests, in particular, the courts have at times allowed exploration which reaches far beyond matters directly linked to the death in question. A recent case may provide assistance.

In *R (on the application of Speck) v HM Coroner for York* [2016] EWHC 6 (Admin) the High Court heard an appeal arising from an inquest where a woman had been taken to a police station having been found acting erratically in the street. She died in police custody. Her family argued that she should have been taken into a healthcare setting, not a police station. The court found that there was no duty to take the deceased to a healthcare setting, and that policy and funding issues relating to the lack of any medical facility which could be used as a place of safety were outside the scope of the inquest.

The High Court agreed. The High Court examined previous authorities, and gave the following analysis:

- A coroner had a *duty* to investigate matters which had caused, or arguably appears to have caused or contributed to the death.
- A coroner conducting an Article 2 inquest had *discretion* to investigate any matter which might arguably have been a contributory factor in the death.
- A coroner *does not have any discretion or power* to investigate matters which could not even arguably be said to have made any real contribution to the death.
- A coroner was entitled to make such a finding before all the evidence had been heard.
- The coroner's discretion would not be interfered with unless it was exercised perversely.

The simplicity of the ruling will not prevent extensive argument as to its application on particular facts. In particular, the difference between matters which *'arguably appear to have contributed to death'* and *'might arguably have contributed to death'* may be impossible to determine in some factual scenarios. This case makes it all the more important that coroners follow the guidance relating to Pre-Inquest Reviews (as set out by the Chief Coroner in *Brown v HM Coroner for Norfolk* [2014] EWHV 187 (Admin). The Chief Coroner required that interested persons should, in more complex cases, be given notice by the coroner of the coroner's preliminary views as to scope. This is frequently not observed, but should be: it would enable legal representatives to make submissions in writing before the Pre-Inquest Review about scope, submissions which may include relatively complex analyses of facts in some cases.

Additionally, the case highlights a practical difficulty for coroners. In *Lewis v Coroner for Shropshire* [2009] EWCA Civ 1403 it was held that the court should investigate matters which were relevant to the possible occurrence of further prison deaths, to allow the coroner to determine whether to make a report under Rule 43 of the Coroners Rules 1984. To do otherwise could breach the state's Article 2 duty to inquire fully. A Rule 43 report could only seek to prevent fatalities 'similar' to the subject-matter of the inquest. That has been replaced by the Report to Prevent Future Deaths under the Coroners and Justice Act 2009. The subject-matter of a 'PFD' report can extend beyond anything causative of death; for example, if a coroner's papers disclose that a hazardous procedure was being followed by medics, even where that procedure did not play any part in the death under investigation, the coroner would be entitled to raise the issue in a PFD report. How is a coroner to comply with their positive duty to make a PFD report where that requires some investigation of facts, without breaching the injunction in *Speck* against investigating matters which are not even potentially causative?

One solution may be to hold a separate PFD hearing, without any jury present where a jury is involved in the inquest. The Chief Coroner, in his Guidance no.5, urges coroners to avoid *'a separate lengthy additional hearing'* but contemplates a medical witness being recalled to enlarge on evidence while a jury is in retirement. It would be prudent for Trusts to have a senior manager on standby to deal with any matters of concern which have arisen. In the most complex cases, a coroner may adjourn the PFD decision to allow written submissions from legal representatives (as happened, for example, in the *Duggan* case).

Whatever procedure is followed, it is now clearer than ever that a jury should not hear about matters of concern which do not touch upon the death in question, and that PFD reports should not be used as a mechanism for widening the scope of an inquest.

Kate Brunner QC

Inquests without bodies

The latest guidance issued by the Chief Coroner concerns reports under section 1(4) of the Coroners and Justice Act 2009 Act. Normally, under section 1(1), the jurisdiction of a coroner arises only where the coroner is "made aware that the body of a deceased person is within that coroner's area". Where, however, a senior coroner has reason to believe that (a) a death has occurred in or near the coroner's area, (b) the circumstances of the death are such that there should be an investigation, and (c) the duty to conduct the investigation into the death does not arise because of the destruction, loss or absence of the body, he/she may report the matter to the Chief Coroner, who may then, under section 1(5), direct a senior coroner (not necessarily the senior coroner who made the report) to conduct an investigation into the death.

