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Issue III July 2022

TGC Inquests & Inquiries

The Newsletter of the TGC Inquests and Inquiries Team

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Editorial

By Nicholas Moss QC and Harriet Wakeman

Welcome to the third edition of the TGC Inquests and Inquiries newsletter, a twice-yearly publication, containing articles on recent key legal developments in these fields, as well as a selection of recent noteworthy cases in which Members of Chambers have been involved.

At the outset of this edition, we wanted to flag some very recent developments of note to coroners and practitioners alike. New provisions applicable to coroners have just been brought into effect (as of 28 June 2022) by the Judicial Review and Courts Act 2022:

- Section 39 allows coroners to discontinue an investigation when it becomes clear during that investigation that the death was from natural causes, notwithstanding there having been no post-mortem.
- Section 40 allows coroners to conduct documentary inquests without the need to sit in a courtroom (in effect, in writing) but this only applies to uncontentious inquests where the coroner has invited representations from each interested person, where there is no real prospect of disagreement among interested persons as to the determinations or findings that the inquest could or should make, and there is no public interest in a hearing.
- Section 41 enables rules to be made in relation to remote hearings.
- Section 42 disapplies the obligation for a coroner to hold an inquest with a jury in relation to a Covid-19 death (thus replicating the effect of the previous provision in the Coronavirus Act 2020).
- Section 43 enables coroner areas within a local authority area to be merged where the new coroner area would not be the entire local authority area.

In addition, the Remote Observation and Recording (Courts and Tribunals) Regulations 2022 enable coroners to permit the public and/or the press to join hearings remotely by video or audio link.

Since our **last edition**, the TGC Inquests and Inquiries team have been particularly busy. Members have been involved in a range of high-profile public inquiries and inquests including the Brook House Inquiry, The Infected Blood Inquiry, Grenfell Tower Inquiry, the Dawn Sturgess Inquiry, the Bugaled Breizh inquests and the inquest into the death of Emiliano Sala. In addition, we are pleased to announce that Andrew O'Connor QC has recently been appointed, as part of a team of QCs, as Counsel to the Inquiry in the UK Covid-19 Inquiry. Several other members of TGC are also instructed in that Inquiry. In other exciting news, we are delighted to announce that Zeenat Islam has joined TGC. Zeenat brings with her a wealth of experience in public inquiry and inquest work and it is brilliant to have her onboard. She is currently instructed as Junior Counsel to the Grenfell Tower Inquiry and the UK Covid-19 Inquiry.

In this edition, Members of Chambers provide an update on recent key case law including:

- ***Lee v Assistant Coroner for County Durham and Chief Constable of Durham*** [2022] High Court QBD (CO/4066/2021);
- ***Senior Coroner for West Sussex v (1) Chief Constable Sussex Police (2) Secretary of State for Transport (3) Mr Hill*** [2022] EWHC 215 (QB);
- ***R (Bilski) v Her Majesty's Coroner for Inner West London*** [2021] EWHC 3339 (Admin);
- ***R (Ginn) v HM Senior Coroner for Inner London*** [2022] EWHC 28 (Admin).

We comment on the return to the pre-covid legislation (slightly adjusted) for death certification and its practical impact and finally, as ever, at the end of this edition, you will find a selection of summaries of recent cases that Members of Chambers have been involved in.

We hope that this edition will be a useful resource for you. If any members of the TGC Inquests and Inquiries team may assist you, please contact the TGC clerking team.

Nicholas Moss QC and Harriet Wakeman

R (on the application of Lee) v HM Assistant Coroner for County Durham & Chief Constable of Durham Constabulary [2022] High Court QBD (CO/4066/2021)

Richard Boyle

A Coroner decided that article 2 ECHR was not engaged by Mr Lee's death and his family sought to challenge this through judicial review. As well as considering article 2, the decision addressed a novel submission concerning the state's investigative duty under article 8 ECHR.

Background

Dylan Lee was of Romani Gypsy heritage. His family moved into a village and stated that they were subject to abuse and harassment from their neighbours. The alleged behaviour of the neighbours was described as deeply concerning and understandably distressing. Durham Constabulary were involved and had some contact with Mr Lee. At a later date, Mr Lee tragically took his own life.

Mr Lee's family suggested that the neighbours' behaviour and the police response had contributed towards his death and wanted the inquest to consider these matters. However, the Coroner ruled that article 2 was not engaged. As a result, the scope of the inquest did not include the alleged behaviour or the investigations of the Durham Constabulary. Mr Lee's family brought judicial review proceedings to challenge the Coroner's decision.

Article 2

HHJ Klein, sitting as a High Court Judge, briefly considered the law in relation to article 2. The key principles are as follows:

1. Where there is an arguable breach of article 2 then, under s.5(2) of the Coroners and Justice Act 2009, the question of how the deceased came by his or her death includes ascertaining in what circumstances the death occurred. Arguable is a low threshold which means anything more than fanciful ***(R (AP) v HM Coroner for Worcestershire*** [2011] EWHC 1453 (Admin);
2. The judge considered the operational duty under article 2, noting that: *"Durham Constabulary will only have had an operational duty if it knew, or ought to have known, of a real (that is, a not remote or fanciful) and immediate (that is, present and continuing) risk to Dylan's life from the conduct of the neighbours.*
3. The judge also cited the decision of the Divisional Court in ***R (Skelton & anor) v West Sussex Senior Coroner*** [2020] EWHC 2813 (Admin); [2021] QB 525. When carrying out a judicial review of a Coroner's decision on article 2, the court had to ask itself the same question as the Coroner: whether the arguability threshold had been reached. The court should therefore carry out its own examination of the merits and consider whether the Coroner was right or wrong (§91-93). It should not apply the ***Wednesbury*** reasonableness test.

The judge refused permission to bring judicial review proceedings. On the facts, he concluded that there was nothing in the interactions between Durham Constabulary and Mr Lee that ought to have put the police on notice that Mr Lee's life might be at risk. Mr Lee had reported, during both encounters, that he was okay and had not raised any serious issues. The judge noted evidence that Mr Lee was upset about the treatment he received from his neighbours but this did not suggest a risk to his life. The behaviour by the neighbours, in of itself, did not engage article 2 because the neighbours were not a public authority.

