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Issue II November 2021

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 second 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.

Our previous edition, published in March 2021, was published one year on from the first Covid-19 national lockdown, which had a huge impact on inquests and public inquiries alike. At that time, inquests and inquiries were tentatively starting again, albeit with social distancing and additional technology measures. Now many inquests and inquiries are going ahead in person (or with hybrid in person/video link arrangements).

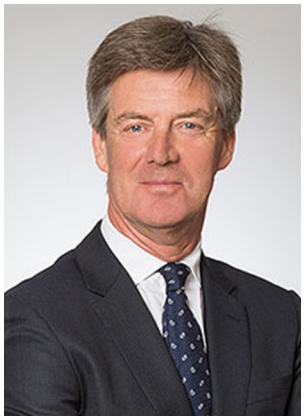
As such, it has been a busy few months for the Inquests and Inquiries team at Temple Garden Chambers. We were delighted to see that our recent work in this area has been rewarded with Chambers being promoted to a Band 1 ranking set for Inquests & Public Inquiries in Chambers and Partners UK Bar Rankings 2022, with a number of individuals being ranked individually, namely Andrew O'Connor QC, Cathryn McGahey QC, David Barr QC, Dominic Adamson QC, Keith Morton QC, Nicholas Moss QC and Fiona Canby. All of these individuals were also ranked in the Legal 500 for Inquests and Inquiries, alongside Sian Reeves. We congratulate all members of the TGC Inquests and Inquiries team on this brilliant news.

In this edition, we provide updates relating to Law Sheet No.1 (which has been updated in light of ***Maughan***), the Coroner's Court competencies and toolkit, and the new Guidance Note 41 concerning Pen Portrait Material. Also on the subject of ***Maughan***, Andrew Prynne QC provides an alternative and forthright perspective in response to Nick Moss QC and Scarlett Milligan's article in the previous edition. Emily Wilsdon explores the case of ***Dove v HM Coroner for Teesside and Hartlepool*** [2021] EWHC 1738 (Admin) and William Irwin considers R. (***on the application of Morahan) v Assistant Coroner for West London*** [2021] EWHC 1603 (Admin). In the inquiries sphere, Andrew O'Connor QC and Piers Taylor provide an insight into Rule 9 Requests.

In terms of recent noteworthy cases that our members have been involved in: Keith Morton QC and Fiona Canby provide an insight into the Croydon Tram Inquests and Richard Boyle reflects on the Fishmongers' Hall Inquests.

We hope that this edition will be a useful resource for you.

Nicholas Moss QC and Harriet Wakeman



Maughan Revisited

Andrew Prynne QC

Maughan[1] was a judicial review concerning the decision of the Oxfordshire Coroner sitting with a jury. The jury was directed that the evidence was insufficient for them to be sure that the deceased took his own life with the intention of so doing (the standard of proof required in criminal proceedings) so as to reach a short form conclusion that the deceased committed suicide. However, the jury was directed as to the questions it should address in a narrative conclusion and, in response, it concluded that the deceased deliberately tied a ligature around his neck and suspended himself from the bedframe. After referring to him having suffered a number of mental health challenges and being agitated that night, it concluded that, on the balance of probabilities (the civil standard of proof), it was more likely than not that he intended to take his own life.

The family of the deceased challenged the lawfulness of the jury's decision, arguing that the narrative verdict amounted to a verdict of suicide on the balance of probabilities and that such a verdict was not permissible in law unless the jury was sure. This case resulted in appeals to the Court of Appeal and thence to the Supreme Court. Despite it being a case concerning suicide, the Supreme Court saw fit to address the standard of proof in cases of unlawful killing when they were not seized of such a case. In all, ***Maughan*** has been considered by 10 Judges of High Court rank and above and has resulted in considerable divergence of judicial opinion and subsequent controversy.

The law was re-stated by the Supreme Court in its majority 3–2 decision that the civil standard of proof should be applied by Coroners and their juries both in cases dealing with potential conclusions of suicide and those of unlawful killing both in a narrative and a short form conclusion.

The path to this decision is worth re-visiting. At first instance, all counsel approached the case upon the basis that the law was well established that a short form conclusion (what used to be called a verdict) in a case of suicide had to be proved to the criminal standard and that Note (III) in Form 2 of the Schedule to the Coroners Rules 2013 which prescribe how short form conclusions should be recorded laid down that requirement in statutory form. It was Leggatt L.J. who at the hearing, ex improviso, raised the point that such was not the law because (1) Note (III) had no statutory effect beyond expressing the common law position and (2) on an examination of the authorities, the common law did not provide authority, binding on the Divisional Court that suicide had to be proved to the criminal standard. This judicial intervention took counsel by surprise, so much so that they did not have time to search a considerable body of cases to see whether Leggatt L.J. was right. As later revealed in the Court of Appeal, Leggatt L.J. was never appraised of the Court of Appeal's decision in ***McCurbin***.[2] His own instincts and rationale in the matter took free rein when he pronounced that, absent binding authority to the contrary, the arguments favoured the application of the civil standard for all forms of conclusion in suicide cases. He went so far as to say that if the narrative conclusion was that on the balance of probabilities the deceased intended to take his own life *"it is sophistry*[3] *to say that such a conclusion is not one of suicide because the required standard of proof has not been met."* This comment from an albeit distinguished former Commercial Court judge and practitioner does not lie easily with opinions expressed by many other distinguished common law judges such as Tasker Watkins V.C. L.J. who considered that it would be unthinkable to reach a verdict of suicide other than to the criminal standard. However, Leggatt L.J. did not

stray beyond the facts in ***Maughan*** and decide, as the majority did in the Supreme Court, that the civil standard of proof should be applied by the Coroners Court to all forms of conclusion not only in potential suicide findings but also to findings of unlawful killing which did not arise in ***Maughan***.

The Court of Appeal, whilst agreeing with Leggatt L.J.'s undoubtedly powerful legal analysis as to the law on the standard of proof in suicide cases, recognised that ***McCurbin*** was authority, binding upon it, that the standard of proof in unlawful killing cases should be to the criminal standard. However, as regards suicide cases, it concluded that the decision in ***McCurbin*** was obiter and that it was not bound to follow it and did not.

The Supreme Court in which the former distinguished Chancery judge and practitioner Lady Arden gave the leading judgment in support of the majority decision agreed with Leggatt L.J. and the Court of Appeal. She carried out a lengthy analysis of Note (III) to Form 2, using a number of aids to interpretation, as to whether it actually had any legislative effect. She concluded that it did not. She agreed that it was no more than an expression of what the common law was understood to be. She went on to say that the authorities did not support the proposition that, in suicide cases, the conclusion should only be reached to the criminal standard but, insofar as they did support that view, they were no longer to be regarded as a correct statement of the law. ***McCurbin***, an unlawful killing case in the Court of Appeal was disapproved. Lady Arden with whom Lord Wilson and Lord Carnwath agreed, expressed the view that societal attitudes to suicide (which was formerly a criminal offence until 1961) had moved on so that, whilst of course it was very distressing to the family of the deceased, it no longer carried the stigma formerly attached to it.

