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TGC Inquests & Inquiries

The Newsletter of the TGC Inquests & Inquiries Team

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A NOTE FROM THE EDITORS

Joint Editors: **Nicholas Moss KC, Harriet Gilchrist and Anisa Kassamali**

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

In the Inquests section of this edition, Keith Morton KC and Daniel Walker provide an insight into the reaffirmation of the *Norfolk* Principles following *R (on the application of Mid and West Wales Fire & Rescue Service) v HM Senior Coroner for Pembrokeshire and Carmarthenshire* [2023] EWHC 1669 (Admin), Harriet Gilchrist and Anisa Kassamali explore *Dalton's application for Judicial Review* [2023] UKSC 36, and Nancy Kelehar considers *Dove v HM Assistant Coroner for Teesside and Hartlepool* [2023] EWCA Civ 289. Ellen Robertson reviews the Independent Advisory Panel on Deaths in Custody "More than a paper exercise" report and Anthony Lenanton provides comment on the Northern Ireland Troubles (Legacy and Reconciliation) Act 2023. Harriet Gilchrist also provides a topical review of the Report of the Chief Coroner to the Lord Chancellor 2023 and the updated position for medical examiners.

In the Inquiries section of this edition, Andrew O'Connor KC and Alice Hands provide an update on the impact of *R (Cabinet Office) v Chair of the UK Covid Inquiry* [2023] EWHC 1702 (Admin). Saoirse Townshend and Paul Erdunast consider interesting legal points arising in the context of the Brook House Inquiry. Zeenat Islam reflects on the adoption of PANEL principles and Trauma Informed Practice when engaging with those directly affected by the matter being examined in a public inquiries.

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

Norfolk Principles Reaffirmed: *R (on the application of Mid and West Wales Fire & Rescue Service) v HM Acting Senior Coroner for Pembrokeshire and Carmarthenshire)* [2023] EWHC 1669 (Admin)

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Introduction

On 12 July 2023 the High Court handed down judgment in this important case which reaffirmed the supremacy of the *Norfolk* Principles. The Claimant launched a wholesale challenge to the application of Norfolk, both in principle and on the facts. Mr Justice Eyre rejected all the grounds of challenge. Amongst other things the judge held that the "*incomplete, flawed or deficient*" test formed part of the ratio of *Norfolk* and that *Norfolk* was compatible with the principles of natural justice.

Background to the Judicial Review

The judicial review arose out of an inquest into the death of a young fire officer. He died during a marine training exercise. The accident was investigated by the Marine Accident Investigation Branch ("**MAIB**") who produced a report on the cause of the accident. The report summarised the investigation which concluded that there were shortcomings in the planning and operation of the training exercise both locally and systemically. The Claimant accepted the shortcoming at station level, but challenged all conclusions of systemic shortcomings. The Claimant argued before the Coroner that there was *"credible evidence"* that the investigation was *"incomplete, flawed or deficient".* By contrast, MAIB submitted that there was not *"credible evidence"* and, applying Norfolk the Coroner should admit the report as conclusive evidence as to the causes of the accident. The Coroner, having considered the arguments, rejected the submissions made by the Claimant and ruled that the evidence was conclusive on the cause of the accident.

The Claimant judicially reviewed the decision arguing *inter alia* that:

1. The Coroner's duty to proceed fairly in accordance with the principles of natural justice was not compatible with the *Norfolk* approach;

2. The principles elucidated in *Norfolk* were obiter and therefore not binding;

3. The Coroner misapplied the test by deciding whether the investigation was in fact "*incomplete, flawed or deficient*" rather than whether there was "*credible evidence*" of it being "*incomplete, flawed or deficient*"; and

4. The Coroner misapplied the test on the facts by not finding there was "*credible evidence*" of the investigation being "*incomplete, flawed or deficient*".

What are the Norfolk Principles?

The judgment in *R (Secretary of State) v HM Senior Coroner for Norfolk & another* [2016] EWHC 2279 (Admin), affirmed by *HM Senior Coroner for West Sussex v Chief Constable of Sussex Police & others* [2022] EWHC 215 (QB), establishes that following a death where the accident is investigated by one of the three Accident Investigation Branches ("AIB")) the Coroner would comply with their duties by *"treating the findings and conclusions of the report of the independent body as the evidence as to the cause of the accident"*. There would be no obligation to re-investigate matters that had been investigated by one of the expert branches. Matters would only need to be 're-opened' if there is *"credible evidence that the investigation is incomplete, flawed or deficient"*. The AIBs are MAIB; Air Accidents Investigation Branch; and Rail Accident Investigation Branch.

What did the High Court decide?

The High Court, in dismissing the judicial review, found that the Coroner correctly applied the *Norfolk* Principles.

Eyre J found that the principles in *Norfolk* formed part of the *ratio decidendi* of the *Norfolk* decision. Further, the Court outlined the public interest grounds that formed the foundations of those principles, namely: that there is no public interest in having unnecessary duplication of investigations or inquiries carried out by an AIB, which are specialist expert independent bodies tasked by parliament with that function (see [55]).

Against that context, the Court dismissed the argument that the binding nature of the Norfolk principles was incompatible with the duty on the Coroner to proceed fairly. Fairness is context specific. Eyre J stated that the ratio confirmed that fairness did not require re-investigation before the Coroner in circumstances where there had already been an investigation by an AIB and there was no *"credible evidence"* that the investigation in question was *"incomplete, flawed, or deficient"* (see [66]).