'Reason to believe'

The Guidance addresses not only each of the three pre-conditions to making a section 1(4) report but also what is needed for a coroner to have "reason to believe". A coroner will decide whether he/she has reason to believe from the information available, which is not limited to admissible evidence. The Guidance makes clear, however, that the belief must be reasonable in the sense that judged objectively it is based on something tangible, not speculative. The coroner must be satisfied that he/she has reason to believe that all three pre-conditions are met, and there must be material before the coroner upon which the coroner is entitled to be so satisfied.

The fact of death does not have to be established with certainty and a couple of examples (one from an actual case) are given of circumstances in which a coroner would be entitled to conclude that he/she had 'reason to believe' that there had been a death and that the death had occurred in the coroner's area even though no body was recovered.

It is for the coroner to determine in all the circumstances whether the death is likely to have occurred 'in or near the coroner's area'. "In or near the coroner's area" has never been defined by statute or case law but the Guidance refers to the dicta of Woolf LJ in *R v Coroner for East Sussex*, *ex parte Healy* [1998] 1 WLR 1194 that 'near' is an ordinary English word in this context, "indicating a short distance or close proximity" and is to be 'applied by the coroner in a common sense manner... it is a matter to be judged initially by the coroner'. There follows a discussion of cases, such as ex parte Healy, in which a body has been lost (or appears to have been lost) at sea.

Coroner's discretion

Once the coroner has reason to believe that the three pre-conditions are met, he/she may report the matter to the Chief Coroner. Whilst there is no requirement to do so, the coroner's discretion as to whether or not to make a section 1(4) report must be exercised reasonably and fairly as with the exercise of any judicial discretion. If the coroner decides against making a report, he/she must have reasons which can be provided on reasonable request.

Chief Coroner's discretion to investigate

The Chief Coroner also has a discretion whether to direct a coroner to conduct an investigation under section 1(5). The Guidance states, however, that before deciding whether or not to exercise his discretion, the Chief Coroner, upon receipt of a section 1(4) report, will first consider whether the three pre-conditions are satisfied. Sometimes this will involve asking the coroner for further information or an explanation. If one or more of the pre-conditions are not met, no direction will be given.

Presumption of Death Act 2013

The Guidance finishes by explaining that the process under the Presumption of Death Act 2013, whereby certain persons may apply to the High Court for a declaration that a missing person is 'presumed to be dead' is completely separate from the section 1(4) report provisions. However, where such an application to the High Court has failed, the Guidance states that coroners will look closely at a subsequent request to them to make a section 1(4) report in relation to the same 'death' and that where the request is supported by similar information as previously put before the High Court, coroners will consider with care the exercise of their discretion whether to make a report.

The full Guidance can be found here: https://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/coroners-guidance/.

Simon Emslie

When is an inquest not an inquest?

This question was recently addressed in the case of *Flower v HM Coroner for the County of Devon, Plymouth, Torbay and South Devon & Anor, Court of Appeal* - Administrative Court, December 16, 2015, [2015] EWHC 3666 (Admin). The case concerned an application under s.13 of the Coroners Act 1988 for a mandatory order to quash the original inquest findings into the death of Keith Dance and to order a fresh inquest. The deceased met his death in violent circumstances and two individuals were convicted of his murder. The Coroner had suspended his investigation into the death pending the outcome of criminal proceedings pursuant to section 11 and paragraph 2 of the schedule 1 to the 2009 Act, but following the convictions certified that the "investigation has not been resumed" as a consequence of the criminal convictions.

The mother of the deceased sought a new inquest pursuant to s.13, but to succeed she had to show that *"an inquest or an investigation has been held"*. Following an extensive review of the authorities and competing views of the editors of *Jervis on Coroners* and *Halsbury's Laws of England*, the Court concluded that in fact no inquest had ever been held. It was clear that the inquest had never been discontinued under section 4 of the 2009 Act but had merely been suspended under schedule 1; effectively adjourning the inquest "sine die". The Court condensed the arguments into one simple (and rather obvious) phrase:

"for an investigation to have been held it has to have been completed; a part investigation is no more than an investigation that has been 'held' than a part inquest has been 'held' ".

On the basis of this finding the Court declined to make any finding pursuant to the s13 application, but invited the applicant to approach the Coroner and invite him to re-consider his decision not to resume the original inquest. The Court did not want to tread on the Coroner's toes and expressed no opinion as to what decision he should make, but suggested that the correct avenue for appealing against a future decision not to re-open proceedings would be by way of Judicial Review.

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