In contrast, Lord Kerr with whom Lord Reed agreed,[4] in unusually strong terms, expressed his disagreement with Lady Arden. He concluded that Note (III) to Form 2 was as much a legislative requirement as any other statutory provision that laid down what was required. He said that to interpret the word *"is"* as no more than an expression of what the common law was understood to be or might be in the future was nonsensical. He concluded that Note (III) to Form 2 was not changing the established law but, like many other legislative provisions, was putting the established common law into statutory form. He saw good reasons why the criminal standard should be applied to both conclusions of suicide and unlawful killing, saying, with some force, that both decisions had a far more serious impact than any of the other short form conclusions available and listed in the Note (III) to Form 2.

Whilst the decision of the majority in the Supreme Court as to the standard of proof to be applied in cases of suicide is binding on all courts apart from the Supreme Court itself,[5] the judgment in its application to unlawful killing is obiter, persuasive but not binding. The application of the civil standard of proof in unlawful killing cases is thus open to challenge. If such a challenge was to come before a differently constituted Supreme Court there is plainly room for a different approach to that of the majority in ***Maughan***.

The remaining question is why should such a challenge be made? The principle rationale for requiring the civil standard of proof to be adopted to all forms of conclusion in suicide and unlawful killing cases is that it accords with the standard applied in civil proceedings even where the allegation is either one of suicide or unlawful killing.

Dealing here solely with the issue of unlawful killing: it is a finding that, unlike suicide, not only requires proof of criminal offences but indeed the most serious of offences in the criminal calendar, namely, murder, manslaughter and infanticide. They are all offences that on a criminal conviction carry the heaviest of penalties and rightly attract a great deal of public opprobrium and stigma.

Those who have practised in the Coroners Court over many years will know full well that, historically, it could be a rather wayward and unpredictable jurisdiction, presided over by Coroners of varying backgrounds. Over recent years there have been attempts to regularise the jurisdiction and to bring in a degree of uniformity and consistency in the decision making by the appointment of a Chief Coroner and the issuance by him or her of guidance and bench books. Further, those now occupying the office of HM Coroner, with a few exceptions, despite sparse resource and limited staff, are now applying a much more rigorous judicial approach to the discharge of their important functions than was evident than when I was a young junior attending inquests. Lastly, in inquests that attract public attention where conclusions of suicide or unlawful killing are in the offing, it is often the practice for the Coroner to appoint suitably experienced counsel to assist in the pre-inquest stages, the gathering of witness and documentary evidence, to advise the

Coroner on matters of law, carry out the examination of witnesses at the inquest and assist with the drafting of rulings, directions and questions for the jury and narrative conclusions.

Inquests are not civil proceedings nor do they bear the slightest resemblance to civil proceedings. The Coroner's ancient jurisdiction is, as described by Lord Reed, a thing unto itself. It has very few rules of practice and procedure. It has nothing like the vast volume of rules that apply to and regulate civil proceedings for the purpose of rendering them fair and just. Compare the slim set of Coroners Rules with the two volumes of the White Book. Lord Lane LCJ. in *R v South London Coroner, ex p Thompson*,[6] reminded us that inquests differ fundamentally from criminal proceedings. There the same sort of distinctions to be found between inquests and civil proceedings. However, when saying that the standard of proof in inquests for these serious findings should be allied to that apply in civil proceedings, none of the courts in ***Maughan*** appear to have considered that unlike Coronial proceedings, civil proceedings have many safeguards available to the parties so as to ensure justice is done.

For example, in civil proceedings against an insurer under a life policy, if the insurer is declining cover by reason of the death of the insured being one of suicide, then the insurer would be required plead its case in full. The party facing such an allegation would have the opportunity to plead a reply and require full particulars of the defence and full documentary disclosure. He or she would be entitled to find and call witnesses and cross-examine any witnesses called by the insurer and then address the court on the merits. The losing party, subject to reaching the threshold for permission would be entitled to appeal. The appellate court will overrule the court at first instance if it concludes that its decision was wrong. None of these procedural safeguards apply to Coronial proceedings.

This point applies *a fortiori* to a person (including corporate or government bodies) against whom civil proceedings are brought for damages resulting from the death of the deceased in which murder or manslaughter are alleged. All the safeguards provided in civil procedure and its rules as to evidence will kick in and be strictly enforced with a defaulting party ultimately being debarred from proceeding further.

What then is the position of a person at risk of a finding of unlawful killing in Coronial proceedings? They may of course apply to be treated by the Coroner as a properly interested person (PIP). However, a PIP has no control over what evidence the Coroner decides to adduce and certainly cannot choose what evidence is to be called in order to present his or case as he or she could and would in civil proceedings. The PIP has no control over the gathering of documentary evidence or what documents are to be put in evidence before the court at the inquest. The PIP has no right to call expert evidence. Expert evidence is purely a matter for the Coroner. The PIP only has limited rights to cross-examine witnesses called by the Coroner to the extent that the Coroner allows. The PIP is not entitled to address the Coroner or a jury as to the facts. The PIP has no right to appeal the decision of the Coroner's court. His or her remedy is limited to the restrictive remedies available upon a judicial review on purely public law principles.

With the absence of the safeguards in civil proceedings available to someone at an inquest who is liable to be found to be responsible for the murder or manslaughter of the deceased, I consider that there was good reason for the previously well understood requirement that to reach the short form conclusion of unlawful killing, a headline finding, the Coroner or Jury should be sure about it. A well-established long-standing rule of law often has its bedrock in common sense and years of practical experience and application. The impressive deconstruction of that rule by clever judges but with little or no hands-on experience of the workings of the Coroners court seems to have overlooked why Tasker Watkins VC. L.J. considered the application of the civil standard of proof in this particular jurisdiction to such serious findings was unthinkable.

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1. *Maughan v Oxfordshire Senior Coroner* [2020] UKSC 46

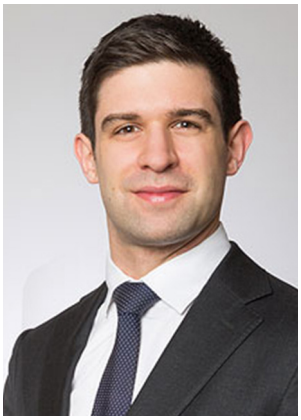
2. *R v Wolverhampton Coroner ex p McCurbin* [1990] 2 All ER 759

3. Sophistry is defined as the use of false or fallacious arguments

4. Both judges from common law backgrounds

5. That can reverse its own decisions

6. [1982] Lexis Citation. 1288, (1982) 126 Sol Jo 625



Witness evidence in statutory public inquiries: Responding to a rule 9 request for witness evidence

Andrew O'Connor QC and Piers Taylor

The Inquiries Act 2005 (the Act), together with the Inquiries Rules 2006 (the Rules), provides a framework for the taking of witness evidence in statutory public inquiries. Many inquiries have published protocols on witness evidence[1] (and other matters of procedure), which practitioners should locate and be familiar with. Such protocols will always be underpinned by the statutory framework, which gives the inquiry chair powers of enforcement.

Who gets the Request?