The decision emphasises that mere contact with authorities in the run up to a death is not sufficient. A Coroner must consider the nature of that contact and whether the authorities should have appreciated any risk to life arising out of their encounters with the deceased.

Article 8

Mr Lee's family advanced a novel ground, suggesting that the state had an investigative duty under article 8, that Mr Lee's rights under article 8 had been breached and therefore the Coroner should investigate the actions of his neighbours and the police. The Coroner noted that there was no authority to suggest that this investigative duty fell on a Coroner. He noted that it was not a function of an inquest to investigate a breach of a person's right to a private and family life. In contrast, he noted the explicit duties that a Coroner must meet under s.5 of the Coroners and Justice Act 2009. He concluded that an inquest is not an appropriate forum to investigate the complaint that, in making decisions, Durham Constabulary breached article 8. The judge noted that, instead, there was the procedure for making complaints against the police. The ambit of article 8 is a wide one and it is easy to foresee cases in which a breach of article 8 may be suggested from the background facts. However, the decision illustrates that this is not a matter for the Coroner's court.

HM Coroner for West Sussex v The Chief Constable of Sussex Police and ors [2022] EWHC 215 (QB) – Coroners Shouldn't Re-invent the Wheel

David R White

The Divisional Court has restated what is expected of the coroner in a case where an independent body has already investigated a matter within its expertise in *HM Coroner for West Sussex v The Chief Constable of Sussex Police and ors* [2022] EWHC 215 (QB). The Court reemphasised that it is generally inappropriate for coroners to reinvestigate in cases where such an examination has already been carried out, save in very limited prescribed circumstances (*where there is 'credible evidence that the investigation... is incomplete, flawed or deficient'*).

The Court also reiterated the importance of the protections afforded to material obtained by the Air Accidents Investigation Branch ("AAIB") in the course of its investigations, and refused the Coroner's application for disclosure of the materials sought.

Facts

On 22 August 2015, a Hawker Hunter G-BXFI crashed into the A27 Shoreham Bypass whilst the pilot, Andy Hill, was attempting to perform at the RAFA Shoreham Airshow. The crash tragically killed eleven men on the ground, and injured a further 13 people, though the pilot survived.

The substantive inquest hearings touching on these deaths have been subject to significant delays for a number of reasons, including the criminal prosecution of the pilot (who was ultimately acquitted of gross negligence manslaughter), and due to the restrictions imposed as a result of the SARS-CoV-2 pandemic. However, HM Senior Coroner for West Sussex is now progressing matters towards the final hearings.

It has been suggested that a possible explanation for the pilot's actions on the day in question is that he was suffering from some form of cognitive impairment as a result of 'G' forces experienced during flight. That issue, amongst many others, was investigated by the AAIB, who found that the evidence did not support such a contention.

In September 2020, Mr Hill presented to the Coroner a report from a Dr Mitchell postulating a possible theory suggesting that cognitive impairment *may* have been suffered. Dr Mitchell acknowledged that he was a friend of Mr Hill, and a paediatric oncologist with no expertise in aviation medicine or neurology.

Subsequently, the Coroner applied to the Divisional Court seeking an order for disclosure of certain protected materials:

i. The *Go-Pro* camera footage recorded by Mr Hill during the accident flight, and on another occasion;
ii. Expert reports used at the criminal trial;
iii. Transcripts of evidence from the criminal trial.

The Coroner's application to the court was presented on the basis that Dr Mitchell's report presented a credible *suggestion* that the AAIB's investigation was incomplete (though the Coroner accepted that it did not amount to *evidence* of the same), and that as a result the Coroner needed the requested material in order to assess whether the AAIB's investigation was in fact incomplete.

Analysis

The Court dismissed the application in full and in clear terms. The Court referred to the domestic and international legislative framework that restricts the disclosure of the requested items, and stressed the importance of protecting such materials, in particular in order to ensure the efficiency and effectiveness of future AAIB investigations.

The Court further re-emphasised the words of Singh J and Lord Thomas CJ (as each of them then was) in ***R (Secretary of State for Transport) v HM Senior***

Coroner for Norfolk and anor [2016] EWHC 2279 (commonly known as the '***Norfolk***' case), in particular:

> *'I can see no good reason why Parliament should have intended to enact a legislative scheme which would have the effect of requiring or permitting the Coroner to go over the same ground again when she is not an expert in the field.'*

and,

'...a coroner conducting an inquest into a death which occurred in an aircraft accident, should not consider it necessary to investigate again the matters covered...by the independent investigation of the AAIB...The coroner would comply sufficiently with the duties of the coroner by treating the findings and conclusions of the report of the independent body as the evidence as to the cause of the accident. There may be occasions where the AAIB inspector will be asked to give some short supplementary evidence...However, where there is no credible evidence that the investigation is incomplete, flawed or deficient, the findings and conclusions should not be reopened.'

Dame Sharp P, giving the Judgment of the court, noted that in the Shoreham case the AAIB report *'shows there was a comprehensive investigation'* determining the causes of the accident, including consideration of the question of 'G'-related impairment. The balancing exercise that the Court had to conduct in considering the application for the release of protected material could not lie in favour of release for the purposes of allowing the Coroner to consider a re-investigation. *'The starting point is...that there is no public interest in reinvestigation...'*, and material could only be considered for release to allow further investigation where *'...there is credible evidence that the AAIB's investigation is incomplete, flawed or deficient'* (emphasis in the original), and not on the speculative basis of determining whether there might be evidence of such. *This was a 'strict requirement' and an 'important control mechanism'.*

Significantly, *'...it was not intended that, on a topic of complexity and technical difficulty, where different experts hold different views...that a coroner...would need to seek a range of independent expert opinion... in order to test whether the AAIB's conclusions were correct or incomplete. Rather, the Coroner should "rely on the conclusion of the body with the greatest expertise in a particular area"'.*

There was no basis for the suggestion that the Norfolk test was two stage, and a coroner should be '*very slow to find credible evidence that an expert investigation was incomplete, flawed or deficient.*' As a final point, it is of note that the court did not accept the submission that the law on the standard of proof in inquests as articulated in ***R (Maughan) v HM Senior Coroner for Oxfordshire*** [2020] UKSC 46 made any difference to the approach to be taken to the Norfolk issues.

