EDITORS: **Nicholas Moss QC and Harriet Wakeman**
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TGC Inquests & Inquiries

The Newsletter of the TGC Inquests and Inquiries Team

LONDON
1 Harcourt Buildings
Temple, London, EC4Y 9DA
T +44 (0)20 7583 1315

THE HAGUE
Lange Voorhout 82, 2514 EJ
The Hague, Netherlands
T +31 70 221 06 50

E clerks@tgchambers.com
W tgchambers.com
DX 382 London Chancery Lane

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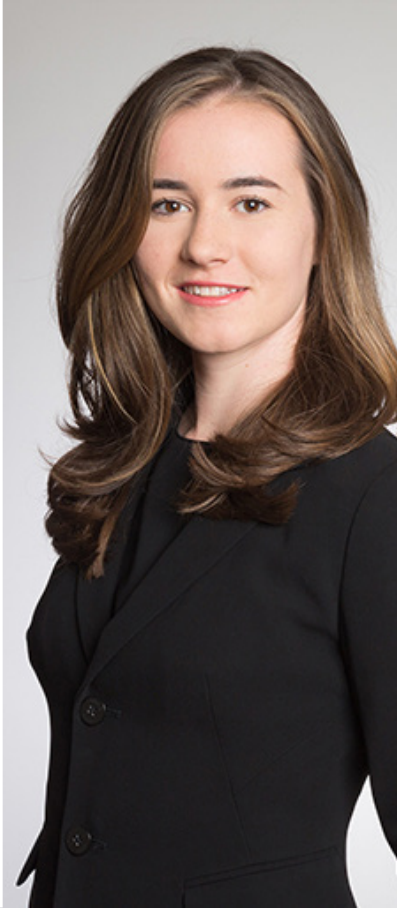
Editorial

By Nicholas Moss QC and Harriet Wakeman



Welcome to the inaugural edition of the TGC Inquests and Inquiries newsletter. This will be 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. This first edition goes to press as we approach the one year anniversary of the nation entering the first Covid-19 national lockdown, forcing courts, coroners and practitioners alike to adapt. Hearings of several large public inquiries initially had to be postponed and the future of inquests, particularly, those involving juries, was uncertain. One year on, public inquiries hearings have largely continued benefitting from the resource that allows effective remote hearings. For inquests the pattern has been far more varied reflecting differences of local practice and resources, as well as the particular challenge of holding jury inquests.

In this edition, Keith Morton QC and Emily Wilsdon provide a detailed analysis of the impact of the pandemic on inquests and coronial investigations, helpfully considering the relevant guidance notes, as well as their own experiences 'on the ground'. Similarly, David White and Olivia Rosenstrom consider the important question at the forefront of everyone's mind – will a public inquiry into the Government response to the Covid-19 pandemic be necessary?

Despite the challenges of navigating the Covid-19 pandemic, Members of Chambers practising in the areas of inquests and inquiries have had a busy few months. In particular, we offer our congratulations to Keith Morton QC, who was appointed an Assistant Coroner for Cambridgeshire and Peterborough in January 2021. Within this edition, we also highlight a handful of recent cases that Members of Chambers have been involved in, and in her article, Fiona Canby considers the wider implications of the landmark inquest into the death of Ella Adoo-Kissi-Debrah, in which Fiona represented the Mayor of London and Transport for London.

In relation to recent guidance updates, Andrew O'Connor QC considers the role of counsel to the inquest, particularly in light of Guidance Note 40, published in August 2020, and Ellen Robertson considers the Chief Coroner's Revised Guidance Note 5, relating to Reports to Prevent Further Deaths, published in November 2020. Harriet Wakeman considers the key differences in practice between the two main routes of challenging a coroner's decision, s.13 applications and judicial review.

Finally, no newsletter relating to inquest law published in recent times could omit a consideration of the recent and highly significant Supreme Court decision in *R (Maughan) v Senior Coroner for Oxfordshire* [2020] UKSC 46. Nicholas Moss QC and Scarlett Milligan consider the decision, and offer a view on whether the outcome was actually desirable for self-inflicted deaths and in cases where unlawful killing may be raised.

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

Nicholas Moss QC and Harriet Wakeman

The impact of the coronavirus pandemic on inquests and coronial investigations

Keith Morton QC and Emily Wilsdon

Inquests

There are approximately 30,000 inquests a year of which in the order of 500 (1.6%) are jury inquests. Pandemics and court proceedings, especially with juries, do not mix. At the end of 2019 2,278 inquests had not been completed within 12 months. As yet there are no reliable statistics of the impact on the pandemic but this figure is bound to have risen significantly.

The experience of members of TGC is that initially all coronial hearings stopped. Coroners (in common with civil courts) were less well placed than the criminal courts to move to remote hearings. At the conclusion of the first lockdown the Chief Coroner indicated that coroners *"should now be moving towards routinely conducting hearings again"*.[1] Sterling efforts have been made to recover, within the bounds of the existing statutory provisions.[2] Jury inquests remain a rarity and many high profile jury inquests have been postponed until later in 2021 and beyond (e.g. Shoreham Air Crash, Croydon Tram Crash, victims of Stephen Port, numerous deaths in custody). Croydon is relisted for May 2021 and may be the first multi-interested person jury inquest of this scale and profile to proceed. Non-jury multi-interested person inquests such as the landmark air pollution case involving the death of Ella Kissi-Debrah have proceeded. Some death in custody cases have resumed.

For coroners the challenges have been compounded by the resources available to them, in particular accommodation and technology. The Rules require all hearings to be in public, which means the coroner must be in court for all hearings (including PIRs)[3] and the court open to the public. It is the presence of the coroner which constitutes the court, not the particular building or room in which the coroner sits.

The Chief Coroner's COVID-19 related Guidance

No 34: Guidance for Coroners on Covid-19 (26 March 2020)

No 35: Hearings During the Pandemic (27 March 2020)

No 36: Summary of the Coronavirus Act 2020, Provisions Relevant to Coroners (30 March 2020)

No 37: Covid-19 Deaths and Possible Exposure in the Workplace (28 April 2020, revised 1 July 2020)

No 38: Remote Participation in Coronial Proceedings via Video and Audio Broadcast (11 June 2020)

No 39: Recovery from the Covid-19 Pandemic (29 June 2020)

The Guidance contains practical measures to enable coroners to keep the coronial service moving during and recover from the pandemic. Practitioners should be mindful of this Guidance, especially Nos 37, 38 and 39 when making submissions about the approach it is submitted should be adopted in a particular case.

All of us involved with the coronial process are learning to work in new and innovative ways. In our experience remote PIRs work well and efficiently. Partially remote inquest hearings have been encouraged by the Chief Coroner[4] and in many cases work well. This requires us all to consider proceeding in a way that a year ago would have been unthinkable. The overriding consideration must be achieving justice in the particular case. In many cases hearing evidence remotely works well, is efficient and causes no injustice. This can be especially so for some experts and key workers. This is reflected is Guidance No 38 where the guidance provides at paragraphs 8 and 9:

"... partially remote hearings should take place wherever possible ... This should not inhibit the use of physical courtrooms in line with social distancing guidelines so long as they can be accessed safely."

There is an important caveat for jury inquests. At paragraph 25 the Guidance says:

"Partial remote hearings are for obvious reasons generally not suitable, save in the most exceptional and limited circumstances, for any jury inquests" (although note also the further guidance given in guidance No 39 at paras 23ff).