In relation to the challenge that the Coroner misapplied the test both in form and substance, Eyre J dismissed those grounds. The Claimant submitted that the report was deficient for reasons such as: MAIB considered the incorrect regulations, held the Fire Service to a higher standard on the basis of their own standard operating procedures rather than national standards and did not properly consider whether the issue was confined to the particular fire station rather than assuming regional issues. Eyre J rejected all of these submissions. The Court found that the correct test was applied and that there was no *"credible evidence"* that the investigation was *"incomplete, flawed or deficient"*.

Eyre J added the following important points of general principle:

1. The requirement that there be *"credible evidence"* that an investigation is *"incomplete, flawed or deficient"* is to be seen as a *"high hurdle"*. He added that *"…minor criticisms of the investigation or of some of the conclusions reached cannot amount to credible evidence for these purposes"* (see [73]).

2. Part of the reason for the *"high hurdle"* is the *"all or nothing effect"* of the Norfolk approach. The focus should not be on whether there is a disagreement about some of the conclusions, but on whether there is "*credible evidence"* that the investigation is "*incomplete, flawed or deficient"*. It is not possible to cherry-pick some conclusions, but disregard others. If there is *"credible evidence"* that the investigation is *"incomplete, flawed or deficient"* then the *"fruits of the investigation"* cannot be relied upon at all (see [73] and [75]). The *"all or nothing approach"* could only be disapplied in circumstances where it was possible to separate distinct parts of the report.

3. In this case, the Coroner permitted five rounds of lengthy submissions and evidence on whether there was *"credible evidence"* that the investigation was *"incomplete, flawed or deficient"*. This went "*well beyond that which was appropriate in the light of Norfolk and West Sussex"*. In such a rare case where there is an *"obvious deficiency"* it should be possible for this to be identified *"shortly and concisely"* without the need for lengthy arguments based on a close reading of the text (see [87]).

The Impact of the Ruling

This decision, by confirming the binding nature of the *Norfolk* principles, makes it clear that where an accident is investigated by one of the AIBs, unless there is *"credible evidence"* that the investigation (not merely the report) is *"incomplete, flawed or deficient"*, the Coroner will be obliged to accept those matters as conclusive evidence on the cause of the accident.

Further, this case provides:

1. A practical example of the "high hurdle" that needs to be reached in establishing "credible evidence" to rebut the presumption that the investigation carried out by an independent expert body needs to be re-opened; and

2. Important guidance on the procedure to be adopted in order to determine whether there is *"credible evidence"* that the investigation is *"incomplete, flawed or deficient"*.

Keith Morton KC acted for the Marine Accident Investigation Branch in the judicial review proceedings.

More than a "paper exercise": Enhancing the Impact of Prevention of Future Death Reports

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On 16 October 2023, the Independent Advisory Panel on Deaths in Custody ("**the IAPDC**") released its report, titled "More than a paper exercise" – Enhancing the Impact of Prevention of Future Death Reports. The IAPDC reports that the potential of Prevention of Future Death reports (**"PFD reports**") to safeguard the lives of individuals in the state's care is not being fully realised, and identifies a number of recommendations to improve the process.

The purpose behind PFD reports

We are now three years on from the Revised Chief Coroner's Guidance on Reports to Prevent Future Deaths. The revisions to the guidance, discussed in a previous Issue of this Newsletter, placed additional emphasis on the purpose of PFD reports as documents intended to benefit the public and facilitate learning rather than to punish Interested Persons.

This theme is heavily echoed in the IAPDC report, which identified concerns from coroners about issuing repeated reports covering the same matters of concern as previous inquests. The report encourages relevant Interested Persons to take an open and non-defensive approach to the PFD process, prioritising public interest over reputational considerations. The report also calls for lawyers to be specifically instructed not to take an adversarial approach to the making of a PFD report.

Some concerns about the evidence available to coroners for the PFD process were identified. The IAPDC encourages further revision of the Chief Coroner's guidance to highlight the importance of evidence-gathering at an early stage. The IAPDC also identifies that deaths of those detained under the Mental Health Act do not, unlike deaths in police custody or prison, automatically attract an independent investigation. The Department of Health and Social Care is encouraged to consider the creation of an independent body to remove that anomaly.

The IAPDC also notes that narrative findings made by juries often contained learning even where no PFD report was issued. It calls for the Ministry of Justice to adequately resource the Chief Coroner's Office in order to allow the recording and publication of jury conclusions.

The drafting, publication and distribution of PFD reports

The report also examines the drafting, publication and distribution of PFD reports, identifying frustrations expressed by many coroners with difficulties in identifying previous relevant reports. The IAPDC recognises the improvements made to the search capabilities on the Chief Coroner's online database of PFD reports but encourages further improvements such as specific tagging functions. It also calls for adequate resourcing of the Chief Coroner's Office to allow for annual reviews of PFD reports for custody deaths, identifying themes and trends, and monitoring the quality of responses.

