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Albion Chambers INQUEST TEAM NEWSLETTER

Change at last

The draft coroners' rules and regulations

The Chief Coroner's keynote address at the annual Albion Inquest Team Seminar 2013 coincided with the launch of the consultation on new rules. The consultation opened on 1st March 2013, and is fashionably brief, ending on 12th April 2013. The consultation paper and questionnaire template for responses are available online at http://www.justice.gov.uk/consultations/index.htm

The Coroners Regulations are to be created under section 43 of the Coroners and Justice Act 2009, and deal with procedural matters. In line with the broad move towards greater transparency, the draft regulations require that the coroner must notify all interested persons of the reason for discontinuing an investigation i.e. for deciding not to hold an inquest. There is a new regulation requiring coroners to release bodies for burial or cremation within 30 days of being notified of the death or, where this is not possible, to explain the reasons to the next of kin.

The new regulations increase the duties on bodies who have received a 'report to prevent future deaths' (previously referred to as 'Rule 43 reports' under the 1984 Rules). A body which receives such a report must respond within one month, and must include in that response a timetable for the action proposed to prevent other deaths. The Chief Coroner will collate those reports and responses, and may publish them. It remains to be seen what action the Chief Coroner will take in relation to those bodies which do not respond to a Report to Prevent Future Deaths within the required time; at present all that happens is that the names of those defaulting bodies are published by the Ministry of Justice as part of their annual summary (the latest of which is at http://www.justice.gov.uk/coroners-burial-cremation/coroners). There is no sanction beyond the limited bad publicity which this exposure generates.

Alongside the proposed new Regulations are the proposed new Rules, created under section 45 of the 2009 Act. The Rules focus on the formalities and management of inquests, and largely replicate the provisions in the 1984 Rules. The Chief Coroner, in his address, highlighted some of the new proposals within the Rules which have been drafted to address long-standing concerns about coronial procedure.

Firstly, it is proposed that there should be a 'target' time within which an inquest will be held (Rule 8); the Chief Coroner suggested a target time of three months. While most would agree that this is a laudable aim, there would be significant problems with many inquests in obtaining relevant documentation within that time. In cases where there is an internal review by a Trust, that review is rarely completed within three months of the death. The Chief Coroner anticipated that the three month target would be appropriate for most inquests, where issues of wider investigation and disclosure did not arise. It is of note, however, that in the recent case of *R (Shaw) v HM Coroner Leicester* ([2013] EWHC 386 (Admin)), the Chief Coroner noted that a delay of over three years 'whilst far from desirable, is not uncommon in connection with inquests which raise complex medical issues and involve a large number of witnesses and substantial documentation... In the context of a complex medical inquest which, in due course, occupied a jury for 13 working days, I am unable to accept that the delay which occurred was inappropriate, still less unlawful either in domestic law terms or in the context of article 2.' Thus, whatever the timeframe which is decided upon, it appears likely that the more complex inquests will still take years rather than months to be heard.

Secondly, the new Rules propose two new 'findings' (in line with all new legislation, there is a change of terminology so that 'verdicts' have now become 'findings'). The proposed additional short form findings are (i) drink/drug related death and (ii) death following road traffic collision. For a bereaved family, the verdict of 'accidental death' can be an insulting misnomer where the death arises from poor driving by another, falling short of unlawful killing. This is particularly so following the decision of the Chief Coroner in the High Court in the case of *R (Wilkinson) v HM Coroner for Greater Manchester* [2012] EWHC 2755 (Admin). In that case, a car spun out of control on icy conditions on a motorway and struck a vehicle on the hard shoulder, killing a vehicle repair man. At the inquest, the coroner directed the jury that they could return a verdict of unlawful killing if they were sure that the offence of 'causing death by careless driving' had been committed.