For so long as there is a requirement for social distancing in person jury hearings will remain a challenge and coroners will have to wrestle with the tension between completing inquests safely, justly and within a reasonable time. The previous Chief Coroner's view was that there will be some large or complex inquests that can only be held with all participants present.[5] The Croydon inquest may well prove a test of this. Nevertheless, it is our experience that some jury inquests have proceeded as partially remote hearings. But, in order to work careful planning is required coupled with a willingness to be flexible and to limit the number of people attending court and the time they are present. We anticipate a more intense focus on identification and narrowing of issues, use of admissions and evidence that can be read.

Although forced upon us, we forecast that many of these changes are here to stay.

The scope of investigations

Guidance Note No 37 'Covid-19 Deaths and Possible Exposure in the Workplace', as amended on 1 July 2020, accepts that *"there are therefore some instances in which a COVID-19 death may be reported to the coroner, such as where the virus may have been contracted in the workplace setting. This may include*

Participating effectively in remote PIRs

- Set up a separate channel of communication between the advocate and the client in advance, and be prepared to ask the coroner for short breaks to take instructions.
- Prepare for the coroner to focus on identifying the issues clearly, narrowing them where possible.
- While restrictions on workplaces continue and affect the gathering of documents, those representing potential providers of evidence to coroners should anticipate and gather evidence that the coroner might require in advance, and check whether there might be any particular difficulties with obtaining hard copy documents within normal timescales.
- We should prepare for a move to use of electronic documents.
- Identify potential witnesses, and prepare statements with a view to persuading the coroner that they may be admitted in writing pursuant to r.23 of the Coroners (Inquests) Rules 2013.
- Check and be ready to explain whether or not witnesses would be able to attend a hearing in person if required. Witnesses who are particularly vulnerable, who are key workers, or simply those who would have to travel and stay overnight would all have good reasons to ask to appear by video-link.

Juries

Section 30 of the Coronavirus Act 2020 removes the requirement for an inquest to be held with a jury if senior coroner has reason to suspect that the death was caused by notifiable disease (s. 7(2)(c) of the Coroners and Justice Act 2009) in the case of coronavirus, for all inquests opened while the section is in force.

However, as before, inquests will still require a jury where s. 7(2)(a),(b) and 7(3) apply, i.e. the deceased died in custody or otherwise in detention and their death was a violent or unnatural one, or the cause of death is unknown, or when the death resulted from an act or omission of a police officer or a member of a police force in the purported execution of their duty or where the senior coroner thinks there is sufficient reason for doing so.

frontline NHS staff as well as others (e.g. public transport employees, care home workers, emergency services personnel)". To this list might be added security guards, factory workers, home carers, bus and taxi drivers, and others.[6]

The guidance emphasises that unless there is reason to suspect that any culpable human failure contributed ***"to the particular death"***, an investigation will *"usually"* not be required. If a coroner has reason to suspect that some human error contributed to the death, an investigation will be required. Investigations will, as usual, be required where the deceased died while in state detention.

The guidance provides examples of human error: human failure which contributed to the infection, *"failures of precautions in a particular workplace"*, and *"some failure of clinical care of the person in their final illness"* if it may have contributed to their death.

The original version of the guidance stated that *"an inquest is not the right forum for addressing concerns about high level government or public policy"* and that *"an inquest would not be a satisfactory means of deciding whether adequate general policies and arrangements were in place for provision of personal protective equipment (PPE) to healthcare workers in the country or a part of it"*. This was the subject of significant criticism from some doctors, lawyers and politicians.[7] The amended guidance continues to point to caselaw indicating that an inquest *"is not usually the right forum for addressing concerns about high-level government or public policy, which may be causally remote from the particular death"*. Particular reference is made to issues such as the adequacy of PPE for staff, reminding coroners that the focus of the inquest should be the particular death. However, the amended guidance does concede that *"the scope of inquiry is a matter for the judgment of coroners, not for hard and fast rules"*.

Since then, at least two PFD reports have been made which address issues regarding testing, risk assessment, PPE and the isolation of positive patients in hospitals.[8]

It is worth noting that neither the original nor the amended the guidance warn coroners against investigating the adequacy of local policies and arrangements, or failures to comply with national or regional policies. However, perhaps hinting at the potential for a future public inquiry, coroners are asked to consider suspending investigations which require evidence or material relating to matters of policy or resourcing (even in relation to an individual hospital) *"until it becomes clear how such enquiries can best be pursued."*

We predict that coroners will be urged to include matters of policy and resourcing within the scope of investigations into deaths in custody and deaths in care homes where there have been significant local outbreaks that may point towards local failures. In one of the worst care home outbreaks, a third of a care home's residents died over a period of three weeks in January 2021.[9]

Possible issues for investigations where the death was part of a cluster of care home deaths might include the local testing regime, the use of agency staff, whether staff were supported and encouraged to self-isolate while awaiting a test result, visiting policies and the return of residents from hospital. The CQC recently issued a statement[10] reminding local authorities and providers that under no circumstances should staff who have tested positive for Covid-19, regardless of whether they are displaying symptoms or not, work in a care setting. Several local authorities have been ordered by the CQC to investigate allegations about this practice, which reflects the severe pressure on care home rotas with record numbers of staff sick or self-isolating.[11]

Between March 2020 and January 2021, 86 prisoners died having tested positive for COVID-19 within 28 days of death or where it was confirmed post mortem, of which 64 deaths were suspected or confirmed to be due to COVID-19.[12] The rate of infection is known to have been particularly high in prisons. As at the end of January 2021 one in eight prisoners had tested positive, as compared to one in twenty in the community.[13]

Potential issues for investigations might include any failures in precautions in a particular prison, the time taken to seek medical help, and whether a particular prisoner's vulnerability to COVID-19 arising from underlying conditions was recognised. Where the cause of death was not COVID-19, the significant change in the regime in prisons may still be relevant. Deaths in prison by suicide appear to have reduced in 2020, but investigations into those deaths that did occur may include the individual impact of restrictions on visits and the decrease in time spent out of cells.

Given the backlog of coronial work it may be some time before we find out whether coroners are willing to consider these issues in investigations. However, they will come under increasing pressure to do so unless and until the scope of any future public inquiry (or inquiries) becomes clear.

1. Guidance No 39 para 6
2. The Coronavirus Act 2020 made provisions for the conduct and broadcast of remote Crown Court hearings, but not the Coroners Court
3. Rule 11, The Coroners (Inquest) Rules 2013, Guidance No 35 para 5
4. Guidance No 39 para 13
5. Annual Report of the Chief Coroner 2020, para 31
6. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand28december2020
7. E.g. https://www.bmj.com/content/369/bmj.m1806
8. https://www.judiciary.uk/wp-content/uploads/2021/01/Anthony-Slack-2020-0264.pdf and https://www.judiciary.uk/wp-content/uploads/2021/01/Leslie-Harris-2020-0280_Redacted.pdf
9. https://www.basingstokegazette.co.uk/news/19043790.coronavirus-outbreak-22-deaths-pemberley-house-care-home/
10. https://www.cqc.org.uk/news/stories/joint-statement-use-covid-19-positive-staff-care-settings
11. https://www.theguardian.com/society/2021/jan/28/cqc-issues-warning-about-care-home-staff-working-with-covid
12. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960361/HMPPS_COVID19_JAN21_Pub_Doc.pdf
13. https://www.theguardian.com/society/2021/feb/12/one-in-eight-prisoners-in-england-and-wales-have-had-covid

The consistent over the desirable? *R (Maughan) v Senior Coroner for Oxfordshire* [2020] UKSC 46

Nicholas Moss QC and Scarlett Milligan

The *Maughan* Judgment

Readers of this newsletter will be familiar with the Supreme Court's November 2020 decision in *Maughan*. By a 3-2 majority, the Court ruled that the civil standard of proof should apply to all short form and narrative conclusions in inquests. This reversed the previously understood position that the criminal standard of proof applied to the conclusions of unlawful killing and suicide.