Pursuant to Rule 9 of the Rules, the inquiry must send a written request for a written statement to any person from whom it proposes to take evidence. This "Rule 9 Request" can be sent to witness directly, a witness's legal representative or, in some circumstances, their employer. Witnesses will not necessarily be core participants to the inquiry and the inquiry legal team may offer to help a witness with the taking and drafting of their statement. Rule 9 also provides for written requests for the production of documents, and so Requests may be for a combination of documents and written statements.

An inquiry in its early stages may be unfamiliar with the personnel or structure of an organisational core participant and in those cases the witness may not be specifically named (or the Request may not be made until a witness has been identified). An organisational core participant may therefore have some considerable input in identifying the most suitable witness (or witnesses) to respond to a Request. This will be worth some careful consideration. Once a witness is identified, they should expect to later be called by the inquiry to give oral evidence, or to be asked to provide further witness statements under successive Rule 9 Requests.

Responding to a Request

A Rule 9 Request must include a description of the matters or issues to be covered in the statement. This will be specific to the Inquiry's Terms of Reference, and the nature of the witness or core participant's involvement in the matters under investigation. The Request will likely specify a deadline for compliance, but it is open to a witness or core participant to discuss the contents of the Request and deadlines with the inquiry. If the response to a Request is not forthcoming or is inadequate, the inquiry may issue further (possibly more detailed or specific) Rule 9 Requests, or use its powers to enforce compliance.

Enforcement

An inquiry's chair can, under section 21 of the Act, issue a Notice requiring a person to provide a written statement, to produce any documents under his or her control and to attend a time and place (usually an oral evidence hearing) to give oral evidence. This is a more formal request, which can carry a penalty for non-compliance. Under section 35 of the Act, a person may be subject to a fine of up to £1,000 or imprisonment of up to 51 weeks if they fail without reasonable cause to do anything they are required to do under a section 21 Notice.

Most inquiries will first issue a Rule 9 Request, but this will not necessarily be the case. In the case of The Leveson Inquiry, section 21 Notices were sent out to all those from whom evidence was sought.

Objecting to a Request or a Notice

Section 21(4) contains a mechanism for objecting to a Notice on grounds that the person subject to the Notice is not able to comply with it, or that it is not reasonable in all the circumstances to require him to comply. An objection under section 21(4) can encompass a number of situations. It may be argued that the information is not available, or that to comply with the Notice would take disproportionate effort or expense. The chair will determine the objection, and must have reference to the public interest in the information being obtained and its likely importance.

Practitioners should have this process in mind when considering a Rule 9 Request. If the chair can be persuaded that there would be valid objections to a Section 21 Notice, it may be the Rule 9 Request is amended or withdrawn and no Notice is given.

Privilege

Under section 22, a person may not be required to give evidence that "he could not be required to do so if the proceedings of the inquiry were civil proceedings in a court in the relevant part of the United Kingdom". This section preserves the right to withhold evidence that is subject to legal professional privilege. Practitioners should consider whether material is genuinely privileged, and keep in mind that the client may choose to waive such privilege.

In some contexts, a witness may also seek to rely upon the privilege against self-incrimination (under section 14 Civil Evidence Act 1968) to avoid giving a statement or answering questions. An inquiry may overcome this privilege if the chair obtains an undertaking from the Attorney General that the evidence given by the witness will not be used against them in subsequent criminal proceedings. Such undertakings have been given by the Attorney General in, for example, the Grenfell Tower Inquiry and the Undercover Policing Inquiry. In the Manchester Arena Inquiry, the brother of the terrorist attacker applied to the chair to request an undertaking from the Attorney General, but that application was refused.[2]

Use of Rule 9 statements

Statements provided to an inquiry are likely to be disclosed to core participants. In some cases the statement itself may be made public (by being uploaded to the inquiry's website), whether or not the witness is called to give oral evidence.

Practitioners should consider the potential consequences of a witness's identity or their evidence being made public. There may be confidentiality issues, commercial sensitivities or security concerns, which should be raised with the inquiry at an early stage. The inquiry may place restrictions on the disclosure or publication of documents and evidence under section 19 of the Act.

1. **Infected Blood** https://www.infectedbloodinquiry.org.uk/sites/default/files/2018-10-03%20Amended%20Statement%20of%20Approach%20-%20Evidence%202%20(1).pdf

   Grenfell Tower https://assets.grenfelltowerinquiry.org.uk/inline-files/Witness%20statement%20protocol%20-%20February%202019_1.pdf

   UCPI https://www.ucpi.org.uk/wp-content/uploads/2018/01/20180122-witness-statement-protocol-v1.0.pdf

2. https://files.manchesterarenainquiry.org.uk/live/uploads/2021/06/11111247/Ruling-on-AG-Undertaking-Issue-10.6.21-96780639_1.pdf

An Update on Guidance and Inquest Competencies

Nicholas Moss QC

Chief Coroner's Guidance

The gradual increase in Chief Coroner's Guidance Notes accelerated rapidly in 2020-2021 with the need to provide guidance on Covid. But new non-Covid guidance notes have been issued too. Excluding the treasure guidance, at the time of going to press, there are some 41 Chief Coroner's Guidance Notes and 5 Chief Coroner's Law Sheets. Unsurprisingly, some of the earlier notes have been reviewed and re-issued, reflecting changes in practice, procedure or the substantive law, most notably of course, the decision in ***Maughan***.

The increasing array of guidance notes and amendments to them, means that printed or e-saved versions can quickly go out of date. By far the safest course is for practitioners to rely on the live guidance page on the Judiciary Website: [www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/coroners-guidance].

For those of the old school, wanting to check that their inquest folder of printed guidance notes is up-to-date, there have been re-issues / amendments to the following guidance notes since their original publication dates (those in **bold** have been amended most recently, where it is particularly important to ensure that the up-to-date version is used):

Guidance Notes:

- 1 (post mortem imaging);
- **5 (reports to prevent future deaths)** and, most recently, **PFD Report Publication Policy**
- 6 (Appointment of Coroners);
- 8 (Pre-Signed forms);
- 9 (Opening Inquests);
- 10 (Warnings to juries);
- **12 (The Inquest checklist);**
- 14 (Merger of Coroner Areas);
- 16 (Deprivation of Liberty Safeguards) – see too 16A on DoLs from April 2017 onwards);
- **17 (Conclusions);**
- 18 (Investigations without a body);
- 19 (Mentors for Coroners)
- 20 (Key Skills for Coroners)
- 24 (Transfers)
- **37 (Covid-19 deaths and possible exposure in the workplace)**
- **39 (recovery from the Covid-19 pandemic)**

Law Sheets:

- **1 (Unlawful killing)**
- 2 (Galbraith plus)
- 5 (The Discretion of the Coroner)

The Coroner's Bench Book is also available on the same link, but it comes with the explicit health warning that it is currently under review and not all of the information contained within should be treated as current and that it may not reflect current case law. A new version is expected to be published soon.

The Chief Coroner's Guide to the Coroners and Justice Act 2009 sits alongside the guidance notes and law sheets. Since it was published back in 2013, the Guide to the Act is easy to overlook. Yet it retains some important practice points. I have always been struck, for example, by the emphasis it gives to the fact that that the 'new' rule 23 expressly permits written evidence in admission form (see §§141-142). It is rare, in my experience, for Coroners to request Interested Persons to agree a form of admission statement yet its potential benefit in saving time and focussing the evidence on the issues actually in dispute is obvious.