The High Court found that the coroner had erred in leaving unlawful killing. Causing death by dangerous driving or by careless driving, even if under influence of alcohol or drugs, was not to be treated as unlawful killing. In spite of contributory factors, such deaths remained 'accidents' and verdicts of 'accidental death' were appropriate. The unlawful killing verdict was quashed, and a verdict of accident substituted. The court reviewed the history of the unlawful killing verdict, and held that it was only appropriate where there was a finding of murder, manslaughter (including corporate manslaughter) or infanticide. Clearly, some dangerous driving will fulfil the criteria of 'gross negligence manslaughter', but if it does not then the coroner will have no choice but to direct that an accident verdict is returned. The perceived insult to the

bereaved of an 'accident' verdict when there has been some fault by the other driver may be mitigated by the proposed new verdict of 'death caused by road traffic collision'.

The new verdicts were supported by campaign groups, and those who gather and analyse statistics from inquests, as they will assist in identifying trends of deaths within those categories. The new rules do not give any definition or guidance in relation to narrative verdicts, although they will be permitted (Schedule 2 to the Rules).

The new Regulations and new Rules are likely to be implemented later this year, following the implementation of the Coroners and Justice Act 2009 in June 2013. It is to be hoped that the new procedures, under the guidance of the Chief Coroner, will result in greater transparency, and greater consistency. Such outcomes would be welcomed by the bereaved, by Trusts and by lawyers alike.

Kate Brunner

'Appealing'

Not so appealing – a missed opportunity

During the 90's and into the new millennium, opinions and views provided by commentators, interest groups and practitioners alike, contributed to a general sense that the methodology of appealing Coroners' 'verdicts' (using the old terminology) was cumbersome and outdated. The drafts of the Coroners and Justice Act 2009 included a wholesale review and refinement of the Coronial appeals process. s.40 of The Coroners and Justice Act 2009 was to come into force in 2012 in various pilot areas, being rolled out nationally in 2013.

Unfortunately, s.40 was quietly assassinated by s.33 of the Public Bodies Act 2011, the latter being described during the Chief Coroner's keynote address at Albion's Inquest Seminar in March 2013, as the 'Quango Bonfire' Act. Unfortunately, like all those who are fond of a little arson, the consequences of their actions can be unforeseen and detrimental, the fire spreading from the derelict to the useful.

Nevertheless, as a result of the decision to put a match to s.40, the methodology for appeal in Coronial law remains fragmented and somewhat tense. Therefore this article attempts to simplify and demystify the classic routes of challenge – but all the while hoping that the previous s.40 draft rises like a phoenix from the flames.

Background

The term 'appeal', in our context, is misleading. Available routes comprise a collection of pre-existing public law and coronial law channels that can, if used thoughtfully, achieve the result of a classic appeal. In the main, there are two options, Judicial Review and s.13 Coroners Act 1988.

Judicial Review

Judicial Review is based on public law principles, primarily, the analysis of the fairness of procedure and whether the Coroner has properly exercised their coronial powers. Therefore a decision or determination can be challenged by way of Judicial Review if the Coroner has acted;

- unreasonably, this is the test of perversity as laid down in Wednesbury
- outside their powers (ultra vires) or,
- when the Coroner hasn't done something which they were obliged to have done.

The remedies available via this route are as follows:

- Quashing Order – a nullification of the decision or determination, often made in ultra vires cases
- Prohibiting Order – preventing a Coroner from making a particular decision or determination, or preventing the Coroner from undertaking a particular action, and
- Mandatory Order – forcing the Coroner to act where there has been wrongful inaction.

As a useful introduction to the JR process in Coronial Law, the authority of R (on the application of) HM Deputy Coroner for the Eastern District of West Yorkshire and others [2012] provides a good illustration of the law in action.

JR is governed by a strict set of time limits and protocols. A party must seek relief 'promptly' and not later than 3 months from the date of act or omissions complained of. The High Court has some discretion to extend the time limits under CPR 3.1(2)(a), in 'exceptional circumstances'. This has been applied strictly.