Giving the lead judgment, Lady Arden concluded that the applicable standard of proof in inquests was a common law matter. She set out four key reasons why the civil standard of proof should apply to the short-form conclusion of suicide [§§68-82]:

1) As inquests are civil proceedings, they should apply the civil standard of proof. This is a general legal principle and there was no "cogent reason" why it should not apply in the inquest context;
2) The application of the criminal standard of proof may lead to suicides being under-recorded. This could prevent society from learning lessons and preventing suicides;
3) Suicide is no longer a crime. Society's attitude toward suicide has changed considerably in recent times. Whilst there are some who still hold negative views of suicide, this is no longer the "prevailing social attitude"; and
4) Other Commonwealth jurisdictions have sought to align the evidential standards in inquests and other civil proceedings.

Lady Arden went on to consider whether a change in the standard of proof should also apply to conclusions of unlawful killing. Largely on grounds of consistency, Lady Arden concluded that it was appropriate for the general civil standard of proof to also apply to unlawful killing conclusions.

In Lord Kerr's dissenting judgment (with which Lord Reed agreed) the prevailing standards of proof had been codified by statute, by virtue of note (iii) in the Record of Inquest Form. Lord Kerr saw no inconsistency in short form and narrative conclusions having different standards of proof, nor anything untoward in putting suicide and unlawful killing in a special category of conclusions that require proof to the criminal standard. In the dissenting view, it was not open to the Supreme Court to change the standard of proof.

Discussion

Who would have foreseen the remarkable outcome of *Maughan* when the family's judicial review was first issued? Here was a case of a self-inflicted death. Neither the family nor the Coroner had suggested that anything other than the criminal standard of proof applied to a short form 'suicide' conclusion. The issue raised at first instance was whether the findings in the narrative conclusion (found to the civil standard) were impermissible having regard to that requirement. It was the Divisional Court that questioned the underlying assumption that the criminal standard applied to conclusions of suicide. With the obvious potential implications for unlawful killing conclusions, the Chief Coroner then intervened in the Court of Appeal and in the Supreme Court. Ultimately, the Supreme Court has found the common law to require the civil standard to apply not just to the suicide conclusion but also to unlawful killing.

Maughan will bring greater consistency to inquest conclusions in two different respects. First, all inquest conclusions will have the same standard of proof. Secondly, inquests will also be in line with the majority of civil proceedings where, even if the issue is whether conduct which would be criminal has occurred, the civil standard applies. This change will be welcome to some. In jury cases affected by the change, directions

as to the standard of proof will generally be more straightforward.

In other respects, has this Court-inspired re-assessment of the coronial standard of proof (with its appeal to consistency) produced an outcome that is actually desirable?

In cases of self-inflicted deaths, the answer may be a cautious 'yes':

1) Recognising the prevalence of suicide is an important part of tackling and reducing its occurrence. It is therefore hugely undesirable that the prevalence of suicide should be under-reported. The lowering of the standard of proof for suicide will surely have a significant impact on the national suicide statistics in England and Wales. Since these are based on coronial conclusions, the Office of National Statistics has already recognised the likely impact of Maughan.
2) There will be bereaved families for whom the lowering of the evidential standard will be unwelcome. This may relate to their personal beliefs (religious or otherwise) or simply an understandable desire to avoid a conclusion that their loved one ended their own lives deliberately. For others it may be the impact on insurance or other benefits which may be adversely affected by a conclusion of suicide, although there was a risk of this from narrative conclusions even prior to Maughan.[1] However, Lady Arden was surely right to identify the importance of society's changing attitude to suicide.
3) For often benign reasons, coroners and juries had resorted to narrative conclusions to make clear that a death was self-inflicted albeit that there was an element of reasonable doubt about the deceased's intention to end their life. That is precisely what the jury in James Maughan's inquest did. In such cases, the traditional short form conclusion of suicide can now be used. Short form conclusions are simple to understand and accessible. Those advantages have been long recognised in the Chief Coroner's guidance on conclusions.

However, it is *Maughan's* impact on unlawful killing conclusions that most sharply divides opinion.

Post-*Maughan* conclusions of unlawful killing will be easier to achieve at inquests. While each and every aspect of a homicide offence will still need to be established, they will now only need to be found to the civil standard. For unlawful killing by gross negligence manslaughter, some will argue that there is a conceptual difficulty in applying the civil standard of proof when one element of the offence is that the conduct is sufficiently grave as to warrant classification as criminal conduct. Despite such complexities, the effect of *Maughan* in relation to unlawful killing may be a welcome development for families, we note that the organisation INQUEST intervened to argue in favour of this outcome. An important consideration is that by lowering the unlawful killing standard of proof, it is said that organisations will now be held more to account. The change may also encourage Coroners to refer more cases to the prosecuting authorities pre-inquest and encourage prosecuting authorities to re-consider criminal proceedings in more cases post-inquest. In the latter case, however, the prosecuting authorities will now be bound to take into account that inquest conclusions of unlawful killing were returned applying the lower civil standard.

What of those individuals or organisations suspected of homicide offences? For them, the implications of *Maughan* are problematic and troubling.

As is well known, the 2009 Act provides that an inquest conclusion *"...may not be framed in such a way as to appear to determine any question of (a) criminal liability on the part of a named person, or (b) civil liability"*. If the inquest is suspended because of criminal proceedings, the determination of the inquest must not be inconsistent with the "outcome of" those criminal proceedings. The paradigm example of the protection afforded by the latter provision was those charged and acquitted at trial of a homicide offence. Pre-*Maughan*, no inquest could return a conclusion of unlawful killing based on the actions of a person or organisation acquitted of a homicide offence because this would breach the prohibition on inconsistent outcomes. However, now that the inquest will apply a lower standard of proof, that protection is effectively removed. The Chief Coroner's recently released Law Sheet Number 6 on the *Maughan* case confirms this, stating:

"If in such an inquest the coroner or inquest jury find that the requisite elements of murder, manslaughter or infanticide are established on the balance of probabilities then a conclusion of unlawful killing will be permissible even though there has already been an acquittal of the offence following a homicide trial."(§21)

Moreover, the different standard of proof will now likely feature as being in itself an argument in favour of resuming inquests following an acquittal. In such cases, the Coroner must resume the inquest if they are satisfied that there is "sufficient reason" for doing so. Pre-*Maughan*, such resumptions most frequently occurred where there were wider issues *beyond* the conduct of the defendant addressed at the criminal trial which required examination. Post-*Maughan*, coroners will face arguments that the very conduct of the acquitted defendant should be re-examined at a resumed inquest because the inquest can judge the facts of that conduct applying a lower standard of proof. These will be difficult arguments. It is hardly surprising that the new Law Sheet 6 indicates that *"Coroners will need to consider requests for resumption with care and give, as with any other judicial decision, a reasoned judgment."* (§20)

For those acquitted at trial, both the more-ready resumption of an inquest and the availability of an "unlawful killing" conclusion to the civil standard at such a resumed inquest, will seem unfair if not perverse. It will be scant comfort that the individual or organisation cannot be named in the inquest conclusion. Lady Arden was not persuaded by such concerns. She noted that a person implicated by an unlawful killing conclusion would be *"...equally liable to suffer prejudice from the findings by way of narrative statement, which can be found on a balance of probabilities"* and that *"...the accused would be in the same position in an inquest as he already is if civil proceedings are brought against him"* (§95).