Harriet Wakeman considers the guidance, No. 41 on Pen Portrait material in her own article in this edition. Most notable amongst the other changes and updates is that the Chief Coroner has issued an updated version of Law Sheet No. 1 on Unlawful Killing and revised Guidance note 17 on Conclusions, both to take account of the important consequences of the decision in Maughan [2020] UKSC 46. At the same time, the Maughan-specific Law Sheet No 6 has been withdrawn because it has been rendered redundant by the changes to Law Sheet No 1.

Four points of note from the amended Law Sheet No 1:

1. The guidance is still to direct the jury to deal with unlawful killing first if it is one of several short form conclusions that are open to the jury (see §7);
2. The guidance explicitly recognises that there is debate within the legal community over whether gross negligence and corporate homicide cases may infringe s10(2) of the 2009 Act (no determination of civil liability). The Chief Coroner's view is that it does not do so (see §11). But the Chief Coroner notes that it is for each individual coroner to come to his or her own conclusion, having heard any relevant submissions from IPs.
3. On gross negligence manslaughter, at §22, the guidance similarly recognises that some legal commentators have suggested there may be a conceptual difficulty in applying the Maughan 'balance of probabilities' test to the sixth element of the offence namely that, 'The circumstances of the breach were truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence and required criminal sanction'. The Chief Coroner again emphasises that Coroners are independent and must make their own decisions, but he goes on to give this guidance: *"However, coroners may wish to consider that, as the court explained in Misra: 'The question for the jury is not whether the defendant's negligence was gross, and whether, additionally, it was a crime, but whether his behaviour was grossly negligent and consequently criminal. This is not a question of law, but one of fact, for decision in the individual case'. Since the sixth element of the offence thus raises an issue of fact, the decision in Maughan would appear to indicate that, like other factual questions in coroners' courts, it is to be resolved according to the civil standard of proof."*
4. On suicide, at §31, the guidance grapples with the potential for unlawful killing conclusions arising from gross negligently or unlawful acts that permit or cause a suicide. Rare though such cases may be, there has always been the potential for such conclusions. With the "lowering" of the standard of proof for the coronial conclusion of unlawful killing, it is inevitable that Coroners will now see this raised more frequently.

Coroner's Court Competences and Toolkit

My own non-scientific quick straw pole suggests that not all practitioners are aware that our respective regulatory bodies have issued the "Coroner's Court Competencies and toolkit". These are important materials. The links are here:

- **Bar Standards Board**: Link
- **Solicitors Regulation Authority**: Link
- **CILEx Regulation**: Link

The competences themselves can be found within each link. They should obviously be read in full but the following are perhaps among the most noteworthy:

- 'You should … Assist the coroner in the disclosure of all facts relevant to the inquisitorial process, regardless of who you represent, whilst being mindful of your duty to your clients.
- 'You should … Recognise the central role of bereaved families and have knowledge and understanding of their vulnerability during an inquest'.

- 'You should … Have knowledge and understanding of the potential vulnerability of interested persons and witnesses during an inquest' and 'Adapt the delivery of your service to the needs of such vulnerable people.
- "You should … Recognise that an inquest is an inquisitorial and fact-finding exercise, and your style of questioning must be appropriate. In particular, recognise that whilst firm and robust questioning may sometimes be necessary, an aggressive and hostile style of questioning is not appropriate' and 'Adapt your style of advocacy and personal interactions to the circumstances and potential vulnerability of those participating in the inquest, demonstrating empathy as appropriate.'
- "You should … Understand how organisations and agencies relevant to the Coroner's Court can assist and support family members, witnesses and other interested persons' and 'Work with relevant organisations and agencies as appropriate, where it will benefit family members, witnesses and other interested persons.'

Prior to these competences, Coroners may – on occasions – have felt that they had to rely on 'carrots' rather than 'sticks' to ensure that inquest practitioners respected the unique nature of the inquest process. Coroners are now likely to use the competences to require:

- **All Legal representatives** to avoid duplication of the Coroners' own questions; to use appropriate clear language in questioning; to be familiar with guidance and training in The Advocate's Gateway (TAG); and to ensure that the role and purpose of the inquest is both understood and respected.
- **Legal representatives of organisations** to give prompt disclosure and assistance to the Coroner and adapt their advocacy (and wider conduct in and around the Court) to ensure that the bereaved are respected, properly involved at every stage, and treated kindly and sensitively.
- **Legal representatives of the bereaved** to remember that witnesses such as first responders to fatalities can be vulnerable witnesses too, and that their own advocacy should reflect this. As the narrative commentary alongside the competences makes clear, vulnerabilities in an inquest will often not be limited to the bereaved family. Hence, "It is important to remember that other interested persons or witnesses may also be vulnerable. For example, a member of the emergency services, or a staff member of an organisation where the person died, may also be vulnerable as a result of seeing a person's death or witnessing an incident."

As well as the competencies and narrative commentary on them, the toolkit material includes short video presentations from:

1. The Chief Coroner on 'Understanding the unique nature of inquests';
2. The Chief Coroner on 'The importance of practising competently in inquests';
3. Leslie Thomas QC on 'Practising effectively in inquests';
4. Donna Mooney on 'Tips from a bereaved family';
5. Derek Winter, Deputy Chief Coroner, on 'Helping the inquest run smoothly';
6. Beverley Radcliffe on 'The importance of working with support organisations';
7. Emma Norton on 'Key considerations when representing a bereaved family in an inquest' and on 'How to communicate and engage with vulnerable people in an inquest'.

The toolkit material will no doubt expand over time. Many may feel that the asserted differences in how practitioners should approach inquests as compared to adversarial litigation is often more theoretical than real. The development of the toolkit, and the enforcement of the competences, are points to watch.

Use of Pen Portrait Materials at Inquests

Harriet Wakeman

An inquest is a fact-finding exercise, in order to ascertain the matters set out in paragraph 5 of the Coroners and Justice Act 2009, namely, who the deceased was and how, when and where they came to their death. However, over the years, many coroners have developed an informal practice of allowing material to be adduced giving a short background to the deceased – what he or she did, their interests and hobbies and their personality. This is typically done in what has become known as a 'pen portrait' statement, typically read by a member of the deceased's family or a friend of the deceased at the outset of the inquest. However, 'pen portrait' material can also take other forms such as a photo of the deceased. On 5 July 2021, the Chief Coroner published Guidance Note 41 on Use of 'Pen Portrait' Material. In short, the Guidance Note welcomes and endorses the inclusion of pen portrait materials, with some important caveats.