There is also a specific protocol by which to bring JR Proceedings, for ease of reference the web-link is included here: www.justice.gov.uk/civil/procrules_fin/contents/protocols/prot_jrv.htm

s.13 Coroners Act 1988

s.13 of the Coroners Act 1988 dictates the methodology and scope of the appeals process. s.13 can be divided into two distinct themes;

- appealing a decision not to hold an inquest at all, or
- appealing a fundamental defect in particular proceedings held, being held or about to be held.

The appeal also arrives at the High Court which will apply the s.13, two fold, either/or test in considering whether the appeal should be heard;

- s.13(1)(a) that the coroner is refusing or neglecting to hold an inquest which *ought* to be held; or
- s.13()(b) where an inquest has been held, that it is necessary or desirable in the interests of justice that another inquest be held.

'Ought' under (a) refers to s.8 of the Coroners Act, setting out circumstances in which an inquest should be held, whilst the test under (b) has been drafted widely to include; *"by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise".* It would seem to this writer that the decision to quash and re-hear the Hillsborough inquests may well qualify under each individual limb of (b)!

Nevertheless, the definition under s.13(1)(b) has been interpreted by the Courts to mean *"Whether there is a possibility (not likelihood – writer's addition) of a different verdict"* see *R (Halpin) v AG* (2011).

However, a feature of the s.13 appeals process necessitates the applicant obtaining the authority/permission of the Attorney General (unless the AG decides to bring the appeal him or herself). It is of note that if the AG (wrongly) refuses to sanction the appeal, some authorities suggest that the AG is not susceptible to being Judicially Reviewed – see *R v AG ex parte Ferrante (1995)* though this has been described as 'unattractive' in *R (Halpin) v AG* (2011).

In terms of remedy through a s.13 appeal, the options are relatively limited, in essence, the High Court may;

- order the inquest to be held, by the same or an alternative Coroner
- order the Coroner to pay such costs as appear just, and/or
- quash the verdict.

If a costs order is being considered against the Coroner, the High Court should do so where it appears 'just'. Unfortunately, that ostensibly simple test has been fettered by the common procedure that in circumstances where the Coroner concerned is unrepresented and the Coroner has taken no part in proceedings, costs will not be ordered unless the Coroner has acted 'entirely improperly'; to this writer, the similarity between the perversity test in JR and 'entirely improperly' is stark.

Despite the unfairness of this situation being recognised in relatively aged authority such as *R v Hammersmith Coroner ex parte Gray* (1986), a family using s.13 to correct a 'bad' inquest, has little prospect of recovering their costs, unless the inquest was 'really bad'. As the title of this article suggests, Appealing – is rather less so.

Richard Shepherd

What is the point?

Article 2 inquests in 2013

An increasingly difficult question for inquest lawyers to answer is 'what is the point of arguing about whether this is an Article 2 inquest? What difference will it make?'

The legalistic answer, repeated in recent case law[1] is that where the State has taken life or failed to protect life, the Article 2 procedural obligation requires a state to carry out an investigation into a death that has the following features: (i) It must have a sufficient element of public scrutiny of the investigation; (ii) It must be conducted by an independent tribunal; (iii) The relatives of the deceased must be able to play an appropriate part in it; (iv) It must be prompt and effective. The obligation of the fact finder inquest to specify how the deceased came by his death should be interpreted in an Article 2 inquest as meaning not simply 'by what means' but 'by what means and in what circumstances'[2]

The practical answer is, in many cases, that an 'Article 2' label will make no discernible difference to the scope of the inquest, which is almost always going to be wider than the verdict eventually reached. As was said in the case of Ex Parte Dallagio[3], to limit any inquest to the last link in the chain of causation would defeat the purpose of holding inquests at all; the facts have to be fully investigated in order to discover which of a variety of verdicts is possible. As an example of wide ambit of enquiry in a non-Article 2 ('standard') inquest, in the recent case of Sreedharan[4] the Coroner allowed evidence relating to the prescribing history of a doctor who had prescribed medication to the deceased in questionable circumstances. The Coroner also allowed evidence relating to previous complaints about the doctor. The High Court said that scope was matter for the Coroner, and wouldn't be interfered with unless the Coroner's decision was perverse.