It is, of course, true that findings to the civil standard can equally be made in civil proceedings where for example assault or sexual abuse are alleged. However, this argument overlooks that the procedural protections of civil, let alone criminal, proceedings are not available to an Interested Person in an inquest. Interested Persons have no right to call evidence at an inquest. They are prohibited from addressing the court as to the facts of what happened. And while disclosure in modern well-run inquests may be unrecognisable from that which occurred only a decade ago, it still falls far short of the protections afforded in both criminal and civil litigation. It is here that the whole 'consistency with civil proceedings' argument arguably breaks down. As Lord Kerr recognised in his dissenting judgment, inquests do not fall squarely into the civil proceedings category: they have a *"unique nature"* and could be considered *"...sui generis proceedings with rules of procedure of their own"* (§§141-142). An inquest's ability to pronounce that a death arose by means of unlawful killing may be thought to exemplify its unique nature. After all, an unlawful killing conclusion at an inquest connotes that a crime has been committed which has caused the death.

The Court of Appeal had urged the desirability of the standard of proof being expressly legislated for in the Inquest Rules. That invitation was not taken up by the Government and the appeal had to proceed. By a narrow majority, the Supreme Court has now decided the path ahead. The Court's decision on unlawful killing conclusions may have unintended consequences. Some of them may yet prove unfavourable to maintaining the inquisitorial spirit in the ever-more challenging inquest arena. tgc

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1. *See Braganza v BP Shipping Limited* [2015] UKSC 17, discussed in *Maughan* at paragraphs 79-80 and 137.

Ella Adoo Kissi-Debrah – A Canary in a Coal Mine?

Fiona Canby

Ella was good at most things she tried her hand at. She wanted to be a pilot. She will now be known as the first person in the UK (and possibly the world) to have air pollution recorded as a medical cause of death. What, if anything, can we learn from her inquest about air pollution inquests in the future?

Ella was born in 2004 and lived in Lewisham in south-east London, about 25 metres from the South Circular. By October half term in 2010, her mother, Rosamund, realised something was wrong when Ella was unable to climb up Monument. 28 months later, after 16 episodes of seizures and 27 hospital admissions, Ella died on 15 February 2013, aged 9.

The first inquest into her death was held in 2014 when Philip Barlow, Assistant Coroner for London Inner South concluded that the medical cause of death was a) acute respiratory failure and b**)** severe bronchial spasm – severe asthma attack which caused acute respiratory failure. There was no investigation into what had caused her asthma.

In 2015 Professor Sir Stephen Holgate, the Royal College of Physicians' special adviser on air quality and the Founder Chair of the government's advisory committee on air pollution (COMEAP), read an article about Ella's case and got in touch with Rosamund. His subsequent report finding evidence of a link between air pollution, Ella's asthma and her death, was relied on by the family in their application for a fresh inquest, which was supported by the Mayor of London.

Philip Barlow (without a jury) was the Coroner again at the fresh inquest. Ella's family was represented by Richard Hermer QC, Adam Straw and Ravi Mehta (instructed by Hodge Jones and Allen). Central government (Defra, DfT and DHSC) was represented by Alan Payne QC and Colin Thomann (instructed by GLD). Lewisham Council was represented by Jonathan Moffett QC and Julian Blake (instructed by Lewisham's Legal Services). I represented the Mayor of London and Transport for London (instructed by TfL Legal).

The Inquest sat for 9 days. We heard from 6 witnesses of fact and 5 experts. The electronic bundle of documents was over 10,000 pages long. We socially distanced in a large hearing room in Southwark Town Hall. Witnesses attended in person or gave evidence remotely via MS Teams. Members of the public and press observed proceedings from a separate room at the Town Hall or logged in via MS Teams. The Coroner gave his conclusion on 16 December 2020 and is currently considering written submissions from the IPs in relation to PFDs.

The issues were:

1) Whether air pollution caused or contributed to Ella's death
2) How air pollution levels were monitored at the time
3) The steps taken to reduce air pollution
4) The information provided to the public about the level of air pollution, its dangers and ways to reduce exposure.

The Coroner considered that Article 2 was engaged. He noted that an inquest is not the right forum to resolve matters of public policy. He looked at issues of air pollution with Ella as the centre point. It was not for him to say whether political decisions were right or wrong. However, he considered the implications of decisions as far as they were relevant to Ella's death.

The key period investigated was 2010 to 2013. It was not in dispute that for the whole of this period, the whole of the UK and London was in breach of NO_2 limits (nitrogen dioxide) set by EU and domestic law. There was also a failure to comply with PM_{10} limits (particulate matter with an aerodynamic diameter of less than 10 micrometres) from 2005 to 2010.

Dr Claire Holman, an expert in air quality management, instructed by Ella's family, described the NO_2 limits as tough targets, especially for London. In oral evidence, she accepted that a diesel ban would have been politically unattractive. Over Ella's life the number of diesel cars increased. In general, at that time, diesel cars emitted more NO_2 and there was a discrepancy between real-world emissions and the European emissions standards.

Vehicle charging schemes, such as the London Low Emission Zone ("LEZ") can accelerate compliance with air quality limits. The LEZ was focussed on PM_{10} and did not include cars. Phase 3 of the LEZ was delayed in the aftermath of the 2008 financial crisis. However, the Coroner found that it was not for him to comment on the policy decisions underpinning the delay.

The Coroner found that opportunities were not taken that would have had an impact on NO_2 levels. Lewisham Council had little opportunity to reduce air pollution, particularly as much of the pollution in the borough originates outside it. The need to improve air quality required coordinated action by all three levels of government and all of us.

Ella was seen by specialists in at least five hospitals. There is no evidence that air pollution was discussed. All the medical experts, including Dr Greg Warner (a GP instructed by the family) and Professor Holgate, agreed that doctors in clinical practice were not giving information to patients about air pollution and asthma.

Rosamund would have mitigated Ella's exposure to air pollution had she been told of the risks. It is possible that moving house would have made a difference but the Coroner was unable to say that it was likely. The difficulty of disaggregating the effects of pollutants meant that the Coroner could not reach conclusions as to whether it would have made any difference if NO_2 levels had been below national or EU limits.

Professor Wilkinson, an expert in environmental epidemiology, instructed on behalf of central government, found no evidence of a relationship between the timing of Ella's hospital admissions and periods of local high air pollution. Professor Holgate would not expect a temporal relationship. The Coroner accepted his evidence that air pollution made a significant contribution to causing damage to Ella's lungs. Other causes were excluded as triggers. The Coroner therefore completed the Record of Inquest as follows:

Record of Inquest

Following an Inquest opened on the 17 December 2019, And an inquest hearing at Main on the 30 November 2020 heard before Philip Barlow in the coroner's area for London Inner South ,

The following is the record of the inquest (including the statutory determination and, where required, findings).