Conclusion

The position for coroners handling inquests where an independent body, with relevant expertise, has already issued a report in relation to a death should now be clear. Unless there is credible evidence that the body's investigation was incomplete, flawed or deficient, the conclusions of the report should be accepted as the evidence on the relevant points in the inquest, even if it is possible, or likely, that alternative experts might take a different view and might have reached different conclusions. Any evidence of incompleteness, flaws or deficiencies should already be in existence if reinvestigation is to be considered, and it would appear that the Divisional Court does not think it is for coroners to go looking for such evidence if it is not already apparent.

Whilst this decision will no doubt disappoint some families, who may feel that they are not able to have the direct input they might like into relevant findings, it provides certainty and avoids the potential for multiple inconsistent decisions. It also allows coroners to focus their resources on cases where there is no other suitable route of investigation available to families. Argument is bound to follow, however, concerning the types of report to which this approach applies.

R (Bilski) v HM Coroner for Inner West London [2021] EWHC 3339 (Admin)

Andrew O'Connor QC

This short permission decision (in which permission to apply for judicial review was refused) is an interesting re-affirmation of *Jamieson* principles in the field of hospital deaths.

The deceased had presented as an emergency case at hospital, and had died later the same day from a sub-arachnoid haemorrhage.

A month before her death the deceased had been diagnosed with a carotid aneurysm at the same hospital, but had been released with a non-urgent outpatient appointment.

The coroner heard evidence at the inquest, including from an expert neurosurgeon, relating to the earlier treatment. She concluded that the decision to discharge the deceased for a follow-up appointment in relation to the aneurysm was a proper one.

There were two grounds of challenge. The theme of both was that the diagnosis of the aneurysm should have played a more significant role in the inquest. The first ground was that the earlier diagnosis of the aneurysm should have been mentioned in Box 3 of the Record of Inquisition. The second ground was that the coroner should have adjourned the inquest to permit the instruction of an expert in vascular neurosurgery, who would have been better placed to comment on the aneurysm than the neurosurgeon already instructed. Whipple J refused permission on both grounds. Her core reasoning was that the history of the aneurysm was part of the background facts only – *"it did not explain 'how' the deceased came by her death for the purposes of this inquest."*

R (Ginn) v HM Senior Coroner for Inner London [2022] EWHC 28 (Admin)

Dominic Adamson QC

On 5 November 2018, Mr Robert Ginn entered HMP Pentonville, having been sentenced to one year's imprisonment for offences relating to indecent images. Three weeks later, he was found in his cell hanging by a ligature, having taken his own life.

An inquest was opened in December 2018. The hearing took place in October 2019. It was common ground that it was an article 2/*Middleton*-type inquest. The jury was directed to deliver a narrative conclusion. The jury concluded that the cause of death was suicide by hanging and a contributory factor was chronic depression. None of this was controversial.

The jury made no reference to the care he received whilst in prison which was the deceased family's central concern. Accordingly, they contended that the investigatory requirement of the state's obligation under article 2 had not been satisfied and sought judicial review.

The Coroners and Justice Act 2009

A Coroner is under a statutory obligation to conduct an investigation into a death in custody (see s.1(2)(c)). Where there is reason to suspect the deceased died a violent and unnatural death whilst in custody an inquest has to be held with a jury (s.7(2)(c)).

The Act also provides the following:-

- s.5(1)(a) and (b) requires the investigation to ascertain who the deceased was and how, when and where he/she came by his/her death.
- s.5(2) requires s.5(1)(b) to be read as including in what circumstances the deceased came by his/her death where it is necessary to avoid a breach of any Convention Rights.
- s.10 requires the senior coroner or the jury to make a determination of the questions in s.5(1)(a) and (b) read with s.5(2) where applicable.

Thus, in order to satisfy the procedural/investigatory requirement of article 2, these provisions ordinarily require a ***Middleton***-type inquest to culminate in an expression, however brief, of the jury's conclusion on the disputed factual issues at the heart of the case.

The Facts

Mr Ginn had a significant history of mental health problems. He had diagnoses of a recurrent depressive disorder and an emotionally unstable personality disorder. He had made suicide attempts in the past.

During his secondary screening on 6 November 2018, the day after he was sentenced, Mr Ginn said he had thoughts of suicide. An Assessment, Care in Custody and Teamwork ("ACCT") plan was opened that morning. The first ACCT review took place the same day. He said that he had experienced "suicidal ideology" for a long time. The risk of harm he posed towards himself was assessed as "raised". The immediate action plan involved hourly observations, three conversations a day and remaining in a double cell. The next ACCT review was set for 12 November.

Over the next 3 weeks, he was subject to a further 3 ACCT reviews. The primary care mental health care team did not attend at any of them. Following the second ACCT on 12 November 2017, the observation and conversation frequency were reduced because it was thought Mr Ginn was in a better place and risk was assessed as low.

Mr Ginn suffered from sleep apnoea and needed a Continuous Positive Airway Pressure (CPAP) machine to sleep. The machine was brought in on 18 November 2018. It was very noisy and he was moved to a single cell on 20 November. On the same day, Mr Ginn was seen by a Health and Wellbeing worker who found him to be suffering from severe depression. He said he had plans to take his life.

On 26 November a prison officer recorded that he said he had suicidal thoughts. At the fourth ACCT review Mr Ginn would not say if he had plans to kill himself. The risk was again assessed at low.

On 28 November Mr Ginn was identified as being in a very bad way. He said he had nothing to live for and felt it would be better if he was dead. On 29 November 2018 he was found hanging. An attempt to resuscitate him was unsuccessful. It was admitted that the attempt to resuscitate was inadequate.

The Coroner's Summing Up and Directions

The Coroner concluded that it would be unsafe to leave the jury to consider admitted failures in the resuscitation attempt because there was no realistic possibility that the outcome was affected. The failures would be dealt with by way of a Prevention of Future Death (PFD) Report.

With respect to the care Mr Ginn received in prison, the family provided a list of issues which they considered the jury should consider and comment upon in order that it could fulfil its role and discharge the investigatory requirement of article 2. They included, but were not limited to, the adequacy of risk assessment, the ACCT procedures, observation levels, communication between prison staff and mental health professionals, steps taken on 28 November, training of staff. It was not disputed that these were central issues in the case.