The report identifies a lack of guidance on interim PFD reports in cases where the coroner identifies an urgent need for action, and a need to expand the list of organisations which should receive PFD reports on deaths in state custody. It encourages further guidance on both issues from the Chief Coroner, and encourages all organisations which scrutinise places of detention to make explicit use of PFD reports to inform their work.

Follow-up and learning from PFD reports

The report records concerns from families and coroners about the responses from Interested Persons to PFD reports, with a high level of variation in the level of detail and in some cases no responses at all. The IAPDC encourages timely and case-specific responses to reports, as well as "horizontal" sharing of reports with equivalent agencies such as other mental health trusts or prisons, particularly where there is scope for national learning. It also recommends a post-inquest learning review meeting by report recipients, with key persons from the inquest in attendance. There is also a recommendation for the government to consider the role of independent bodies in auditing and following up on PFD reports.

Conclusion

The report (*here*) makes a total of eighteen recommendations for government departments, agencies and private providers, for the Chief Coroner and his office, and for other bodies with a key role in preventing custody deaths. It is rather too early to assess whether the report will lead to significant changes in the approach towards or processes involved PFD reports, but in the meantime the report is useful reading for all those whose practice involves deaths in state custody.

A comment on the Northern Ireland Troubles (Legacy and Reconciliation) Act 2023

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The Northern Ireland Troubles (Legacy and Reconciliation) Act 2023 (the Act) received Royal Assent on 18 September 2023. The UK Government introduced the legislation following a commitment made in the 2022 Queen's Speech. The stated aim of the Act is to address the legacy of the Northern Ireland Troubles and to promote reconciliation. Subject to certain exceptions, the Act extends to the whole of the UK.

Background: the Troubles

The Act defines the Troubles as the events and conduct that related to Northern Ireland affairs and occurred during the period from 1 January 1966 to the signing of the Good Friday Agreement on 10 April 1988. In total more than 3,500 people were killed during the Troubles.[1] Finding a consensus on how to deal with the legacy has been difficult. The issue has been dominated by the process for investigating the deaths of people killed, which began in 2006.[2] Many of the cases remain unsolved and as of May 2022, the Police Service of Northern Ireland had a caseload of over 900 cases, involving nearly 1,200 deaths.[3]

Overview of the Act

The Act seeks to address the legacy of the Troubles by establishing a new Independent Commission for Reconciliation and Information Recovery (ICRIR), which will carry out reviews into deaths and other harmful conduct. State authorities throughout the UK will be under an obligation to provide disclosure to the ICRIR, which will produce reports on the findings of its reviews. Immunity from prosecution for Troubles related offences will be offered to individuals who cooperate by providing information to the ICRIR. The Act will end all Troubles related criminal investigations, civil remedies, inquests and Police Ombudsman investigations.

Inquest related legislative changes

The Act introduced a new Schedule 1A to the Coroners and Justice Act 2009 to provide for existing coronial investigations and inquests into Troubles related deaths in England and Wales to end on 1 May 2024, unless the only part of the investigation that remains to be carried out is the coroner or any jury making the determination and any findings required by section 10 of the 2009 Act, or something subsequent to that. The Act also amended section 13 of the Coroners Act 1988 (application by the Attorney General for a new inquest) to provide that it has no application to a death that resulted from the Troubles.

1. See Explanatory Notes to the Act.
2 Commons Library Research Briefing, 20 May 2022.
3 See Explanatory Notes to the Act.

The effect of the amendments is the obligatory discontinuance of any existing investigations and inquests into a Troubles related death on 1 May 2024. To illustrate the stark consequence – if an inquest into a Troubles related death is underway but has not concluded evidence and submissions by the appointed date, then it will simply time out. From 1 May 2024, the death will be a matter for the ICRIR to review.

The author is not aware of any inquest currently open in England and Wales that will be impacted by these reforms. The Act contains equivalent provisions that will amend the law in Northern Ireland to the same effect. The situation there in terms of outstanding inquests is very different. As of November 2023, there were more than 30 so called "legacy" inquests (some of which concern more than one death) that were working their way through the system in Northern Ireland.[4] The consensus is that some of those inquests will not conclude before 1 May 2024.

Human rights issues

The measures introduced by the legislation (not all of which were directly related to inquests) have generated significant controversy in Northern Ireland. The Irish government opposed the legislation and in January 2024 lodged an inter-state application against the UK with the European Court of Human Rights (the first such application since the 1970s).[5]

The key question raised by the Inquest-related provisions set out above is whether the ICRIR is capable of carrying out an effective investigation into deaths occurring during the Troubles, including those involving allegations of State involvement or collusion, in compliance with the procedural requirements of Article 2.