1. Name of Deceased (if known)

   Ella Roberta ADOO KISSI-DEBRAH

2. Medical cause of death

   1a Acute Respiratory Failure

   1b Severe Asthma

   1c Air Pollution exposure

   II

3. How, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death

Ella Adoo Kissi-Debrah had severe, hypersecretory asthma causing episodes of respiratory and cardiac arrest and requiring frequent emergency hospital admissions. On 15 February 2013 she had a further asthmatic episode at home and was taken to University Hospital Lewisham where she suffered a cardiac arrest from which she could not be resuscitated.
Air Pollution was a significant contributory factor to both the induction and exacerbations of her asthma. During the course of her illness between 2010 and 2013 she was exposed to levels of Nitrogen Dioxide and Particulate Matter in excess of World Health Organization Guidelines. The principal source of her exposure was traffic emissions. During this period there was a recognized failure to reduce the level of NO2 to within the limits set by EU and domestic law which possibly contributed to her death.
Ella's mother was not given information about the health risks of air pollution and its potential to exacerbate asthma. If she had been given this information she would have taken steps which might have prevented Ella's death.

4. Conclusion of the Coroner as to the death

   Died of asthma contributed to by exposure to excessive air pollution

So, what are the wider implications of Ella's case? Will we see more air pollution inquests in the future? It could be argued that in some respects Ella's case was unusual: she suffered from severe, hypersecretory asthma; she lived very close to the South Circular and she was growing up during a time when the proportion of diesel cars was increasing on the roads. On the other hand, whilst levels of NO_2 have reduced after Ella's death, Professor Holgate was clear that it there is no safe level of air pollution and air pollution can contribute to all types of asthma.

Ella's case illustrates that any family who wishes to explore the link between air pollution and a death will need very thorough analysis from a medical expert in this field. Local authorities should anticipate that in the future they will be asked to provide evidence to a Coroner as to the steps that they have taken to reduce air pollution. Given the likely historical nature of such inquests, they would be well advised to keep good records of their air quality action plans, progress reports, minutes, policies, monitoring results and modelling.

Professor Holgate said that Ella's death should act as a canary in a coalmine, warning about the dangers of air pollution. Her inquest was the first to investigate the role of air pollution in a death. It seems unlikely that it will be the last.

Counsel to the Inquest

Andrew O'Connor QC

Coroners have been appointing barristers to act as Counsel to the Inquest ("CTI") since at least the 1980s, and the practice has become far more common in the past decade or so. Curiously, however, the role was not officially recognised until very recently. In contrast to the (closely analogous) position of counsel to a public inquiry, which is expressly established in the Inquiry Rules 2006, the position of CTI does not warrant a single reference either in the Coroners and Justice Act 2009 or in either the Inquests or the Investigations Rules 2013.

This lack of official recognition was rectified last year by the publication of the Chief Coroner's Guidance Note (No.40) on Counsel and Solicitors to the Inquest. The Guidance Note is an informative and useful resource, which brings overdue recognition and helpful definition to this long-established practice.

As an introduction to the Guidance Note, I consider briefly here the types of inquests in which CTI have typically been instructed, how the practice might develop, and, most importantly, how CTI can add value in coronial proceedings.

The role of CTI is perhaps most often thought of in connection with large scale inquests, often involving multiple fatalities and conducted by specially appointed retired or serving judges (also, more recently, the Chief Coroner). Inquests in this category include those into the deaths of Diana Princess of Wales and Dodi Fayed, the 7/7 inquests and the inquests arising from more recent terrorist attacks that have followed it, the Hillsborough inquests, the Litvinenko inquest, the Deepcut inquests, and so on. These inquests often resemble public inquiries, and the wide-ranging role that CTI perform in such cases is in fact very similar to that of counsel to a large public inquiry. In the early stages CTI advise on scope, on the disclosure exercise, and on requests for witness statements. They prepare for and assist in conducting PIRs. They assist in planning for substantive hearings and then examine the witnesses at those hearings. Typically in such cases CTI form part of a larger legal team comprising one or more solicitors to the inquest and often also paralegals – nowadays this team is often referred to as the 'ILT', the Inquest Legal Team.

It would be wrong, however, to think that the appointment of CTI is only appropriate or justifiable in high-profile or judge-led inquests. Indeed, in recent years there has been a steady growth in the number of cases in which senior coroners have appointed CTI to assist in inquests that they are conducting themselves. This is perhaps unsurprising given the general trend towards longer and more procedurally complex inquests. As the Guidance Note makes clear, there are real practical advantages that flow from the presence of CTI to assist a senior coroner hearing a difficult inquest – advantages that justify the cost involved. For example, CTI can develop informal working relationships with IPs' legal representatives that can have significant case management benefits – streamlining hearings and narrowing or ideally avoiding legal disputes. And, particularly in longer cases, the allocation of the examination of witnesses to CTI removes a considerable burden of preparation from the coroner, allowing them to spend non-sitting time on other work.

Nor should it be thought that CTI need necessarily be instructed for the duration of an entire case, or even that CTI needs to be senior counsel with a role that

involves making oral submissions in court. As to the former, a coroner may decide to instruct CTI solely to make submissions on a particular legal issue – relating for example to disclosure or anonymity – perhaps because the issue has become contentious to the point of judicial review being anticipated. The involvement of CTI in such situations should bring the double benefit of a reduction in the JR risk and also the availability of further legal support should that risk eventuate. And as to the latter, as the Guidance Note suggests, more junior counsel may be instructed as CTI in order to assist the coroner in what is essentially a supporting role – collating documents, managing disclosure, and taking a detailed note of key parts of the evidence.

Finally, it is worth noting that another of the Chief Coroner's Guidance Notes (No.30, on Judge led inquests) identifies (at paragraphs 24 and following) a very particular function that can be discharged by security-cleared CTI. That process involves CTI reviewing material that is of potential relevance to an inquest, but which cannot be seen by the coroner either because it is too sensitive (PII material) or because there is a statutory prohibition on it being disclosed to the coroner (e.g. intercept material – see Investigatory Powers Act 2016, s.56). In a nutshell, the process involves CTI reviewing the material, considering its relevance to the inquest and, if relevant, attempting to provide a gist which captures the relevance of the material whilst avoiding the sensitivity. Whilst the need to conduct this particular process is only likely to arise in a small number of cases, it is not at all unusual for coroners to face acute difficulties in connection with the disclosure or handling of sensitive documents, and this is very much the type of area in which CTI might assist as a discrete exercise.

The point to emphasise for the future, which is underlined in the new Guidance Note, is that the role of CTI is an inherently flexible one. As inquests become ever more complex and the workload of senior coroners increases, the role of CTI should be thought of not as a 'one size fits all' function reserved for the largest inquests, but rather as a flexible resource, capable of providing bespoke and cost-efficient assistance to coroners in a wide range of cases.

Routes to challenging a Coroner's Decision: Section 13 Applications and Judicial Review

Harriet Wakeman

Unlike many other types of proceedings, there is no statutory right of appeal following an inquest. Instead, those seeking to challenge a coroner's decision have two options: an application under Section 13 of the Coroners Act 1988 and an application for judicial review. These processes can be pursued individually or concurrently, and practitioners need to be alert to the scope and limitations of both when advising on the appropriate course of action in any given case. This article highlights some of the key differences between these two routes.