Content of the Guidance Note

The Guidance Note sets out the four categories of inquests: documentary inquests; inquests where only the coroner and some family members are present; inquests with some interested persons, with or without lawyers; and inquests with a coroner and jury. In summary, the Guidance Note makes the following points:

i Documentary inquests: Pen portraits do not usually arise in such inquests because there is just the coroner in the courtroom and no family members are present.

ii Inquests where only the coroner and family members are present: This type of inquest is often more informal and relaxed, and this would enable the family to tell the coroner something about their loved one.

iii Coroner sitting without a jury but with interested persons present: In such circumstances, the Chief Coroner would expect a coroner to adopt a flexible approach to the admission of 'pen portrait' material. It is for the coroner conducting the inquest to decide what is permissible and when the material is to be adduced.

iv Coroner sitting with a jury: In such cases, the type of material, amount of it and timing of its admission will be a matter of judgment for the coroner. The Guidance notes that it would be sensible for the coroner to seek disclosure from the family of the material they would like to adduce by way of 'pen portrait' as well as the format of such material and directions at a pre-inquest review should cater for this. Depending on the content of the pen portrait statement, a coroner may need to warn the jury that what was said is not evidence – the coroner should make clear to the jury that the pen portrait is a reflection of the person in life rather than in death and it is not a matter of evidence to be taken into account when deciding on the conclusion.

Comment

As is seen from the above, the Guidance Note recognises the wide degree of discretion afforded to coroners when determining whether pen portrait material should be permitted, and if so, its form and extent. It is obviously important that this discretion is carefully exercised and I flag two key points in particular:

i Whilst, in my view, coroners should be slow to refuse a bereaved family the opportunity to give a 'pen portrait' in appropriate inquests, coroners and advocates for other interested persons should be alert, particularly in jury inquests, to the inclusion of potentially prejudicial material within a pen

portrait, which for example, implies fault of a particular party or suggests a cause of the death. In order to avoid such a scenario arising, coroners should be proactive and clearly explain to the bereaved family, for example at a pre-inquest review hearing or in pre-inquest correspondence, the purpose of a pen portrait, and what it should and should not cover, well in advance of the provision of such material.

ii. Further, as is set out in the guidance, it will be important for coroners in jury cases to emphasise that a pen portrait is not a matter of evidence to be taken into account when deciding on the conclusion.

With these important caveats, it is in my view a very positive development that the Chief Coroner has recognised and endorsed the approach of including pen portrait materials. An inquest can be a difficult, emotional and intense process for the bereaved family and friends of the deceased. The inclusion of a pen portrait at the outset of the hearing can humanise the process, give dignity to the bereaved and – importantly – be one part of honouring the duty to keep the family at the heart of the inquest process.

Croydon Tram Inquest

Keith Morton QC and Fiona Canby

At about 06.07 hrs on 9 November 2016, tram 2551, travelling between Lloyd Park and Sandilands on the Croydon tram network, derailed, and overturned, at the Sandilands curve. It was dark and raining heavily. On board were 69 passengers. Tragically 7 passengers were ejected from windows or doors of the tram. They died instantly.

Trams are driven on 'line-of-sight', with drivers expected to drive at a speed which will enable them to stop the tram in the distance that they can see ahead. This contrasts with railways, where the movements of trains are regulated by lineside or in-cab signals. Railways have engineered systems that enforce compliance with signals and obedience to speed limits. At the time of the overturning, tramways did not have such systems and, like road vehicles, relied on the driver to comply with signals, signs and speed restrictions.

The Rail Accident Investigation Branch ("RAIB"), an independent accident investigation body with statutory responsibility to investigate accidents on Britain's rail and tramways carried out an investigation into the accident over 13 months. Their detailed report runs to 180 pages.

The immediate cause was that the tram overturned because it was travelling too fast to negotiate the curve. The tram would have overturned if it had entered the curve at any speed greater than 49 km/h (30mph); its actual speed was 73 km/h (45 mph). Before the curve there was a reflective sign which marked where the tram's speed should have been reduced to 20km/h (12mph).

The driver did not apply sufficient braking. There was no evidence of any fault with the tram. There was no evidence that the driver's health or medical fitness contributed to what happened. The RAIB concluded that the most likely cause for the driver applying insufficient braking was a temporary loss of awareness of the driving task during a period of low workload, which possibly caused him to microsleep. It was also possible that, when regaining awareness, the driver became confused about his location and direction of travel.

The RAIB's investigation found that the risk of trams overturning due to excessive speed around curves, had not been addressed sufficiently by UK tramway designers, owners, operators, or the safety regulator.

The Inquests started on 17 May 2021 at Croydon Town Hall before the Senior Coroner for South London and a jury. In due course Article 2 of the ECHR was held to be engaged. Over four weeks the jury heard evidence from 6 RAIB inspectors; a former Chief Engineer at TCL; a BTP officer about the operational response and BTP's investigating officer. The interviews under caution from the tram driver were read. The Coroner then invited submissions as to which issues, if any, required further exploration and which further witnesses it was necessary to call.

This issue fell to be determined in the light of the decision of the Divisional Court in ***R (Secretary of State for Transport) v HM Senior Coroner for Norfolk*** [2016] EWHC 2279 (Admin). Significantly, the Divisional Court (Lord Thomas LCJ and Singh J (as he then was)) held that in cases where an independent, specialist state entity such as the RAIB, with the "greatest expertise in determining the cause of [in that case] an aircraft crash" then:

"56 … In the absence of credible evidence that the investigation into an accident is incomplete, flawed or deficient, a Coroner conducting an inquest into a death which occurred in [in that case] an aircraft accident, should not consider it necessary to investigate again the matters covered or to be covered by the independent investigation of the AAIB …

57. It should not, in such circumstances, be necessary for a coroner to investigate the matter *de novo*. 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: see, for example, ***Roger v Hoyle*** [2015] QB 265 at paragraph 94. However, where there is no credible evidence that the investigation is incomplete, flawed

or deficient, the findings and conclusions should not be reopened ..."

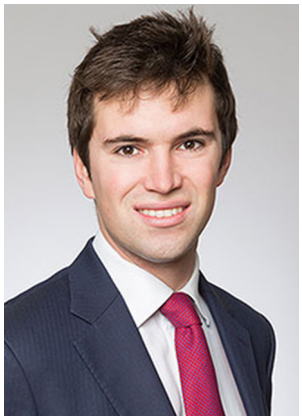
In a Ruling running to 49 pages, the Senior Coroner applied these principles and concluded that there was no credible evidence that the investigation of the RAIB was "incomplete, flawed or deficient". The RAIB evidence, together with the additional evidence heard by the jury, had covered sufficiently all of the matters within the scope of the Inquests. The Senior Coroner held that not only was she not required to call further evidence, but that she was not permitted to call further evidence as a matter of law.

The Senior Coroner rejected the families' submissions to leave unlawful killing on the basis of corporate manslaughter. She found that the threshold for grossness was not met and that it would be "perverse" to leave that conclusion. Unlawful killing was left based on gross negligence manslaughter by the tram driver (to be determined on the balance of probabilities following ***Maughan***), together with accident and a narrative.

The jury deliberated for three weeks. They reached a unanimous decision that the deaths had been accidental and delivered a narrative conclusion.