Insofar as Northern Ireland is concerned, there is an unhappy background. Between 2001 and 2003, the ECtHR held in the *McKerr* group of cases that there had been a violation of the Article 2 investigative duty in the way that inquests were previously conducted in Northern Ireland. In response, the UK Government introduced a "package of measures" to remedy the violations, which made changes to the Northern Ireland inquest system. There was some sense amongst bereaved families in Northern Ireland[6] that the "package of measures" had started to deliver justice. See, for example, the reaction to the findings of the Ballymurphy Inquest in 2021.[7]

In *Dillon* [2024] NIKB 11, victims and families brought a judicial review challenge against the Act in the High Court in Northern Ireland. Judgment was handed down on 28 February 2024.[8] The Court made declarations of incompatibility with Convention rights in respect of several of the other provisions of the Act, but with regard to the Inquest related provisions the Court was satisfied, *"at this remove",* that the Act left sufficient scope for the ICRIR to conduct an effective Article 2 investigation. The Court did, however, register its concern:

> *"[364] Focusing on the question of the reviews, they stand in contrast to the current inquest system where hearings are conducted in public, in the context of full legal representation of all those involved, including the next of kin, who have access to materials, who can engage expert evidence, who can call and cross-examine witnesses and who ultimately obtain a detailed narrative verdict from a coroner."*

The judgment in *Dillon* will not be the last word on the matter: the UK government has indicated that it will appeal[9] and it appears possible that the matter may end up in the Supreme Court. If the Act does survive its legal (and political) challenges, then the question will remain whether it can go any way to achieving its stated aim of reconciliation.

4 Statement of Mr Justice Humphreys, Presiding Coroner Re. Outstanding Legacy Inquests, 17 November 2023.

5 https://www.echr.coe.int/w/new-inter-state-application-brought-by-ireland-against-the-united-kingdom

6 *McKerr v. UK* [2001] ECHR 329; *Kelly & Ors v. UK* [2001] ECHR 328; *Jordan v UK* [2001] ECHR 327; *Shanaghan v. UK* [2001] ECHR 330; *McShane v. UK* [2002] ECHR 469; *Finucane v. UK* [2003] ECHR 328

7 https://www.bbc.co.uk/news/uk-northern-ireland-56986784

8 https://www.judiciaryni.uk/judicial-decisions/2024-nikb-11

9 https://www.bbc.com/news/uk-northern-ireland-68499113.amp

How long is too long: The requirement to investigate deaths that took place before the Human Rights Act 2000 *In the matter of an application by Rosaleen Dalton for Judicial Review* (Northern Ireland) [2023] UKSC 36

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Background

In *Re Dalton*, the Supreme Court considered the application of the procedural obligation on public authorities to investigate deaths occurring in circumstances which potentially engage the state's responsibility under Article 2 of the European Convention on Human Rights ("the ECHR") to deaths that took place prior to the Human Rights Act 1998 ("the **HRA**") coming into force on 2 October 2000.

Sean Eugene Dalton was one of three people killed in the "Good Samaritan bombing" on 31 August 1988 when he unknowingly detonated a bomb which had been placed in his neighbour's house by the Provisional Irish Republican Army ("**the IRA**") with the intention of killing members of the security forces.

The police subsequently opened an investigation into the incident. This did not result in any individual being charged or convicted of an offence in connection with the deaths. On 7 December 1989 an inquest was held into Mr Dalton's death, in which the coroner found he died from his injuries.

There was limited further investigation by the police following the inquest. In February 2005 on of his sons lodged a complaint with the office of the Police Ombudsman for Northern Ireland ("**the Ombudsman**") regarding the behaviour of the police in relation to the event leading up to Mr Dalton's death and the subsequent investigation. The Ombudsman investigated and published its findings on 10 July 2013. The report concluded that a number of the complaints were substantiated and made criticisms of the way in which the police had conducted their investigation.

On 2 October 2014 the Attorney General for Northern Ireland ("**the AGNI**") refused the request to order a further inquest into the death of Mr Dalton. His daughter challenged this decision by way of judicial review on the basis that it was incompatible with the state's procedural obligation to investigate deaths that have occurred in circumstances which potentially engage the state's responsibility under Article 2 ECHR. That challenge was dismissed at first instance but was successful on appeal before the Court of Appeal of Northern Ireland. The AGNI appealed that decision to the Supreme Court.

The Supreme Court unanimously allowed the AGNI's appeal, holding that there was no obligation to order a further inquest into Mr Dalton's death on the basis that it took place too long before the HRA came into force. However, the seven Justices were divided on their reasoning on particular points of principle.

Judgment

The starting point was whether the Supreme Court's previous decisions in *Re Finucane* [2019] UKSC 7 and *Re McQuillan* [2021] UKSC 55 should be upheld. Lord Reed explained how these authorities work together at [2]: "*…it was held in Finucane that the procedural obligation to investigate deaths under article 2, as given effect in our domestic law by the Human Rights Act, does not apply to deaths which occurred before the commencement date unless either there was a "genuine connection" between the death and the commencement date,* or the *"Convention values" test was satisfied…In McQuillan, the court held that the genuine connection test could not normally be met where the death occurred more than ten years before the commencement date, but that a period of up to 12 years was permissible in specified circumstances."*

For the purposes of this case, Mr Dalton's death fell outside the temporal scope of the Article 2 ECHR procedural obligation. It had taken place not just before a ten year limit, but also before the maximum twelve year limit before the HRA came into force. Moreover, it was not suggested that the *"Convention values"* test was met. None of the Justices considered that the facts of the case met the *"extremely high hurdle"* imposed by the test where *"…what is principally in mind are serious crimes under international law, such as war crimes, genocide or crimes against humanity."*

However, notwithstanding the Supreme Court's unanimous conclusion, the Justices disagreed in relation to certain points of principle. Of particular interest for practitioners are the following: (i) the approach taken to the 'mirror principle', and (ii) what is required to satisfy the Article 2 ECHR procedural obligation.