It was also common ground that a narrative conclusion was appropriate. The Coroner directed the jury accordingly. But the Coroner chose not to give the jury any written directions, or to pose questions in a questionnaire, or to give them a list of issues to consider.

Having instructed the jury that they must decide whether Mr Ginn hanged himself, the Coroner addressed the care issues in the following way:

"*But if you want to , you can go on further and you may wish to talk about some of the other events, some of the events which led up to this, particularly in terms of the care he received in prison.*"

As noted, above, the jury did not address the care he received at all.

The Challenge

The claimant's principal argument on ground was that the Coroner's directions failed to elicit the jury's conclusions on the central factual issues at the inquest and, consequently, failed to comply with the procedural requirements of article 2. This was not a case where there was any doubt that Mr Ginn took his own life and there was plentiful evidence of suicidal ideation.

The claimant also challenged the decision to withdraw the resuscitation issue from the jury. It was contended that the Coroner had erred in not directing the jury to record the admitted failures under the '***Tainton***' principle (see ***R (Tainton) v HM Senior Coroner for Preston and West Lancashire*** [2016] EWHC 1396 (Admin)).

The Analysis and Decision

Steyn J set out the statutory framework and noted that rule 33 of the Coroners (Inquests) Rules 2013 requires the coroner to direct the jury as to the law and provide it with a summary of the evidence.

She also referred to the Chief Coroner's Guidance No. 17 which concerns *'Conclusions: Short-Form and Narrative'*. The 2016 version of that Guidance applicable at the time of the Inquest advised coroners in more complex cases to invite submissions on what written directions should be given to the jury and what questions if any may be asked of them. No written directions were given.

Steyn J. rejected the MoJ's argument that the 2016 Guidance was inapplicable because this was not a complex inquest. Evidence regarding numerous arguably contributory issues was heard. Moreover, the jury had to be directed not only as to the standard of proof required to prove causation of death but also the threshold for causation of death. The concept that a fact or circumstance which more than minimally, negligibly or trivially contributes to the death meets the threshold for causation was not simple.

It would have been advisable to give written directions. Where nothing is provided to the jury in writing, whether in the form of written directions or a questionnaire, errors are liable to occur.

The jury were required to make a determination, inter alia, as to the circumstances in which Mr Ginn came by his death: see s.10(1)(a) of the 2009 Act. They were required to determine whether the core issues which the inquest raised caused or contributed to Mr Ginn's death. And they were required to record in their narrative any facts or circumstances that they determined caused or contributed to his death.

Whilst the Coroner had made clear that there were certain matters it had to determine (e.g. they had to answer the question whether Mr Ginn died by suicide) he had directed the jury that they could, if they wished, include in their narrative reference to some of the other events in the lead up to his death, particularly his care in prison.

The directions would have given the jury the clear impression that there was no need for them to make any determination in respect of any of the central issues canvassed in evidence. As she observed *"There is a vital distinction between telling a jury that they must consider certain identified matters and giving them the option to address them"*. Steyn J. referred to the decision of Maurice Kay LJ in ***R (P) v HM Coroner for the District of Avon*** **[2009] EWCA Civ 1367** who observed that it would not be surprising if a jury, having to navigate *"confusing waters "* opts for the *"the simplest solution".*

Accordingly, Steyn J. rejected the MoJ's contention that one could infer that the jury concluded that care issues were not causative because they were not recorded. It was simply not possible to say in the light of the directions.

Thus, the inquest had failed to discharge the state's investigative function under article 2. It was necessary to order a fresh inquest because the Judge was not in a position to make findings on the central issues. Her judgment could not fill the gap left by the misdirection. Nor could the PFD report because it did not address the central issues.

As for the withdrawal of the resuscitation issue, the Coroner's decision was beyond reproach. Unlike in ***Tainton***, where there was no PFD report, the inadequacy of the resuscitation was adequately addressed by the PFD report. It could not sensibly be suggested that a detailed published PFD Report addressing a failure which did not contribute to the death was inadequate to meet the state's article 2 obligation in relation to those failures.

Takeaways from Ginn

First, it is imperative that a jury is appropriately directed with regard to their responsibility to consider the central issues. The jury must understand their obligation to consider the central issues, and where appropriate, record causative failures.

Second, the safest means of ensuring that the central issues are appropriately considered, is by way of clear written directions. The benefits are obvious: a jury can revisit them after they have retired, without having to rely on their memory or notes.

Third, it will be rare for written directions not to be given to a jury. The 2021 version of Guidance No.17 states it is good practice for the coroner to give the jury a copy of the directions of law. It does not limit that advice to complex cases.

Fourth, it is questionable whether non-causative failures which can be dealt with by way of a PFD report should ever be left to a jury to consider. Given that their task is to determine how the deceased came by their death, it is an inappropriate and unnecessary distraction.

Death certification: (nearly) back to the old rules. But far from business as usual

Nicholas Moss QC

Coroners rarely miss the opportunity to remind us that the in–court inquest work is merely the tip of the coronial iceberg. Understandably so. Unseen to many inquest practitioners is the daily referrals of deaths that need both judicial decisions and the requisite documents signed (100A's; 100B's; post-mortem authorisations; homicides, RTAs, health and safety, or child deaths where the police want an early word; bodies being repatriated to the UK; bodies to be moved out of the country; organ transplants etc.). To that list can be added the management responsibility for coroner's officers and administrative support staff, for the court facilities, the budget from the local authority, correspondence and calls from the disgruntled (and sometimes the grateful), monitoring mortuary space, liaison with medical examiners, not forgetting that if a mass fatality were to occur in their area, the coroner has a key role to play in any response, a duty that applies 24/7/365. Given such wide and complex demands, it is mystifying that it took so long to recognise that the complexities of the modern coronial role equated to that of Circuit Judges. The challenge of managing this on top of Covid has been an enormous challenge for all coroner areas.

This article focuses on just one practical but important facet of the non-inquest pressures on coroners. It is easy to remain blissfully ignorant of quite how problematic and time consuming it is for coroners and their officers to identify medical practitioners who can appropriately sign the medical certificate as to cause of death (MCCD) in cases where it is plain that the death has been entirely natural.