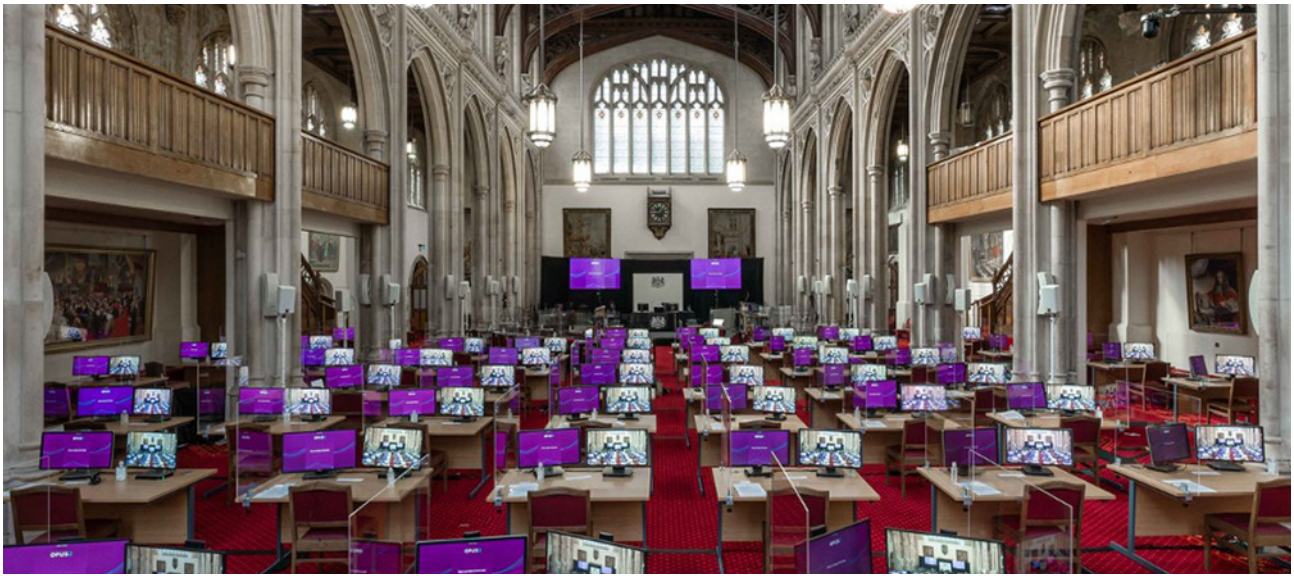
The Senior Coroner heard further evidence in relation to PFD. She subsequently made a PFD report in which she identified four areas of concern: automatic braking systems to prevent trams over-speeding; strengthened doors on existing and new trams to prevent passenger ejection in the event of overturning; all tramway operators to consider subscribing to an anonymous staff reporting scheme and scope for a government-funded, national tram safety passenger group.

Some of the families disagree with the Coroner's application of ***Norfolk***. They have written to the Attorney General asking that she use her powers under section 13 of the Coroners Act 1988 to apply to the High Court for an order seeking a fresh inquest. They have also indicated that they will apply for judicial review.



The Fishmongers' Hall inquests

Richard Boyle



These inquests arose from the terrorist attack on a Cambridge University event at Fishmongers' Hall on 29 November 2019. The attack led to the tragic deaths of two Cambridge University graduates: Jack Merritt and Saskia Jones. The attacker, Usman Khan, was killed by police firearms officers. The inquests explored how Khan came to attack attendees of a prisoner rehabilitation event that sought to help ex-offenders like Khan. I acted for the Secretaries of State for Justice and the Home Department ("SoS"), led by Samantha Leek QC.

The inquests were heard by HHJ Lucraft QC (the former Chief Coroner) who sat with a jury over nine weeks from mid-April 2021. They were held at London's Guildhall which accommodated a significant number of attendees with social distancing (as pictured above).

Khan was convicted in 2010 of acts preparatory to terrorism, under section 5 of the Terrorism Act 2006 ("TACT"). He pleaded guilty to seeking to establish a militant training camp in Kashmir, from which terrorist attacks might be launched against the UK. He discussed attacks on the UK, including with the use of improvised explosive devices. He was 19 years old at this time and remained in prison until his release on licence eight years later.

Khan's behaviour in prison was generally poor and he was assessed to be a High Risk Category A prisoner. He generated significant amounts of negative prison intelligence over the course of his sentence. However, there was some improvement in his overt behaviour over the final year of his sentence. This improvement coincided with his involvement with Learning Together, a Cambridge University project which aimed to help prisoners rehabilitate through educational programmes. Jack worked for Learning Together and Saskia attended a number of Learning Together events while studying at Cambridge.

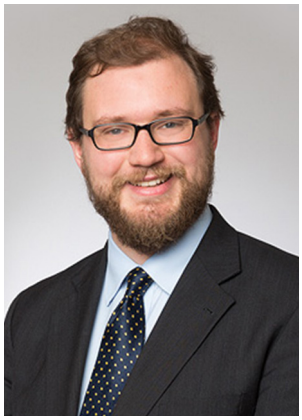
After release, Khan was subject to restrictive licence conditions and supervision from the Probation Service and Staffordshire Police. His management was considered at regular Multi-Agency Public Protection Arrangements ("MAPPA") meetings. He was also subject to a priority investigation by the Security Service and West Midlands Counter Terrorism Unit. While on licence, Khan did not breach any of his conditions and gave the outward impression that he was committed

to rehabilitation and had renounced extremism. He continued to communicate with Learning Together and attended a Learning Together event inside a prison. However, the day before the Fishmongers' Hall event, Khan purchased many of the items that he would use in the attack. Midway through the event, he attacked a number of attendees with knives before running onto London Bridge, revealing a fake suicide vest. He was shot by police firearms officers.

The jury found that Khan had unlawfully killed Jack and Saskia. It also concluded that there had been an omission or failure in the management of Khan (as an offender in the community) by agencies of the State which contributed to the deaths of Jack and Saskia. By way of explanation, the jury referred to: issues with the management of Khan; a lack of accountability; serious deficiencies in the management of Khan by MAPPA; insufficient experience and training; blind spot to Khan's unique risks due to 'poster boy' image; and lack of psychological assessment post release from prison. The jury concluded that there was an omission or failure in the sharing of information and guidance by agencies responsible for the monitoring/investigation of Khan which contributed to the deaths of Jack and Saskia, referring to a missed opportunity for those with expertise and experience to give guidance. The jury concluded that there was an omission or deficiency in the organisation of and security measures for the event at Fishmongers Hall which contributed to the deaths of Jack and Saskia, referring to: lack of communication and accountability; inadequate consideration of key guidance between parties; serious deficiencies in the management of Khan by MAPPA; and failure to complete event specific risk assessment by any party. The jury at the inquest into the death of Khan concluded that he had been lawfully killed by the police firearms officers.