The Mirror Principle

A notable minority consisting of Lord Hodge, Lord Sales and Lady Rose considered that the Supreme Court should depart from its earlier reasoning in *Re Finucane*. They were of the view that the decision did not properly apply the 'mirror principle' i.e. the principle that the scope of ECHR rights given effect in domestic law by the HRA should mirror the scope of ECHR rights enforceable against the United Kingdom in the European Court of Human Rights (the **ECtHR**"). In the case of *Janowiec v Russia* (2013) 58 EHRR 30, the ECtHR had laid down a *"strict ten-year time limit as one limb of the genuine connection test, not a flexible time limit capable of being extended beyond ten years according to a multifactorial approach"* [164]. Where *Re Finucane* had extended the potential time limit to 12 years, it had *"left the law in an unsatisfactory state"* [166]. Re McQuillan was implicitly criticised insofar as it adopted the approach in Re Finucane. That said, they accepted that the ECtHR's approach should be modified insofar as the commencement date for the purpose of counting back was the date that the HRA entered into force in the United Kingdom.

However, other members of the Supreme Court did not consider that the mirror principle applied to this scenario. For example, Lord Reed's position was that there was no *"clear and constant jurisprudence"* from the ECtHR establishing an absolute ten year limit, as is required for the application of the mirror principle [39].

Satisfaction of the Article 2 ECHR obligation

Of particular interest for practitioners involved in inquests are the Supreme Court's comments on what is required in order to meet the procedural obligation under Article 2 ECHR. Lord Leggatt, Lord Burrows and Dame Siobhan Keegan all considered that the obligation was met by the Ombudsman's report such that no new inquest was required [232], [320], and [324]. Lord Hodge, Lord Sales and Lady Rose also indicated that this was strongly arguable, although they did not make a definitive finding on this point, for reasons including the passage of time that had passed since the death [194].

Dove: New Evidence and a Fresh Inquest, but No Article 2 Duty

Dove v HM Assistant Coroner for Teesside [2023] EWCA Civ 289

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In the context of a suicide death by overdose, the Court of Appeal considered the circumstances in which new evidence will mean a fresh inquest is necessary or desirable in the interests of justice under section 13(1)(b) of the Coroners Act 1988.

It was held that the new evidence went to issues of causation and there was a legitimate public interest in knowing whether the abrupt termination of benefits was a causative factor in the death. As such, a fresh inquest was desirable in the interests of justice.

The Court also usefully reiterated the way in which narrative conclusions can be used in non-Article 2 (Jamieson) inquests and the threshold for engagement of Article 2.

Background

Jodey Whiting died on 21 February 2017 having taken an overdose of prescription medication at her home. Following a reassessment process by the Department of Work and Pensions ("**DWP**"), her Employment and Support Allowance ("**ESA**") was stopped on 7 February 2017, also terminating her entitlement to housing and council tax benefits.

At the first inquest on 24 May 2017, her family stated that they believed the removal of her ESA and the way in which this was handled by the DWP was a contributing factor in her death. The Coroner considered that it was not her function to question any decisions made by the DWP and ultimately recorded a short-form conclusion of 'suicide'.

The family subsequently obtained two new pieces of evidence. First, a report from an Independent Case Examiner ("**ICE**") which examined the handling of Ms Whiting's case by the DWP highlighting a number of failings and missed opportunities. Second, an expert psychiatrist's report which drew a causal link between the abrupt cessation of Ms Whiting's entitlement to ESA and her state of mind prior to her death.

Upon an application under s.13, the Divisional Court concluded that even in light of the new evidence *"it would be extremely difficult for a new inquest to conclude that the Department caused Jodey's death"*, and that Article 2 was not engaged. In summary, the first inquest was short but fair and a fresh inquest was not required.

The decision of the Divisional Court was appealed on two grounds:

1. It was wrong to conclude that a fresh *Jamieson* inquest was not necessary or desirable in light of the new evidence; and

2. It was wrong to conclude that a fresh Middleton inquest was not necessary or desirable in light of arguable breaches of the Article 2 operational duty owed to Ms Whiting by the DWP.

Applicable Principles

The Court of Appeal reiterated the following key principles:

- The purpose of an inquest is to determine who the deceased was, when, where and how they came by their death. The scope of an inquest depends upon the engagement or otherwise of Article 2 of the ECHR.

- In an inquest which engages Article 2 *(Middleton inquests)*, the 'how' question encompasses the wider circumstances of the death and ought ordinarily to culminate in a narrative conclusion on the disputed factual issues at the heart of the case.

- However, narrative conclusions are not confined to Middleton inquests. In non-Article 2 (or *Jamieson*) inquests, a narrative conclusion will often be required where the death results from more than one cause. In a *Jamieson* inquest, any narrative conclusion should be a brief, neutral, factual statement which does not express judgment or opinion.

- For causation of death to be established the question is whether, on the balance of probabilities, the conduct more than minimally, negligibly or trivially contributed to death. A conclusion of suicide requires proof that the deceased took their own life and that they intended to do so.