Scope and Application

Section 13 is a form of statutory review which involves an application by, or under, the authority of, the Attorney General to the High Court. It is relevant, broadly speaking, in cases where the coroner has not held an inquest or investigation which ought to have been held, and in cases where an inquest has already been held, but it is necessary or desirable in the interest of justice that a fresh inquest be held. It is specific to coroners and s.13(1) states:

"(1) This section applies where, on an application by or under the authority of the Attorney-General, the High Court is satisfied as respects a coroner ("the coroner concerned") either—

(a)that he refuses or neglects to hold an inquest or an investigation which ought to be held; or

(b)where an inquest or an investigation has been held by him, that (whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise) it is necessary or desirable in the interests of justice that an investigation (or as the case may by, another investigation) should be held."

Whilst s.13(1)(a) is fairly self-explanatory, s.13(1)(b) requires some further consideration. The circumstances where s.13(1)(b) will be relevant are set out within the statute: *"fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise"*. Whilst the discretion under s.13 is broad, and the specific reasons set out in s.13(1)(b) are not exhaustive, the inclusion of *"or otherwise"* within s.13 does not mean that it is boundless in scope (see, for example, *Jones v HM Coroner for Gwent* [2015] EWHC 3178 at [18] where it was held that the judges in *Tabarn*, Re [2000] Inquest L.R. 52 and *R. v Divine Ex p. Walton* [1930] 2 K.B. 29 were not intending to say that s.13 could be invoked whenever there appeared to be a cogent case for judicial review based on a coroner's alleged failure properly to apply the law).

It is also important to consider the meaning of *"necessary or desirable in the interests of justice"*. Helpful guidance is given in this regard in the Hillsborough application, *Attorney General v South Yorkshire (West) Coroner* [2012] EWHC 3783 (Admin), where at [10] it is stated:

"The single question is whether the interests of justice make a further inquest either necessary or desirable. The interests of justice, as they arise in the coronial process, are undefined, but, dealing with it broadly, it seems to us elementary that the emergency of fresh evidence which may reasonably lead to the conclusion that the substantial truth about how an individual met his death was not revealed at the first inquest, will make it both necessary and desirable in the interests of justice for a fresh inquest to be ordered. The decision is not based on problems with process, unless the process adopted in the original inquest has caused justice to be diverted or for the inquiry to be insufficient."

The aspects of an inquest or investigation that can be challenged within judicial review proceedings are wider than under s.13. As set out above, s.13 relates to the decision of the coroner to order investigations/inquests and provides a means of quashing determinations or findings. In contrast, judicial review enables review of

all actions and decisions of the coroner, including: the coroner's inquisition, determination, and findings, as well as preliminary and interlocutory decisions.

The grounds for judicial review are widely known and are not rehearsed here, save to note broadly, that in the inquest context, those most likely to be of relevance include irrationality, procedural irregularity and unfairness. It should be noted that judicial review is a discretionary remedy and therefore, even if made out, the court retains a discretion as to whether it should grant the relief sought.

Time Limit and Procedure

The key point to note in relation to time limits is that for judicial review proceedings, the claim form must be filed promptly, and in any event, no later than three months after the grounds upon which the claim is based, first arose (CPR r.54.5(1)). This time limit cannot be extended by agreement between the parties (CPR r.54.5(2)). In contrast, there is no time limit for advancing an application under s.13, provided the relevant conditions are met. However, a word of warning: the Court has made clear that s.13 should not be used to attempt to obtain judicial review by the back door where a timely application for judicial review has not been advanced (*Jones v HM Coroner for Gwent* [2015] EWHC 3178).

Whilst readers will no doubt be familiar with the procedure for applying for judicial review, which is set out in CPR Part 54, it is worth pausing here to note that there is a distinct procedure for initiating applications under s.13. In short, permission of the Attorney General (a fiat) must be obtained in order to proceed. The Attorney General uses a test similar to that applied to applications for permission for judicial review when considering whether permission to proceed ought to be granted.[1]

Relief

Following a successful s.13(1) application, the High Court may order:

i. an investigation to be held into the death (by the coroner concerned, or by a senior coroner, area coroner, or assistant coroner in the same area);

ii. order the coroner to pay the costs of and incidental to the application as may appear just; and,

iii. where an inquest has been held, quash any inquisition on, or determination or finding made at that inquest (Section 13(2)).

Judicial review proceedings offer greater flexibility than s.13 in terms of the relief that can be granted following a successful application. Whilst the Court may quash the inquest and order that a fresh inquest take place, the Court can also grant relief falling short of quashing the entire inquest. Notably, in previous cases the Court has substituted a conclusion[2], added a narrative[3], and deleted paragraph 4 of the Record of Inquest (the conclusion as to death) and remitted it to the Coroner to enter such conclusion as was appropriate in light of the judgment on the judicial review.[4]

Conclusion

Until such time as a system of appeals for inquests is introduced, such as that originally envisaged in Section 40 of the Coroners and Justice Act 2009 (which was repealed before it came into force), s.13 and judicial review proceedings remain the only routes of challenge. The above analysis demonstrates that it will be important in each individual case to consider the scope and limitations of both methods of challenging a coroner's decision. Whilst the lack of a time limit and the broad prerequisites in s.13 may be attractive in some cases, the breadth of actions and decisions that can be reviewed and the flexibility of the relief that can be granted in a judicial review will be appealing in others. What is clear is that there is no 'superior' route and instead, the best course of action in any given case will turn on its facts.

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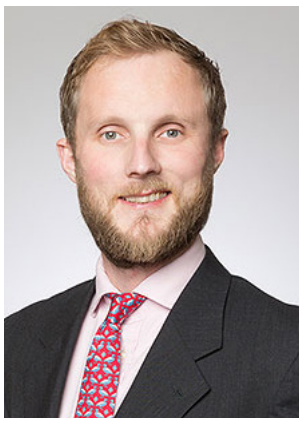
1. Jervis on Coroners (14th Edition) at 19-21

2. *R. (Wilkinson) v Greater Manchester South Coroner* [2012] EWHC 2755 (Admin)

3. *R. (Longfield Care Homes Ltd) v Blackburn Coroner* [2004] Inquest L.R. 50

4. *R. v Southwark Coroners Court Ex p. Kendall* [1988] 1 W.L.R. 1186



Is it likely that a public inquiry into the Government response to the Covid-19 pandemic will be necessary?

David White and Olivia Rosenstrom

Introduction

According to S.1(1) of the Inquiries Act 2005:

1) A Minister may cause an inquiry to be held under this Act in relation to a case where it appears to him that–

(a) particular events have caused, or are capable of causing, public concern, or

(b) there is public concern that particular events may have occurred.

It is difficult to think of anything that has occurred in the lifetime of the vast majority of readers that has caused as much sustained and widespread public concern as the COVID-19 pandemic. The pandemic, and the government's response to it, have not just touched the lives of every single subject of the United Kingdom over the last twelve months, they have substantially altered the day-to-day existence of most, and will continue to do so for months (or, whisper it, perhaps years) to come. Even before we consider the significant, and growing, number of deaths that have resulted from COVID-19, it seems impossible to avoid the conclusion that there will have to be a public inquiry (or inquiries) of some nature into the events of the last 12 months. Perhaps the better question is not will there be an inquiry at all, but what shape will the inquiry take, and when will it begin?