Pre-Covid the position was effectively as follows. An attending registered medical practitioner had a legal responsibility to complete a MCCD and arrange for the delivery of it to the relevant registrar as soon as possible to enable the registration of the death to take place. However the duty arose only if the registered medical practitioner:

1. Was able state the cause of death to the best of their knowledge and belief;
2. Was satisfied that the death did not need to be notified to the Coroner under Regulation 3 of the Notification of Deaths Regulations 2019.
3. Had attended the deceased in their last illness; and
4. Either:
   i had seen the deceased after death; or
   ii had seen the deceased in the 14 days* prior to the death

If these conditions were met, the attending medical practitioner was under a duty to sign the MCCD; the Coroner did not need to be notified; and the Registrar could register the death relying on the practitioner's MCCD.

Additionally, if conditions (1) – (3) were met but the registered medical practitioner had not seen the deceased after death or in the 14 days* prior to death, that doctor could sign the MCCD and refer the death to the Coroner. Provided that the Coroner was satisfied that the duty to investigate under section 1 Coroners and Justice Act 2009 was not engaged, the Coroner would then report to the Registrar on a signed Form 100A, certifying to the registrar that no post mortem had been held but that the Coroner was not required to investigate and the death could be registered accordingly.

(*The "14 day rule" had a statutory basis but a slightly indirect one. Regulation 41 of The Registration of Birth and Death Regulations 1987 required the Registrar to refer a death to the Coroner if it appeared that the registered medical practitioner who had signed the MCCD had not seen the deceased either after death or in the 14 days prior to death. In common parlance, the death would have been "bounced" by the Registrar and referred to the Coroner in such circumstances. To avoid this, doctors would instead sign the MCCD but refer to the case to the coroner for support under a form 100A. This avoided families attending to register their loved one's death only to be told that the case needed to be referred to the coroner.)

Even pre-covid, all of this meant that, for natural causes deaths in the community a good deal of coroner's officers' time would be spent in trying to find a medical practitioner who could appropriately sign an MCCD. These were not, and are not, technicalities. They were and remain an important everyday part of the coroner's workload. And they significantly affect bereaved families. If no doctor can be identified who can sign an MCCD, traditionally at least, the main alternative was to order a post mortem: sometimes necessary but often not desirable. Thus, in appropriate cases, coroner's officers would work hard on the 'phones and emails to try to find a doctor who could appropriately sign an MCCD.

During the pandemic, these rules were radically altered under the emergency Coronavirus Act 2020. With far fewer patients being seen in person by GPs, excess mortality, and huge strains on all relevant services, it was seen as both necessary and expedient to relax the rules (retaining some protections) so that the coronial services (and others) were not overwhelmed by deaths that could not be certified and registered. The core emergency provisions were essentially that any doctor who knew the cause of death could sign the MCCD, provided that *any* doctor (and it did not need to be the doctor signing the MCCD) had seen the deceased (including by videolink) in the 28 days before death or seen the deceased (in person) after the death.

Post-pandemic, from midnight on 24 March 2022, the relevant parts of the emergency legislation ceased to have effect and – with one significant change – the law has reverted to the pre-pandemic position.

The change is that the 14 day provision has been permanently changed to 28 days (see Reg. 2(11) of the Registration of Births and Deaths (Amendment) (England and Wales) Regulations 2021 [**https://www.legislation.gov.uk/uksi/2021/1436/made**], substituting 28 days for 14 days into the wording of the Reg. 41 of the 1987 Regulations).

But this change aside, the key point is that we are back to the position whereby the doctor signing the MCCD needs to have attended the deceased in their last illness and either seen them in the 28 days prior to death (including by videolink) or seen them (in person) after death.

In practice, however, it is very far from 'business as usual'. Anecdotally, it is widely reported there are fewer cases where doctors (most typically it is GPs) meet all of the MCCD requirements: either they have not attended the deceased at all in their last illness or have not seen them in the 28 days prior to death or after death). There is no obligation on a GP to attend on their patients after death; they are not required to attend merely to verify the fact of death.

Cases where it is difficult or impossible to identify practitioners who can complete MCCDs in natural death cases add significant pressure to the coroners service. The immediate and obvious risk is that it will give rise to more post mortems, with the attendant distress for families. That in turn may place further pressure on pathology services leading to longer lead times for PMs to be conducted, thereby further adding to distress of bereaved families; for not only may a PM required, but it will take longer to be done.

Post mortems are not the only alternative if no one can sign an MCCD. In appropriate cases, where a short medical report can attest to the cause of death but the practitioner does not meet the requirements to sign an MCCD, a paper inquest may potentially be quicker and less distressing for the family than a post mortem. But paper inquests are not a panacea, not least because, even if simple in form, there is an unavoidable administrative burden in their preparation.

It is also possible to have an uncertified death. To quote from the current ONS guidance, *"...a doctor who has not been directly involved in the patient's care at any time during the illness from which they died cannot certify under current legislation but should provide*

the coroner with any information that may help to determine the cause of death. The coroner may then provide this information to the registrar of deaths. It will be used for mortality statistics, but the death will be legally "uncertified" if the coroner does not investigate through an autopsy, an inquest, or both. While this option remains one that is technically available in individual cases, it is hardly desirable that there should be an increase in the numbers of death that are uncertified by the Registrars.

The reality, therefore, is that medical practitioners and coroners alike are having to adjust to the quite sudden return to the pre-Covid rules. The change to 28 days may have mitigated some of the impacts but significant challenges certainly remain. In the meantime, in addition to familiarising/re-training staff in all relevant service areas on the (slightly adjusted) "old rules", there is debate concerning:

- the meaning of "attended" (which is not legally defined);
- the use of, respectively, more PMs, more paper inquests or more uncertified deaths;
- whether it is ever appropriate for an MCCD to be offered if the practitioner did not attend the deceased in their last illness. On this latter point, the NHS guidance is admirably clear: *"In all cases, without exception, only a medical practitioner who has attended the deceased for their last illness, and can state the cause of death to the best of their knowledge and belief, will be allowed to complete a MCCD".* However this guidance has not been uniformly accepted. Some are seeking to hold to the dissenting view that it is not in fact prohibited for a medical practitioner to offer an MCCD even if they did not attend during the deceased's last illness.