A Fresh *Jamieson* Inquest

In respect of the first ground, it was held that the Divisional Court were wrong to draw a distinction between causes of Ms Whiting's mental health deterioration and causes of her death by suicide: *"her suicide was the end point to which her mental health problems brought her"*. The caselaw confirms the wide discretion conferred on coroners to establish the background facts, whether those facts were causative of death and to establish the substantial truth. As such, the Court held that it is open to a coroner in a suicide case to consider the extent to which acts or omissions contributed (more than trivially) to the deceased's mental health deterioration, which in turn led them to take their own life.

In considering the ICE report, the Court of Appeal did not criticise the Coroner's determination that the DWP's failings lay outside the remit of the inquest. Whilst it had been accepted by all parties that the DWP's failings were extensive, the specific errors and breaches of policy appeared to be beyond the scope of a *Jamieson* inquest.

However, the Court of Appeal held that the second new piece of evidence – the expert psychiatrist's report – went to the issue of intention and raised wider issues of public interest. The Court was of the view that an investigation of the causes of the disturbance of the mind related to matters which were already before the Coroner. Further, the significance of these issues to the family and the wider public interest made a fresh inquest desirable: the public has a legitimate interest in knowing if the death was connected with the abrupt cessation of benefits and it is in the interests of justice for the family to have the opportunity to invite such a finding of fact to be recorded in the conclusion.

The Court also emphasised that although the conclusion at a fresh inquest may not be different to the first inquest, this is not a reason not to direct one.

Article 2

In respect of the second ground, the Court of Appeal held that no Article 2 operational duty was owed by the DWP to Ms Whiting. The operational duty requires the state to take positive steps to protect life including in some circumstances to prevent a real and immediate risk to life. The Court referred to the criteria set out in *Rabone*.

Whilst Ms Whiting had made references to suicidal thoughts in previous communications with the DWP, the exchanges which immediately preceded her death were not centred on her ideas of suicide. At the material time, the DWP were not on notice, nor ought to have known, that Ms Whiting was at real and immediate risk.

The Court also held that there was no assumption of responsibility by the DWP. The fact that the Department is responsible for administering benefits to vulnerable people does not of itself involve any assumption of responsibility to safeguard them against the risks of suicide.

Takeaways from Dove

This case provides useful guidance on the approach to be taken to the s.13 test in the context of new evidence, having made a different determination in respect of the two new pieces of evidence. It also reiterates the distinction between *Middleton* and *Jamieson* inquests and the appropriate use of narrative conclusions in the latter. Lastly, it confirms that even where there are multiple and extensive (and uncontested) failings by a state institution, that does not of itself render engagement of Article 2.

Topical Update: A review of the Report of the Chief Coroner to the Lord Chancellor: Annual Report 2023 and the new statutory Medical Examiner System

By Harriet Gilchrist
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In May 2024 the Chief Coroner published his final Annual Report as Chief Coroner, for the year 2023. The Chief Coroner considered the purpose of an inquest, coroner statistics, training, mergers, appointments & retirements, security, judge led inquest, disaster victim identification, treasure and the public understanding of the corners service for 2023 and future changes in the form of the medical examiner system (see 'The New Statutory Medical Examiner System' below) and recommended changes in law. This update provides a summary of the salient points from this report. A copy of the full report can be found *here*.

The Chief Coroner observed the pressure placed on coroners to expand the scope of their investigations and provided his response as to why an inquest should remain a hearing that is narrowly focussed on establishing a person's immediate cause of death as opposed to becoming a surrogate public inquiry. The Chief Coroner's observations in many ways echo those of Lord Burnett, then Lord Chief Justice, in *R (Morahan) v West London Assistant Coroner* [2022] EWCA Civ 1410, as he concluded that:

i. The scope of inquests should be narrowly focussed on the death of the deceased;

ii. The inquisitorial nature of the coroner service should be protected;

iii. The issuing of a prevention of future death ("PFD") report is an important yet ancillary duty as prevention of future deaths Is not the primary function of a coroner's investigation; and

iv. Avoiding unnecessary delay must be a key priority for the coroner service.

However, whilst the Chief Coroner placed great emphasis on protecting the narrow inquisitorial approach of the coroner's investigation and inquest, he accepted that there is still much to be done to ensure the role of the coroner service is properly understood and to ensure that all coroner areas are sufficiently funded and resourced to make achieving a quick and efficient service with the deceased at its heart attainable.

In relation to the matter delay, the number of inquests not concluded within 12 months was 6,149 in 2023 an increase of 1,337 from the preceding 12 months. This was attributed to the residual effects of the COVID-19 pandemic, the underfunding of the coroner service, the increase in quantity and complexity of referrals and the ongoing shortage of pathologists. Consequently, whilst this increase is disappointing it is not unexpected. Other factors, outside the coroner's control, which have contributed to delay include:

i. Awaiting charging decisions from the Crown Prosecution Service and the outcome of criminal proceedings;

ii. Reports arising from investigations by other organisations including the Heath and Safety Executive, the Accident Investigation Branch, Prisons and Probation Ombudsman and the Independent Office for Police Conduct;

iii. Other investigations, including those overseas.

These delays are most prevalent in coroner areas covering major cities in England and Wales where most homicides take place and where the largest prisons are located. However, despite these backlogs, the Chief Coroner reported that he was cautiously optimistic that support in local areas could bring about tangible improvement, whilst recognising the limit in the Chief Coroner's capacity to intervene and the ability of local authorities to respond positively to requests in the current financial climate.