Several issues of wider relevance arose during the inquests:

1. The approach to Article 2: the Coroner declined to find that the Article 2 procedural obligation was engaged prior to the start of the hearings. Instead, he kept the matter under review and carried out an investigation that was broad enough to allow conclusions even if Article 2 was engaged. This was consistent with the common observation that the decision as to whether Article 2 is engaged will have little, if any, effect on the scope of the inquiry (see, for example, ***R (Smith) v Oxfordshire Assistant Deputy Coroner*** [2011] AC1 (at §§152-154) and ***R (Sreedharan) v Manchester City Coroner*** [2013] EWCA Civ 181 (at §18(vii)). After the evidence, the SoS accepted an arguable breach by the authorities, collectively, of the Article 2 operational duty. Once it is found that Article 2 is engaged in one respect, then Article 2-compliant conclusions must be returned on all material aspects of the evidence (***Sreedharan***). The SoS's concession meant that Article 2 applied to the whole inquest and therefore the Coroner did not need to rule on the actions of each individual public authority when considering the ambit of the jury's conclusions;
2. The use of a questionnaire: a questionnaire was drafted for the jury following submissions from Interested Persons ("IPs"), as is typical for inquests of this complexity. The jury was provided with guidance, asked to agree a summary of the basic facts of the attack and then asked whether there were omissions which contributed to the deaths of Jack and Saskia on various topics (as above). Alternatively, the jury was asked if there were omissions which may have contributed to their deaths. The jury was invited to give an explanation for its answer. It was provided with a list of issues which may be relevant;
3. The approach to the Preventing Future Deaths ("PFD") report: the Coroner first invited written submissions from IPs who suggested that a PFD report should be made. He then allowed IPs permission to respond to those submissions. He allowed further submissions in reply. He took time to consider his PFD report which was very recently published: **https://fishmongershallinquests.independent.gov.uk/documents/**;
4. Management of TACT offenders in prison and on licence: this is an issue which also arose in the inquest into the death of Sudesh Amman, who carried out the terrorist attack on Streatham High Road (an inquest in which I acted for the Secretary of State for the Home Department). It will be explored in the Manchester Arena Inquiry (in which I am also instructed for the SoS, led by Cathryn McGahey QC of TGC) and may arise in inquests which may follow the Forbury Gardens attack in Reading. Khan was among the first TACT offenders to be released on licence, certainly in his local area. Since the attack, a number of changes have been brought into place, including an end to the automatic release of TACT offenders on licence, polygraph testing and changes to the systems and structures that are used to manage TACT offenders. All will, of course, hope that these new measures prevent further inquests/inquiries that look into these issues.



R(Morahan) v Her Majesty's Assistant Coroner for West London [2021] EWHC 1603 (Admin)

William Irwin

The Divisional Court in *R(Morahan) v Her Majesty's Assistant Coroner for West London* [2021] EWHC 1603 (Admin) has provided clarity about the circumstances in which there is a duty to hold a Middleton inquest – i.e. an inquest which fulfils the enhanced investigative duty under article 2 ECHR as originally explained in *R(Middleton) v West Somerset Coroner* [2004] 2 AC 182.

Facts

Tanya Morahan died at the age of 34 as a result of cocaine and morphine toxicity. She had a significant history of mental health problems and substance abuse. Between mid-May 2018 and 30 June 2018, she had received treatment as an inpatient at a psychiatric unit, initially as a detained patient under s.3 of the Mental Health Act 1983 (MHA) and then as a voluntary inpatient. She left the unit on 30 June 2018 and failed to return that night, contrary to an agreement she had made with her treating clinicians. She returned to the unit on 1 July 2018. On 3 July 2018, she left the unit (with the agreement of clinicians) but failed to return as she had agreed.

The police were asked to trace her and visited her flat on 4 July 2018. There was no reply when they knocked on the door. Ms Morahan was then discovered dead in her flat on 9 July 2018.

The Coroner's decision re article 2 ECHR and the challenge

The Coroner decided that there was no ***Middleton*** investigative duty, although she undertook to keep the question under review. The Ms Morahan's family challenged the ruling that the article 2 investigative duty was not engaged.

The family contended that the circumstances of the death fell within a class of cases which gives rise automatically to a duty to conduct a ***Middleton*** inquest. Alternatively, that on the facts of this case there were breaches of the article 2 operational duty to take steps to avert a real and immediate risk of Ms Morahan's death by drug overdose, which risk – the family argued – was or ought to have been known to the NHS trust providing psychiatric inpatient care to her.

The Divisional Court's judgment

At paragraph 30, the Court reiterated the familiar tripartite positive duties under article 2 ECHR – the framework or systems duty, operational duty, and investigative duty.

At paragraphs 38–40 the Court restated in clear terms the nature of the positive operational duty. At paragraphs 42–67 the court made a detailed survey of four cases relevant to the scope of the operational duty, namely ***Rabone, Lopes de Sousa, Fernandes de Oliviera***, and ***Maguire***.

Regarding ***Rabone v Pennine Care NHS Foundation Trust*** [2012] 2 AC 72, the court at paragraph 44 summarised the passages of that judgment which set out four essential features of cases which led to Strasbourg recognising the existence of an operational duty. They are the real and immediate risk to life being a necessary but not sufficient condition for the existence of the duty; an assumption of responsibility by the state for the individual's welfare and safety including by the exercise of control; the special vulnerability of the individual; and the nature of the risk being an exceptional risk, beyond the ordinary risk of the kind that individuals in the relevant category should reasonably be expected to take.

Court's guidance on the enhanced investigative duty

At paragraphs 122–123, the court identified nine principles regarding the enhanced investigative duty and when it arises.

At (3)–(5) of those principles, the court held that the enhanced investigative duty which is procedural and parasitic upon the substantive obligation investigative obligation. The enhanced duty arises when there is an arguable breach of the state's substantive duty or automatically in certain cases including killings by state agents, suicides or attempted suicides and unlawful killings in custody, suicides of conscripts, and suicides of involuntary mental health detainees.

At principles (6) and (7) the court held that the underlying rationale for the categories of cases which automatically give rise to the enhanced investigative duty is that all cases falling within the category will always, and without more, give rise to a legitimate suspicion of state responsibility in the form of a breach of the state's substantive article 2 duties. The touchstone for whether the circumstances of a death are such as to give rise to an automatic enhanced investigative duty is whether they fall into a category which necessarily gives rise, in every case falling within the category, to a legitimate ground to suspect state responsibility by way of breach of a substantive article 2 obligation.

These findings are significant beyond being merely a summary of principles because they are an answer to a question arising from ***R(Letts) v Lord Chancellor*** [2015] 1 WLR 4497: namely whether the enhanced investigative duty could arise in a case where there was no arguable breach of the state's substantive duty. At paragraph 123, Popplewell LJ confirmed that in his view the enhanced investigative duty could never arise without an arguable breach of the substantive duty.

At paragraphs 124–138, Popplewell LJ analysed Ms Morahan's case and concluded that the enhanced investigative duty did not arise on the facts. There was no operational duty on the facts of the case. At paragraphs 137 and 138 the Court confirmed that the automatic duty did not arise in the case of a genuinely voluntary psychiatric inpatient; and that there was no justification for extending the automatic duty to cases of accidental death.

Dove v HM Assistant Coroner for Teesside And Hartlepool & Anor [2021] EWHC 2511 (Admin)

Emily Wilsdon

Dove v HM Assistant Coroner for Teesside And Hartlepool & Anor **[2021] EWHC 2511 (Admin) provides detailed guidance on the sufficiency of an inquiry by a coroner both at common law and under article 2 of the ECHR.**

The family of Ms Whiting applied under section 13 of the Coroners Act 1988, with the *fiat* of the Attorney General, for an order quashing the Coroner's determination and directing that a new inquest take place. The application was dismissed.

Ms Whiting had died of an overdose of prescription medication. The Coroner concluded that she had died by suicide. The conclusion itself was not contested. Her family submitted that a new inquest was required to look at the failings of staff at the Department for Work and Pensions, who shortly before her death had made a decision to stop paying Employment and Support Allowance, and their contribution to her death.