Useful reference material

1. **Chief Coroner's Guidance 34** (re-revised 5 April 2022) https://www.judiciary.uk/wp-content/uploads/2022/04/Guidance-No-34-Chief-Coroners-Guidance-for-coroners-on-COVID-19.pdf
2. **Death certification processes**: information for medical practitioners after the Coronavirus Act 2020 expires (NHS Guidance C1566) https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/03/C1566-information-for-medical-practitioners-after-the-coronavirus-act-2020-expires-march-2022.pdf
3. **ONS Guidance for doctors completing Medical Certificates of Cause of Death in England and Wales**: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1062236/Guidance_for_Doctors_completing_medical_certificates_Mar_22.pdf
4. **Cremation Forms** (Not covered in the article above but see: The Cremation (England and Wales) Regulations 2008 Guidance to medical practitioners completing form Cremation https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1062509/medical-practitioners-completing-form-cremation-4-25-march-2022.pdf

Inquest into the death of Emiliano Sala

Keith Morton QC

Emiliano Sala was a professional footballer. On 21 January 2019 he died when the Piper Malibu single engine aircraft registration N264DB in which he was a passenger was flown at night in poor weather and crashed into the sea 22 nautical miles north north west of Guernsey. He was aged 28. His body was recovered from the seabed on 6 February 2019 and transferred to Portland Port in Dorset. The body of the pilot was not recovered.

The investigation into the crash, the operation of that and other flights and the circumstances in which Mr Sala came to be a passenger fell within the concurrent jurisdictions of the Dorset Police, the Air Accident Investigation Branch ("AAIB"), the Civil Aviation Authority ("CAA") and, in respect of Mr Sala, the Senior Coroner for the County of Dorset.[1]

Dorset Police investigated possible homicide offences but did not seek any charging decision from the CPS. The CAA investigated the arrangements of the accident and other related flights. The CAA prosecuted the operator of those flights for offences under the Air Navigation Order 2016. The offences related to the legality of the flights and endangering the safety of the aircraft. The operator pleaded guilty to one offence and was convicted by a jury of the other. On 12 November 2021 Foxton J sentenced him to 18 months' imprisonment. The AAIB conducted its investigation in accordance with the statutory scheme under which it operates. The AAIB produced a detailed report.[1]

In brief summary:

1. The offences which were prosecuted are risk based. It was not, therefore, part of the criminal prosecution that the breaches caused the accident;
2. The criminal proceedings established that the accident flight was a commercial flight but was not operated in accordance with the regulatory requirements for such flights in a number of respects including: the pilot did not hold a commercial pilot license, he was not qualified to fly at night and the aircraft was not operated or maintained in the manner required for commercial use;
3. Analysis of one of two very small blood samples retrieved by the pathologist from Mr Sala revealed a high level of carbon monoxide ("CO") at 58% saturation (a level likely to result in unconsciousness). That could only have been present in such concentration if it entered the aircraft cabin from the engine exhaust;
4. The AAIB's conclusions as to the cause of the accident included that the pilot was probably affected by CO and that his loss of control of the aircraft was more likely because the flight was not conducted in accordance with safety standards applicable to a commercial flights.

An Inquest was held before the Senior Coroner and a jury over 4 weeks concluding on 17 March 2022. In the course of the inquest new evidence emerged which appeared to suggest the levels of CO in Mr Sala's blood were very much lower than that relied upon by the Police and the AAIB. The Coroner took care to explore this issue fully. In the event the original level of CO was found to be reliable. The jury heard evidence from witnesses including the pathologist, toxicologist, the operator of the flight (remotely, from prison), the arranger of the flight and from a number of AAIB inspectors.

Legally the inquest is of interest because in addition to the legal principles applicable in all cases the Senior Coroner had to wrestle with the practical application of two further legal principles: The Inconsistency Principle and the ***Norfolk*** Principle.

The Inconsistency Principle

The determination made under section 10(1)(a) of the CJA 2009 may not be inconsistent with the outcome of criminal proceedings: see CJA Schedule 1 paragraph 8(5) and ***R (Skelton and another) v West Sussex Senior Coroner* [2021] QB 525**. In Skelton the Divisional Court explained this was a principle of wide application even where the precise criteria of Schedule 1 are not met. The Court's decision and reasoning is summarised in the headnote as follows:

> *"… any investigation into whether the claimants' daughter had died otherwise than as the result of an unlawful killing would constitute a collateral attack on T's conviction and be contrary to the public policy that, if a fact in issue had been established to the requisite standard of proof in a criminal trial, it would be offensive to the administration of justice and the rule of law for the same issue to be re-litigated in any forum other than through the prescribed route of appeal …"*

The significance of this was that jury were directed that they could make findings about the operator of the aircraft and the arranger of the flight (both of whom gave evidence) but they must not be inconsistent with the outcome of the criminal proceedings (that is to say both the convictions and the factual basis of the convictions). This necessarily meant that the jury was bound to reject aspects of the oral evidence it had heard. This was achieved by providing the jury with careful written directions, the trial indictment, the sentencing remarks of Foxton J and a list of factual findings from those proceedings with which the inquest jury's findings had to be consistent.

The *Norfolk* Principle

***R (on the application of the Secretary of State) v Her Majesty's Senior Coroner for Norfolk* [2016] EWHC 2279 (Admin)**, considered and followed in Her Majesty's Senior Coroner for ***West Sussex v Chief Constable of Sussex Police, Secretary of State for Transport and others* [2022] EWHC 215 (QB)** establishes the following principles (references are to the judgement of Lord Thomas CJ in Norfolk):

1. The AAIB[3] *"as an independent state entity, has the greatest expertise in determining the cause of an aircraft crash …"* (para 56);
2. In the absence of *"credible evidence"* that the AAIB's investigation is *"incomplete, flawed or deficient"* a Coroner should not investigate again the matters covered by the AAIB's investigation (para 56);
3. The coroner (and jury) *"would comply sufficiently with the duties of the coroner by treating the findings and conclusions of the report of the independent body as the evidence as to the cause of the accident"* (para 57).