The Annual Report for 2023 accepts that delays cannot be eradicated because of the need for coroners to wait for external investigations and processes to conclude. However, it reports that there is currently an unacceptable level of avoidable delay within the coroner service.

The Annual Report for 2023 then turns its attention to PFD reports, noting an increase of 132 reports issued in 2023. The Report concludes that PFD reports should only highlight risks and not contain recommendations. The Report also reflects on the Chief Coroner's decision to change the way PFD evidence is published. Since 1 January 2023 all PFD reports have been published directly onto webpages making them fully text searchable increasing the ease with which reports can be analysed and themes identified.

Throughout 2023 work on comprehensive bench guidance continued under the leadership of the Deputy Chief Coroner Her Honour Judge Durran. The Chief Coroner is in the process of reviewing and approving each of the finalised chapters for publication. In addition, the following were issued/updated in 2023:

i. Guidance No. 3 on Oaths and Robes

ii. Guidance No. 4 on Recordings

iii. Guidance No. 26 on Organ and Tissue Donation

iv. Guidance No. 45 on Stillbirth and Live Birth Following Termination of Pregnancy.

The merger of some coroner areas which took place in 2023 were also reported on positively, as were the appointments of 13 further area coroners and 5 senior coroner appointments. However, concerns over the robustness of the process used to select senior coroners remained and reform of this process to ensure that the most meritorious candidates are selected was recommended.

The Chief Corner reported on judge-led inquests and raised a concern over their funding as when local authorities fund a complex judge-led inquest it can have a detrimental effect on their ability to fund the routine work of the area.

In relation to treasure there were positive developments in 2023. On 30 July 2023 the changes to the Treasure (Designation) Order 2002 came into force and widened the definition of what constitutes treasure to encompass any object at least 200 years old of a class designated by the Secretary of State as being of outstanding historical, archaeological or cultural importance. This change means that more finds can be acquired by museums. To date, the impact of this change on the coroner service has been low.

Finally, the Chief Coroner set out the amendments he recommends the government considers making to improve the functioning of the coroner service. In short, these are:

i. Amending section 13 of the Coroners Act 1988 to enable the High Court, where appropriate and subject to the bereaved family's consent, to amend the Record of Inquest without ordering a fresh inquest where it quashes an inquest and to enable to coroner to apply to the High Court to quash an inquest and hold a fresh investigation without the preliminary need to seek authority from the Attorney General to make such an application;

ii. Enabling a British Sign Language interpreter to assist deaf jurors serving on an inquest jury;

iii. To amend section 24 of the 2009 Act to define the division of responsibility between the local policing body and the relevant local authority for the coroner area to clarify statutory arrangements for the provision of staff;

iv. To extend the relevant provisions under section 9C of the 2009 Act to enable treasure inquests to be held in writing;

v. Amend Schedule 3 of the 2009 Act to make it a statutory requirement for coroners to take the judicial oath;

vi. Amending section 39 of the Children and Young Person's Act 1933 to cover children within a bereaved family who are not witnesses in the proceedings; and

vii. Enabling retired Circuit Judges to be nominated to conduct judge-led inquests.

Whilst 2023 was a difficult year for the coroners service, the Annual Report for 2023 contains many positive developments and indicates at further positive developments in 2024.

The New Statutory Medical Examiner System

From 9 September 2024 all deaths in any health setting that are not investigated by a coroner will be reviewed by NHS medical examiners. This change forms part of the Department of Health's Death Certification Reforms, which were announced by the government on 15 April 2024. As part of the changes, there will be a new medical certificate cause of death (MCCD).

From 9 September 2024, medical practitioners will be able to complete an MCCD if they attend the deceased in their lifetime, representing a simplification of the current rules. Prior to reform coming into force the current rules require the referral of a case to a coroner for review if the medical practitioner had not seen the patient within 28 days prior to death or had not seen in person the patient after death.

In his May 2024 report, the Chief Coroner noted that advising government on the impact that these forthcoming changes was one of the most significant areas of work for his office and himself in 2023. The purpose of the Chief Coroners advice was to ensure that the practicalities of the implementation of the statutory medical examiner scheme were properly considered as operational decisions were made.

The Chief Coroner has observed that "the implementation of the statutory medical examiner scheme has provided an opportunity for government to consider where to draw the line between medical certification and judicial certification should be drawn and the structure the corresponding duties on a principled basis. As such, "the implementation of this scheme will therefore bring about wide-ranging changes to the coronial process."

Fishing for documents: Powers under Section 21 of the Inquiries Act 2005
R (Cabinet Office) v Chair of the UK Covid-19 Inquiry [2023] EWHC 1702 (Admin)

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On 28 April 2023 the Chair of the UK Covid-19 Inquiry issued a notice under s.21(2)(b) of the Inquiries Act 2005 ("**the Act**") to the Cabinet Office, requiring the production of unredacted copies of certain WhatsApp messages and Boris Johnson's diaries and notebooks. A dispute had previously arisen as to whether the Cabinet Office was entitled to refuse to provide material that it considered to be 'unambiguously irrelevant' to the Inquiry's Terms of Reference. On 15 May 2023, the Cabinet Office made an application pursuant to s.21(4) of the Act to revoke the entirety of the s.21 notice. The Chair rejected the application, ruling that *"the entire contents of the documents that were required to be produced were of potential relevance",* and that the notice was therefore valid. The Cabinet Office then issued proceedings challenging the Chair's ruling by way of judicial review.