The courts have, in recent years, noted that the difference in scope between an Article 2 inquest and a standard inquest is often insignificant. In the Smith case[5] Lord Phillips of Matravers observed that:

'the only difference that the decision of the House in Middleton's case would have made to either the Jamieson inquest or the Middleton inquest would have been to the form of the verdict. In each case the coroner appears to have permitted exploration of the relevant circumstances despite the fact that he did not permit these to be reflected in the verdict. I question whether there is, in truth, any difference in practice between a Jamieson and a Middleton inquest, other than the verdict. If there is, counsel were not in a position to explain it.'

Similarly, in the recent case of Barry[6] the High Court noted that it was 'debateable'whether there would be any difference between an Article 2 and a standard inquest in the circumstances. In that case, a 14 year-old boy was assessed as "in need". He was known to social services for shoplifting, using drugs. He died after drinking methadone at the flat of an older man. The High Court held that the Coroner had erred at first instance in holding that Article 2 applied, but noted:

'[counsel] accepted in the course of argument that ultimately there may not be all that much difference in the scope of the inquest and which witnesses are called (albeit that he indicated that the focus of their evidence is likely to differ by reason of it being a Jamieson inquest). He conceded that, bearing in mind the coroner's Rule 43 responsibilities (which the coroner had referred to), the coroner would wish to hear evidence from the claimant local authority and other agencies.'

If the scope of the inquest may not be different in Article 2 inquests, what about the verdict? It was the case for many years that it was difficult to secure a narrative verdict in a 'standard' inquest. That has changed. In the case of Longfield[7] the High Court encouraged the use of narrative verdicts in 'standard' inquests: 'In cases where the death results from more than one cause of different types, a narrative verdict will often be required.' The percentage of verdicts which are 'unclassified' has been rising steeply, from 1% in 2001 to 15% in 2011[8]. There are, again, significant regional variations - in Birmingham almost 70% of verdicts are narratives whilst the figure in Hampshire is only half a percent. Narrative verdicts in 'standard' inquests have traditionally been more narrow than narrative verdicts in Article 2 cases, following case law such as Hurst[9], where it was held that although a standard inquest could allow for examination of systemic failings, including the conduct of the police and the housing authority, 'the jury would be debarred from expressing any views whatever upon the conduct which they had been examining'.

Increasingly, however, some coroners' narrative verdicts, even in 'standard' inquests, are becoming akin to findings of fact in the civil courts. A celebrated example of this approach in a first-instance inquest was the verdict in the case of Gareth Williams[10], the MI6 employee whose body was found in a holdall. The Coroner took two hours to deliver a complex narrative verdict, in which she found that, although there was insufficient evidence to find beyond reasonable doubt that he had been unlawfully killed, his death was "unnatural and likely to have been criminally mediated". The Coroner concluded that another party placed the bag containing Williams into the bath, and on the balance of probabilities locked the bag. The Coroner was critical of SIS for failing to report Williams missing for seven days, which caused extra anguish and suffering for his family, and led to the loss of forensic evidence. This type of critical and detailed narrative has been seen in other first instance cases, particularly those involving complex medical procedures, and is far from the neutral statement envisaged in previous cases. It remains to be seen whether this practice will be reined-in by the High Court.

In many coronial courts in 2013, then, there is often no difference in either scope or verdict between Article 2 and 'standard' inquests. For bereaved families, the most significant ramification of the 'Article 2'

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label is that public funding is far more likely to be available, removing the burden of self-representation in a difficult and alien forum. For those who represent Trusts, however, securing a finding that Article 2 does not apply is increasingly a pyrrhic victory, given that a critical narrative verdict may still follow.