This is the second high profile inquest in which the principle has been applied (the first was the Corydon Tram Inquest: see the 2nd Edition of the TGC Inquests and Inquiries Newsletter) but the first in which a coroner has had to grapple with emerging evidence (relating to the blood samples and levels of CO) which had the potential to contradict the findings of the AAIB (and cause the police to review their position). This is a further illustration of the way in which the specialist AAIB investigation may impact upon an inquest. In the event this did not happen, but had it done so it would almost certainly have derailed the inquest either because it would have caused the AAIB to conclude there was *"new and significant"* evidence requiring the Chief Inspector to reopen the AAIB investigation[2] and/or the police to reopen their homicide investigation. In either case it is hard to see how the inquest could have continued.

The Coroner provided detailed written directions to the jury which enabled them to navigate the obligation to accept the AAIB's findings as to the cause of the crash while also leaving the jury free to make findings on matters which did not form part of the AAIB investigation which the jury may conclude were causative. This was achieved by providing the jury with a summary of the AAIB's conclusions and examples of further issues the jury may conclude were causative. The jury completed Box 3 with detailed findings of fact and Box 4 with a short narrative conclusion as to the cause of death which demonstrated the jury had carefully followed the directions.

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1. And the Rail Accident Investigation Branch and Marine Accident Investigation Branch
2. Regulation 18 of the Civil Aviation (Investigation of Air Accidents and Incidents) Regulations 2018/321

R(Boyce) v Teeside and Hartlepool Senior Coroner [2022] EWHC 107 (Admin)

Benjamin Seifert

In light of the death of her daughter Grace, whilst in a care home, the Claimant, Kelly Anne Boyce, sought judicial review of a decision of the Teeside and Hartlepool Senior Coroner to refuse to direct that the inquest into her death be an enhanced investigation under Article 2 of the European Convention on Human Rights ("ECHR").

The challenge was on the basis that, as a child in the care of the local authority her position was the same as that of a person who had committed suicide whilst in state detention and this would automatically trigger an Article 2 inquest. The second ground was that the Coroner had erred in concluding that, on the available material, there was no arguable case of a breach of Article 2 ECHR and, thirdly, that the Coroner had erred in concluding that the only material difference in the inquest not being held in accordance with Article 2 ECHR was in relation to the conclusions which could be returned as opposed to the scope of the inquest.

The Court rejected the claim but provided a useful analysis of the law in relation to these fundamental points of coronial law.

Facts

Grace died on 10 September 2018 at the age of 15 while she was under the care of Middlesborough Borough Council which had placed her at Farm House, a private care home operated by Tees Valley Care Ltd. In February 2017 she was made subject to a care order and was initially placed in her grandmother's care but after a further, unsuccessful, placement, in June 2018 she was placed at Farm House. On 5 September 2018 she started her new school year. She had dyed her hair purple and, after a confrontation with staff at the school, she was excluded. At a reintegration meeting, two days later, she was abusive and then excluded again. On 10 September she was found hanging from a scarf in the shower cubicle of her room at Farm House.

In the weeks before her death she had been subject to a number of psychological questionnaire tests so that her risk management and care planning could properly be addressed. On 30 August 2018 the professionals did not note any mental health disorder or self-harm ideation. None of the individuals with responsibility for Grace's care believed that she presented with a suicide risk. The day before her death it was reported that she was in a positive mood. The following day there was no answer to a knock on the door at around 9 am and staff decided not to disturb her but only at 12:20 was a decision made to unlock the door and she was found hanging. After her death Farm House was subject to Ofsted inspections which expressed criticisms of management. The reports stated that the standard of care was generally inadequate.

The Coroner's directions

The Coroner ruled on 1 July 2019 that there was insufficient evidence that there had been a real and immediate risk to Grace's life and therefore there was no breach of the operational duty under Article 2. However the Coroner did say that she would consider if there were flaws in higher level systems which gave rise to an arguable breach of the Article 2 general duty of the state. She addressed whether or not Farm House was an appropriate venue for Grace. She considered expert evidence from a consultant in Child and Adolescent Psychiatry and then, in her decision, accepted that there were issues with the systems and procedures operated by the social services department and Farm House. However she did not find that it was even arguable that there was a real and substantial chance that improved systems and procedures could have saved the deceased's life on account of the level of care she had received at Farm House. She ruled that she would not conduct an inquest with the enhanced procedural obligation of Article 2 ECHR.

The Grounds of review

Ground 1

This Ground concerned the submission that a child in the care of a local authority is in the same position as someone who is in state detention and because the inquest into the death of someone who committed suicide in state detention automatically attracts an Article 2 inquest it is therefore the case that this case should have had the same legal parameters.

The Court considered the leading case of ***(R)Morahan v West London Assistant Coroner*** [2021] EWHC 1603 **(Admin)** where the Divisional Court considered the enhanced investigative duty under Article 2.

However the Court found that there was an obvious difference between exercising a statutory power to take a child into care in order to protect her and whether or not, once in care, she would be said to be detained. There was furthermore a difference between a child in secure accommodation who has been deprived of her liberty and, on the other hand, a child in care, such as Grace, who is free to come and go even if she had left the home the police would have been called. The Claimant's submission that Grace was living in a "gilded cage" was rejected. It was a matter of substance over form. There was no automatic enhanced investigation inquest pursuant to Article 2 ECHR simply because Grace was a child in care who took her own life.

Furthermore the Court concluded that even if it had considered that Grace was deprived of her liberty and/or detained at Farm House it would still not be pursuant to any action by the state and therefore Article 2 could not be engaged because Farm House was a private organisation.

Ground 2

The Claimant argued that the Coroner was wrong to conclude that there was not an arguable case of a breach of the Article 2 duty in relation to Grace's death. Here counsel for the interested parties accepted that there had been systemic failings. The Coroner concluded that there was no causal link between any failings and a failure to protect Grace's life, given the care and support she had received at Farm House. Furthermore the Coroner was not wrong to conclude that it was unarguable to submit that improved systems and procedures would have presented Grace with a real and substantial chance of survival.

Ground 3

It was argued that there was a difference in scope between an Article 2 inquest (***Middleton***) and a ***Jamieson*** inquest. It was also important to note that a decision that the Article 2 obligation is engaged can alter throughout the course of an inquest. Nevertheless any properly conducted inquest will always consider the circumstances surrounding and events leading to death. The Court observed that the practical solution is for inquests to consider the broad circumstances especially if there is the possibility that Article 2 will become relevant in future. In this way the enquiry should be broad enough to cover the ground for the Coroner or jury to make the necessary conclusions.