The report of an Independent Case Examiner (not available at the date of the inquest), who had examined the DWP's handling of the case, had made multiple criticisms of the Department, both in relation to actions (or inaction) prior to Ms Whiting's death, as well as afterwards. The findings included that the DWP Department had failed to consider Ms Whiting's mental health condition and had failed to give careful consideration to her case. She had not been given a home visit, she had not been called to find out why she had not attended an appointment, no safeguard visit to her as a vulnerable claimant (who had been in the support group of claimants) had been considered, and her GP had not been contacted. Giving the lead judgment in the High Court, Mrs Justice Farbey (with whom Lord Justice Warby and HHJ Teague QC agreed) saw no reason to disagree with the report's conclusions about the failures, which she described as shocking, and found that the withdrawal of ESA should not have happened.

The family had also obtained a psychiatric report which concluded that "On the balance of probabilities... it is likely that her mental state at the time of her death would have been substantially affected by the [Department's] reported failings."

None of the fresh evidence was sufficient to justify a new inquest. All agreed that the correct conclusion, suicide, had been reached. It was likely to remain a matter of speculation as to whether or not the Department's decision caused Ms Whiting's suicide.

The standard of review to be applied in section 13 applications

Mrs Justice Farbey found that, in a section 13 application, the ***Wednesbury*** principle should apply. This is consistent with authority that it is not the function of a section 13 review to revisit matters lawfully determined by a coroner (the test for fresh evidence however required discrete consideration). In this case the approach adopted to the review made no difference to the outcome.

The requirements of the common law

Farbey J found that the Coroner had undertaken a sufficient inquiry to determine 'how' Ms Whiting had come to her death, in accordance with ***R v HM Coroner for North Humberside***, Ex Parte Jamieson [1995] QB 1. She had considered Ms Whiting's medical background, the medical cause of her death, the circumstances in which she was found dead and (to the extent that it could arise from the evidence before her), apparent reasons for her suicidal mental state, and what evidence she could from Ms Whiting's family on the effect on Ms Whiting of the decision to stop ESA.

In this case the public interest did not require any broader inquiry. There was no lack of accountability or a lack of public scrutiny of the DWP's actions in the case which a coroner ought to remedy. Mrs Justice Farbey outlined multiple other avenues for accountability: a departmental complaints procedures culminating in the Independent Case Examiner; the ICE themselves was amenable to judicial review; and appeals from substantive benefits decisions were available to the specialist Tribunal.

Lord Justice Warbey added, in his concurring judgment, that there was "no reason to believe that the ICE's findings are incomplete or inadequate, or that a further coronial investigation is necessary or desirable to supplement them, or to provide further publicity, or for any other reason".

Mrs Justice Farbey adopted the observation of Singh J (as he then was) that "there is no public interest in having unnecessary duplication of investigations or inquiries" (***R (Secretary of State for Transport) v HM Senior Coroner for Norfolk*** [2016] EWHC 2279 (Admin), para 49. However, her judgment shows a more fundamental constitutional objection, based on the respective roles and competencies of the coroner, the court, and the Tribunal. A coroner was not specialised in or equipped to become "the guardian of the public interest in matters relating to social security", it was "the constitutional function of that court, not the Coroner, to hold the executive to account", and it would be "contrary to the administration of justice for coroners to stand in the shoes of specialist tribunal judges", who are "best placed to carry out the difficult balance between protecting the rights of vulnerable social security claimants and ensuring that precious public resources are allocated in accordance with fair but proportionate procedures".

Article 2 ECHR

The remainder of the judgment deals with the inquest from the perspective of article 2 ECHR. It contains, at paragraphs 48–59, a clear summary of the law in relation to state responsibility under article 2:

- the negative duty on states not to take life without justification and, in limited circumstances;
- positive obligations to protect life, comprising an operational duty to take reasonable steps to prevent real and immediate risk to life (including the risk of suicide) first recognised by the European Court of Human Rights in ***Osman v United Kingdom*** (2000) 29 EHRR 245;
- a systems duty to establish a framework of laws, procedures and means of enforcement that will protect life, the breach of which entails a failure to provide an "effective system of rules, guidance and control within which individuals are to operate in a particular context" ***(R Long) v Secretary of State for Defence*** [2015] EWCA Civ 770, [2015] 1 WLR 5006, para 25, per Lord Dyson MR); and
- in conjunction with the above a procedural duty to investigate deaths for which the state might bear responsibility.

Article 2: the operational duty

Mrs Justice Farbey concluded that it was not open to the Court, either considering the three indicia of the existence of the operational duty set out by Lord Dyson in ***Rabone v Pennine Care NHS Trust*** [2012] UKSC 2, [2012] 2 AC 72 (the assumption of responsibility by the state for the individual's welfare and safety, the vulnerability of the victim, and the nature of the risk), or standing back, to find that there was an arguable assumption of state responsibility or an article 2 duty.

There is no general obligation to prevent suicide in the absence of the assumption of responsibility. The Court rejected the submission that the Department had assumed responsibility for Ms Whiting's welfare and safety by providing her with the income necessary to survive. The Court found that the "reason the Department allocated ESA to Ms Whiting in the years before her death was that she satisfied the statutory eligibility criteria; the decisions had nothing to do with article 2".

The guidance for DWP staff used the language of safeguarding in relation to vulnerable claimants – this was "everyday, practical language" to communicate guidance to decision makers, it was not law and should not be read as such.

Ms Whiting had significant physical and mental health problems which made her particularly vulnerable, but she was not in the position of a prisoner (in the control of the state), a vulnerable person in the care of the state, or a child.

The risk posed to Ms Whiting by the withdrawal of benefits arose from long standing problems with her mental state and did not arise from an "inherently dangerous situation of specific threat to life such as risks posed by hazards which a person would not ordinarily assume".

Article 2: the systems duty

There was no arguable breach of the systems duty. The system for administering ESA claims has "a comprehensive framework for decision-making". The Court was asked to infer an arguable breach of the systems duty from the number of failings identified in the ICE report.

However, the Court considered that the evidence in fact showed that the Department's errors amounted to individual failings attributable to mistakes or bad judgement, not failures that were systemic or structural in nature. In light of the Court's clear focus on the constitutional role of the Coroner as contrasted to other institutions, it is perhaps unsurprising that reference to a National Audit Office report and 'concerns of parliamentarians' did not assist the Claimant.

Conclusion

Having focussed heavily on the constitutional role of the Coroner and the limitations imposed by sections 5 and 10 Section of the Coroners and Justice Act 2009, the Court declined to extend the requirements of a sufficient inquiry at common law, to find an assumption of state responsibility, or to extend the article 2 duty. The outcome may divide opinion. It will be disappointing for those wishing to use inquests as a venue to highlight failures in the welfare system if they contribute to deaths – a venue which may have more public impact and lead to greater scrutiny than the alternatives referred to in this case (a departmental complaints, the Independent Case Examiner, and the specialist Tribunal) and where the death of the individual is at the centre of proceedings. For others the judgment may be viewed as an orthodox restatement of the discrete nature and limits of the coronial process.

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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