Kate Brunner

[1] R (on the application of Smith) v Oxfordshire Assistant Deputy Coroner [2011] 1 AC 1 referring to the *Middleton* case and *R (L(A Patient)) v Secretary of State for Justice* [2009] AC 588.

[2] *R (Middleton) v West Somerset Coroner and another* [2004] 2 AC 182

[3] R v Inner West London Coroner, Ex p Dallaglio [1994] 4 All ER 139, per Simon Brown LJ

[4] R (Sreedharan) v HM Coroner for Greater Manchester (Admin 2012,EWHC 1386

[5] R *(on the application of Smith) v Oxfordshire Assistant Deputy Coroner* [2011] 1 AC 1

[6] R (Kent CC) v HM Coroner for Kent ex p Barry [2012] EWHC 2768 (Admin) 15 October 2012

[7] R (Longfield Care Homes) v HM Coroner for Blackburn [2004] EWHC 2467 (Admin)

[8] Ministry of Justice statistic, at http://www.justice.gov.uk/statistics/coroners-and-burials/deaths

[9] R (Hurst) v Commissioner for Police of the Metropolis [2007] UFHL 13

[10] (23 April, HM Coroner for Inner West London)

Disclosure

The greatest hurdle of all

Most who practise in the inquest arena find that issues presented by disclosure, or lack of disclosure, require a great deal of time to address. There is at present no mandatory disclosure, save for disclosure of the post mortem (under Rule 57). There is not even a statutory requirement for a coroner to disclose witness statements to interested persons (*Peach v Metropolitan Police Commissioner [1986] 2 All ER 129*), although interested persons should at least receive sufficient disclosure to be able to participate effectively in the inquest process (*R(Bentley) v HM Coroner for Avon [2002] 166 JP 297*). In the Article 2 case of *R on the application of Catherine Smith v Oxfordshire Assistant Deputy Coroner [2008] EWHC 694* it was held that there was a 'presumption in favour of as full disclosure as possible', although this is obiter in relation to non-Article 2 cases. Despite these moves towards fuller disclosure, the High Court has repeatedly emphasised that there is no general duty on coroners to arrange disclosure to interested persons, and a failure to disclose is unlikely to form a proper ground for appeal (*R (Cairns) v Coroner for West London [2011] EWHC 2890*).

Disclosure is a particularly thorny issue in relation to the internal investigation reports from Trusts and other bodies which examine their own apparent failings. Some bodies, particularly NHS Trusts, refuse to give such reports to Coroners, while some Coroners in receipt of the reports refuse to share them with other interested persons. The practice of an investigative body sharing only part of its report was noted without comment by the High Court in *R (Kent CC) v HM Coroner for Kent [2012] EWHC 2768*.

The proposed new Coroners Rules contain the first regime for disclosure, setting out categories of documents that should be disclosed, and in what circumstances; a welcome step forward. It would be particularly helpful if the rules envisaged some timescales for disclosure, even if this were not detailed and were to use a formula such as "not later than X days before the inquest hearing".

Controversially, the proposed new Rules also contain the first regulatory presumption in favour of disclosure of internal reports. In summary, the proposed rules would mean that a coroner must normally disclose copies of relevant documents to an interested person on request, at any time during or after an investigation. This includes a presumption of disclosure of 'any report that has been provided to the coroner during the course of the investigation'. This wide-reaching rule is likely to be the subject of adverse comment from those who represent Trusts and public authorities. There are significant concerns that if employees know that their statements to an internal investigator are likely to be the subject of external scrutiny, they may be less forthcoming and the effectiveness of internal investigations compromised as a result. Clearly, a report which is neither candid nor complete is of as little use to a bereaved family as it is to a coroner.

Anna Midgley