Timing

It is unlikely that the Government would want an inquiry to start whilst the pandemic is on-going, but what do we call the 'end' of the pandemic? By some definitions, it may never be over; unlike a war, there will be no single 'VC Day' when the spike proteins fall silent. Over time, things will drift back towards 'normality', and there will come a point at which we can say it is sensible to look back at what might have been done differently. Whilst we cannot precisely list all the parameters of that time now, like Justice Potter Stewart I suspect we will know it when we see it. Of course, like scope, the question of timing is an inherently political one, that can only really have a political answer. The incumbent government is unlikely to want to press ahead quickly with an inquiry that will re-examine its own failings, particularly if the vaccination programme sparks a speedy economic recovery, and a bounce in the polls. Similarly, any politically adept government would seek to ensure that COVID inquiries were kept well away from the headlines in the run up to a General Election.

The perfect scenario for the Government would probably be to timetable an inquiry so that it says nothing substantive until after the next election (and they will probably hope the polls are sufficiently favourable for them to go to the country in summer 2023 – assuming they fulfil their intent to revoke the Fixed Term Parliaments Act). The likelihood, then, is that an inquiry will not start imminently, or if it does then it will start with more peripheral and less controversial issues.

Form and Scope

The potential scope of a COVID inquiry is enormous. It conceivably crosses every government department, as well as vast swathes of the private sector. There is the potential for the question for an inquiry chair to become, in essence: 'How effectively was the United Kingdom governed between 23 March 2020 until the end of the pandemic?' Clearly, that would be an unwieldy task, and one no government would allow, and so it is much more likely that there will be a desire to circumscribe and compartmentalise.

There are alternative methods of review that fall short of a public inquiry under the Act. The Government could choose to conduct internal reviews of certain decisions and approaches during the pandemic, or to appoint an independent panel to carry out an inquiry outside the scope of the Act. Indeed, some smaller acts of scrutiny are already underway. For example, the House of Commons has published a number of reports on aspects of the government's response to the pandemic. Additionally, several select committee inquiries are either in progress or have already published. Whilst such approaches may be suitable for some questions, given issues of potential lack of independence, or lack of sufficient power to compel witnesses and require disclosure, it is difficult to see that the public would be satisfied with less than a full inquiry in the key areas of concern.

One option would be to carry out a number of smaller sub-inquiries running concurrently under the umbrella of a wider inquiry, broadly similar to the Inquiry into Child Sexual Abuse. To succeed with this approach, it will be crucial to have a system that enables overarching coordination and collaboration between the smaller inquiries as required. The scope of the individual inquiries would also need to be well defined, as repetition is a risk. Organising the overall inquiry like this is one of the only ways to make it manageable. It also feeds into the issue of timing, as it makes it possible to commence smaller inquiries into some, perhaps less controversial, areas sooner, whilst leaving other elements for a later time.

Likely Key Areas of Inquiry

Whilst the overall span of inquiry is still uncertain, there are some issues whose consideration seems unavoidable.

Care Homes

Age and underlying health conditions render care home residents particularly vulnerable to COVID-19. Likely areas of scrutiny include: risk assessments, procedures for preventing the spread within care homes, COVID-19 isolation procedures for residents and, in particular, the early failures in relation to testing prior to discharging hospital patients back to care homes.

A number of these areas of concern are reflected in the Prevention of Future Deaths report arising from the inquest into the death of Mr Anthony Slack by HM Senior Coroner, Alison Mutch. Mr Slack contracted COVID-19 at the care home where he was a resident, and died as a result. It was unclear whether staff had brought the virus in, or if the spread resulted from the admission of new residents without prior testing. There was no risk assessment relating to admission of new residents. It also became apparent during the inquest that staff were unclear as to the PPE requirements due to frequent changes in guidance. Issues and defective practices of this nature are not unique to Mr Slack's care home, and will certainly be explored more broadly to consider if systemic failings were at play.

Health Services

There are likely to be several dimensions to this part of any inquiry. The measures taken to prepare for a pandemic, including stocks of adequate PPE are central issues, are likely to be considered, both at local and national levels.

Other key issues will be: the treatment of COVID-19 patients, risk assessments, support and protection offered to healthcare workers, and the systems for preventing the spread of COVID within, and from, hospitals (here there is clearly potential overlap with the consideration of care homes) including testing.

Another aspect which may be considered is access to health care for non-COVID related health issues, as well as the general management of non-COVID health care during the pandemic. The Regulation 28 report by HM Senior Coroner Mutch following the inquest into the death of Mr Leslie Harris highlights some of these issues. Mr Harris was in hospital due to a hip fracture. He contracted COVID-19 in hospital due to being transferred to a bay with patients that had been exposed to a COVID-19 positive patient. Mr Harris had been recovering, but died as a result. He had been moved to the bay in question due to the hospital's interpretation of Public Health England guidance, again raising the possibility of systemic failings.

Measures of General Public Control

The timing, extent and methods of implementation and enforcement of social distancing measures, the use of face coverings, social restrictions and limitations, the test and trace programme, and the use of lockdowns are all potential areas for consideration. The obvious question is whether more substantial, or different, measures could, or should, have been implemented sooner in order to save lives.

On the other hand, the measures taken to curb the pandemic have had many negative effects, including upon the economy, public mental health, social care, the prevalence and frequency of domestic violence, and the quality and social benefits of education. Accordingly, such measures may be scrutinised not only for their efficacy in saving lives, but also for their "side-effects" and the steps required to ameliorate these.

These matters are intrinsically political, and involve balancing competing interests in difficult and unprecedented times. It is likely government will, perhaps with some justification, seek to control scrutiny in these areas. For others this topic ought to be at the very heart of the future inquiry. A review short of a full public inquiry in this area cannot be ruled out.

Conclusion

As with so many issues arising from the pandemic, the precise detail of any COVID-19 public inquiry is yet to be finalised. For Government and the putative inquiry itself, the biggest question would seem to be how to design one or more inquiries that will deliver tangible, independent, and thorough results into such a huge subject without incurring inordinate costs and delay, or crossing the line into matters political that are really for Parliament or the ballot box. However, it seems certain that there will be some form of inquiry, and the message to clients, particularly in the health, social care, and related sectors is clear: now is the time to start preparing.

1. https://publications.parliament.uk/pa/cm5801/cmselect/cmpubacc/404/40402.htm;
2. https://publications.parliament.uk/pa/cm5801/cmselect/cmpubadm/377/37702.htm

Reports to Prevent Future Deaths: An Update

Ellen Robertson

The Chief Coroner has released revised guidance on Reports to Prevent Future Deaths, as of 4 November 2020. Much of the previous guidance remains unaltered, but there are some important amendments to note.

1. Guidance on when to make a report

The Revised Guidance places additional emphasis upon the statutory duty of Coroners to publish reports where appropriate, and reminds Coroners that the reports are intended for the benefit of the public and not as a punishment.

As in previous Guidance, the Revised Guidance notes that it is for the Coroner to determine whether the statutory duty to report arises on a case by case basis. The Revised Guidance reminds Coroners to focus on the present situation when considering whether that duty arises, and to consider evidence and information about relevant changes made since the death. A Coroner may not need to make a report in circumstances where a potential report recipient has already implemented appropriate action. If the Coroner considers that a risk of future deaths may arise nationally and national action should be taken, a report to a relevant national organisation may be appropriate even when changes have been implemented by the local organisation.

The Coroner's role as a local judge is emphasised in the Revised Guidance, which notes that Coroners may be assisted by considering local trends and any previous reports made in respect of a potential report recipient.