Lessons from *Boyce*

a) The requirements for an enhanced investigation under Article 2 are strict and if it cannot be demonstrated that the deceased was deprived of her liberty they do not apply. It also cannot apply if the deceased was not a resident of an organisation which had been given coercive or statutory powers over her.
b) There must be a causal link between any failures and the death in order to find breaches of Article 2 ECHR.
c) There is essentially no difference in scope between a ***Middleton*** and ***Jamieson*** inquest but the coroner can always change her decision and, in any event, the inquiry must permit as broad a conclusion as appropriate.

Inquest into the death of Mrs S – finding of unlawful killing made due to conduct of anaesthetist

Ellen Robertson

Ellen Robertson, led by Ali Naseem Bajwa QC and instructed by Faradays Solicitors, represented the family of Mrs S, a 78-year-old woman, in the inquest into her death following an elective revision total hip replacement operation in September 2018 at the Gateway Centre, a Barts Health NHS Trust surgical centre.

Mrs S was assessed as a suitable candidate to undergo the surgery at the Gateway Centre despite its lack of any critical care facilities and her significant pre-existing morbidities. The Trust conceded that Mrs S was not a suitable candidate for the Gateway Centre. Due to failures in the pre-operative assessment, Mrs S was not given accurate information about the risk of death. During the operation, the surgical team breached the femoral cortex and the operation was extended to allow for the placement of a metal plate. The lead Consultant Surgeon left prior to the conclusion of the operation. Mrs S's blood pressure was dangerously low for lengthy periods, which led to organ failure. Despite the efforts of an intensive care team, Mrs S passed away some hours after the operation ended.

The Acting Senior Coroner found that the Consultant Anaesthetist, despite his decision not to use cardiac output or other monitoring that would have given greater diagnostic information about Mrs S's condition, allowed Mrs S's blood pressure to remain at dangerously low levels for extended periods of time. Further, he failed to appreciate that Mrs S required urgent fluid resuscitation. The Acting Senior Coroner also identified numerous failures of the anaesthetist in the post-operative care, including his decision to leave the Gateway Centre for the day when Mrs S was in a critically unwell condition.

In particular, the Acting Senior Coroner criticised the agreement of the Consultant Anaesthetist to extend surgery despite Mrs S's critically unwell state, and determined that to be an act that amounted to such a truly and exceptionally bad breach of duty, that the test for gross negligence manslaughter was met. He therefore entered a conclusion of unlawful killing.

In addition to the failures by the Consultant Anaesthetist, the Acting Senior Coroner found that there were a number of other failures in the Trust's care, including failures to adequately assess Mrs S's condition in pre-operative checks or to appreciate her serious comorbidities, a failure to use any appropriate pre-operative assessment algorithm, a failure to obtain adequately informed consent, a failure to appreciate that the Gateway Centre was not an appropriate location for the operation and a number of failures in the post-operative care provided to Mrs S.

The Acting Senior Coroner formed the view that the circumstances amounted to a failure in basic medical care by the Trust, which were gross failures and had a clear connection with Mrs S's death. He formed the view that the failures amounted to neglect, but given the findings in relation to the anaesthetist, the appropriate conclusion was one of unlawful killing.

The Acting Senior Coroner has issued a Report to Prevent Future Deaths in relation to the failure of the Trust to utilise any formal risk assessment tool when assessing the pre-operative risk to Mrs S, and the ongoing failure of the Trust to require the use of such a tool. The Report also addressed the poor communication between the orthopaedic surgical team and the anaesthetist, finding that no targeted questions had been asked about Mrs S's condition and that a different outcome may have arisen had such questions been asked. The Report also found that the lead consultant surgeon's decision to leave the surgery early had lengthened the procedure, yet no system was in place to assess whether that decision was appropriate.

In addition to Barts Health NHS Trust, the Report has been sent to the Department for Health and Social Care, the Royal College of Surgeons and the Royal College of Anaesthetists.

Inquest into the death of Mark Marshall (aka Mark Castley)

Sian Reeves

Sian Reeves represented Her Majesty's Courts and Tribunals Service and Her Majesty's Prison and Probation Service in an Article 2 inquest, with a jury, into the death of a defendant who ingested an acidic substance in the dock at court, after having been sentenced to a lengthy prison sentence. Mr Marshall died nearly two months later as a result of multiple organ failure.

Prior to sentencing, Mr Marshall had been on bail, and concealed the acid either on his person or within his belongings when coming into court. The inquest explored the security arrangements at Inner London Crown Court (provided by different private contractors), including on reception and in the dock, and how it was that had been able to conceal the acidic substance. It also explored the role of the Probation Service, and their assessment of self-harm risk in his pre-sentence report.

The jury returned a conclusion of suicide.

The inquest attracted considerable media attention because of the profile and circumstances of the incident.

Inquest into the death of Andriejus Kostiajevas

Richard Boyle

Richard Boyle appeared on behalf of the Ministry of Justice in this article 2 inquest held with a jury at Milton Keynes Coroner's Court. Mr Kostiajevas sadly died while imprisoned at HMP Woodhill. The jury returned a conclusion of suicide. Mr Kostiajevas had a complex medical history and had previously been on an Assessment, Care in Custody and Teamwork ("ACCT"), however he was not on one at the time of his death. The jury found no evidence of any indication of suicidal or self-harm thoughts and noted that, although Mr Kostiajevas had limited English, he would have been capable of expressing them. There were also issues in relation to the prison's response. The Prisons and Probation Ombudsman had raised issues with the timing of prison staff calling a Code Blue, which summons an ambulance in response to a breathing issue suffered by a prisoner. However, prison staff explained that it had been difficult to see Mr Kostiajevas clearly in his dark cell after he had failed to respond to the roll call. The jury found that prison officers acted promptly upon receiving no response from the prisoner and nothing could be done for Mr Kostiajevas by the time that he was discovered.

Disclaimer

These articles are not to be relied upon as legal advice. The circumstances of each case differ and legal advice specific to the individual case should always be sought.

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