The Revised Guidance also reminds Coroners that although a report may be sufficient to meet the state's duty to inquire fully in an Article 2 inquest, a report is not mandatory simply because Article 2 is engaged.

2. The content of reports

Coroners are also given further guidance as to the nature of reports, with a focus on their purpose as a learning tool. A reminder is given that reports should not contain a detailed rehearsal of the facts of the death or the history of the inquest.

The previous Guidance had noted that the duty to make a report is not limited to circumstances creating a risk of deaths only in similar circumstances to the death in question. The Revised Guidance repeats that position, but clarifies that while a Coroner may shed light on a system failure, the Coroner should not be drawn into reporting about matters which have not been explored properly at inquest. Coroners should not make reports in relation to matters that are not at all germane to the relevant investigation.

The previous Guidance is repeated – a report is a recommendation for action to be taken and not a recommendation that a specific action should be taken. The phrase "raises issues" has been added and further clarification provided on the distinction between reports and specific remedial recommendations. The Revised Guidance repeats the recommended wording as provided in templates that should usually be used regarding action to be taken. That wording states:

"In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action."

3. After sending a report

The Revised Guidance reminds Coroners that there is no power to withdraw a report after it has been sent. The appropriate remedy was confirmed in *R (Siddiqui & Paeprer-Rohricht) v HM Assistant Coroner for East London* (28 September 2017) Admin Court CO/2892/2017, which concerned a failed attempt by two GP partners to judicially review an Assistant Coroner's decision to issue a report following the death of one of their patients. Those who wish to take issue with the contents of a report should respond to the report, pursuant to paragraph 7(1), Schedule 5 of the 2009 Act.

4. Letters instead of reports

The previous Guidance had provided for Coroners to write a letter expressing concern to an individual or organisation, where the duty has not arisen but the Coroner wished exceptionally to draw attention to a matter of concern which had arisen during the investigation. However, the Revised Guidance stresses the exceptional nature of this course of action, and that a report remains the default position.

5. Juries

The Revised Guidance reminds Coroners that their discretion to leave facts relevant to the reporting power to the jury is a discretion and not a duty. Coroners are cautioned that it is better, generally, for matters relating to reports to be dealt with by the Coroner alone. Even if facts are disputed, that will not prevent the making of a report. There is no requirement for a matter raised in the report to have been proved causative of the death under investigation.

6. Templates

As in previous Guidance, Coroners are directed to always use the template form. Several additional examples of reports have been included in the revised guidance in the Annex. The previous Guidance gave just one example.

Recent Noteworthy Cases

Highways England to be referred to the CPS over fatal collision on smart motorway

Nicholas Chapman and Ellen Robertson both appeared before the Senior Coroner for South Yorkshire (East District) in a Pre-Inquest Review on 11 February 2021 concerning the death of Nargis Begum.

Mrs Begum, 62, was a passenger in a vehicle which broke down on the M1 in 2018, on a stretch of "All Lanes Running" smart motorway without a hard shoulder. She and her husband had exited the vehicle and were waiting for help when their stationary car was hit by another vehicle, pushing it into Mrs Begum and causing fatal injuries.

Following submissions, Senior Coroner Nicola Mundy suspended the inquest into the death of Nargis Begum, and will refer the matter to the CPS. The CPS has confirmed that the driver involved in the collision will not face prosecution, following an earlier referral from the Senior Coroner after an initial Pre-Inquest Review in December 2020.

The inquest is now suspended for the CPS to consider whether Highways England should be charged with corporate manslaughter in relation to Mrs Begum's death.

Ellen Robertson acted for the family of Mrs Begum, instructed by Christopher Kardahji of Irwin Mitchell LLP.

Nicholas Chapman acted for the Department for Transport and Highways England.

Inquest into the death of Carl Marrows

Sian Reeves acted for the Department of Health and Social Care in the inquest into the death of Carl Marrows, a 5 year old boy, who died in hospital in 1978 following muscle transfer surgery.

The original inquest into Carl's death concluded in 1986 with an open conclusion. The Coroner found that Carl's cause of death was due to shock and circulatory failure following the muscle transfer operation, but could not be satisfied what had caused that shock.

In 2018 Carl's father applied under section 13 of the Coroners Act 1988, under the authority of the Attorney-General, for an order quashing the original conclusion, and for a fresh inquest to be held. The High Court granted the application, and the fresh inquest took place on 12 and 13 January 2021 before the Senior Coroner for Hull and East Riding of Yorkshire.

The Senior Coroner instructed experts in anaesthesia, orthopaedic surgery and forensic pathology to provide evidence in relation to the medical cause of death and the care provided to Carl by the treating clinicians. All three experts agreed that the 1a medical cause of death was shock due to haemorrhage (blood loss).

The Senior Coroner found that blood loss was a foreseeable risk of the muscle transfer operation, that appropriate action was not taken to manage that risk, and that Carl's death had been contributed to by neglect.

The treating clinicians did not give evidence at the fresh inquest (they were presumed dead or simply not traceable). This meant that neither the family nor DHSC were able to explore their evidence on key issues. The prejudice caused by the non-availability of key witnesses in fresh inquests into historical deaths is thus very real. An important practice point is, therefore, the need for careful consideration of how to manage the fact that the relevant witnesses are no longer available to give evidence in respect of their acts/omissions.

Recent Noteworthy Cases

Inquest touching on the death of Janet Scott – concluding on 19 February 2021

William Irwin represented the National Probation Service (NPS) in the inquest touching on the death of Janet Scott. Mrs Scott was murdered by her former partner, Simon Mellors (SM), in January 2018.

This was the second time SM had murdered a former partner. In 1999 he was sentenced to life imprisonment for murdering his former partner Pearl Black.

SM was an outwardly compliant prisoner and completed various courses whilst in custody designed to reduce his risk of reoffending.

SM was released from custody on life licence in April 2014. Thereafter he was subject to supervision by an offender manager (i.e. probation officer), Andrew Victor (AV). AV was separately represented at the inquest.

SM started a relationship with Mrs Scott in April 2017. The relationship quickly became intense. It ended for a short period in November 2017 and then resumed. However, in January 2018 the relationship ended for a second time and Mrs Scott made it clear that she did not wish the relationship to resume once again.

SM would not accept the end of the relationship. He stalked Mrs Scott, culminating with him appearing outside her work at 4.30 am.

On 19 January 2018, Mrs Scott told SM's offender manager – AV – about this stalking behaviour. A few days later, concerns about SM's behaviour were also raised with AV by a clinician treating Mrs Scott. However, AV did not take action to safeguard Mrs Scott beyond telling SM to stay away from her. SM ignored this direction and – on 29 January 2018 – murdered Mrs Scott.

The Assistant Coroner for Nottinghamshire – Jonathan Straw – concluded that Mrs Scott had been unlawfully killed.

Applying the guidance regarding causation given by the Divisional Court in *R (Tainton) v Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin) the Coroner found that AV's errors in SM's management during the critical period in January 2018 were causative of Mrs Scott's death.

The Coroner also found that the NPS office in which AV worked had had a high workload since the Transforming Rehabilitation probation reforms introduced in 2014. However, he held that the workload was not causative of Mrs Scott's death.

The Coroner was satisfied that he was not obliged to make a report to prevent future deaths under Regulation 28 of the Coroners (Investigations) Regulations 2013.

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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