The issue to be determined was the scope of the Chair's powers to require the production of material. The questions for the Court were 1) whether the s.21 notice was valid; 2) whether the Chair's conclusion that the material identified in the notice was or might be relevant was irrational.

The Cabinet Office argued that roughly a third of the material that the Chair had sought was "*unambiguously irrelevant"* to the Inquiry's Terms of Reference, thus the notice was ultra vires.

The Chair's position was that the documents were of "*potential relevance"* to the lines of inquiry. Notably, Mr Johnson supported the Chair's approach.

The Divisional Court granted permission to the Cabinet Office to apply for judicial review, but dismissed the substantive claim.

The Court found that the documents required to be produced under the s.21 notice related to a matter in question at the inquiry (s.21(2)(b)) and that the notice was valid [61]-[71]. Further, the Court held that the Chair did not act irrationally in issuing the s.21(2)(b) notice and making the ruling [72]-[75].

The case confirmed that:

1. a s.21 notice will not be invalidated on the basis that it will *"yield some irrelevant documents"*, in fact, this is almost inevitable in such an exercise [65];

2. inquiries are to be given latitude to *"fish"* for documents by making *"informed but speculative requests for documents relevant to lines of inquiry or documents that lead to new lines of inquiry"* [65]

3. if the recipient of a notice considers that material identified in a notice is not relevant and therefore should not be produced, he may apply to the Chair to vary or revoke the notice under s.21(4) of the Act. The Court held that this mechanism under s.21(4) was inconsistent with the Cabinet Office's assertion that a notice will be unlawful if it includes *"obviously irrelevant"* material [67]-[68].

Finally, the Court provided an answer to the practical dispute that had arisen between the parties, *"the Chair of the Inquiry may examine the contested documents, and if the Chair of the Inquiry agrees that they are obviously irrelevant, will return them"* [71].

The case confirmed the wide-ranging powers of the Chair of a public inquiry to secure the production of 'potentially relevant' material. If a body holding material wishes to resist providing documents (or parts of documents) to an Inquiry, and informal discussions / negotiations with the Inquiry team have been unsuccessful, the correct procedural course is not to challenge the legality of the s.21 notice, but rather to seek the variation / revocation of the notice by an application under s.21(4).

The Brook House Inquiry

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The Brook House Inquiry examined the mistreatment of detainees at Brook House Immigration Removal Centre between 1 April and 31 August 2017. The Inquiry Report was published on 19 September 2023.

Its terms of reference included provision to *"reach conclusions with regard to the treatment of detainees where there is credible evidence of mistreatment contrary to Article 3 ECHR"*.

As for evidence of mistreatment, the Inquiry was provided with, and analysed, numerous sources of evidence:

1. Videos recorded by Callum Tulley, an officer at Brook House, who went undercover for the BBC Panorama programme and recorded a number of incidents;
2. CCTV, handheld and other video footage disclosed by G4S and the Home Office;
3. Witness evidence from detained persons and staff members;
4. Expert evidence from the Inquiry's use of force expert, for example on restraining techniques; and
5. Documentary records of incidents.

The Inquiry made a number of findings, including:

1. 19 instances regarding which there was credible evidence of inhuman or degrading treatment prohibited by Article 3 ECHR;
2. A toxic culture with frequent abusive and derogatory language towards and about detainees;
3. The safeguarding systems at Brook House were dysfunctional in a number of areas;
4. Serious failings in the application of Detention Centre Rules 34 and 35 (medical processes designed to protect vulnerable detainees); and
5. Not enough was done to prevent the use of the psychoactive drug 'spice'.

In terms of the findings regarding instances of mistreatment, an interesting legal point arose, following submissions from core participants, regarding an apparent tension between the terms of reference: *"to reach conclusions with regard to the treatment of detainees where there is credible evidence of mistreatment contrary to Article 3 ECHR*[10]*"*, and s.2(1) of the Inquiries Act 2005; that the Inquiry's function is not to determine civil or criminal liability. In Chapter C.1 of the Report, the Inquiry emphasised that it was not making any determination that any party acted in *"breach"* or in *"violation"* of Article 3, nor was in making a determination that any person had been subject to treatment in *"breach or in "violation"* of Article 3. The Inquiry pointed out that s.2(2) of the IA 2005 qualifies s.2(1) in providing that a chair must not be inhibited in discharging their functions by any likelihood of liability being inferred from the facts that are determined. The issue was a complex one, but was ultimately resolved by the formulation and then application of a two-stage test which was applied to the incidents considered:

- Stage 1: Is there 'credible' evidence of acts or omissions that are capable of amounting to mistreatment contrary to Article 3 – that is to say, torture, inhuman and/or degrading treatment or punishment?

- Stage 2: Where that evidence is 'credible', what are the underlying facts?

The question of "breaches" or "violations" will now be for other courts to determine, as in accordance with s.2 IA 2003.

The full report can be read found here.

Saoirse Townshend and Paul Erdunast formed part of the Counsel to the Inquiry team.

10 Article 3 of the European Convention on Human Rights (Article 3) states: "No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

Effective engagement with affected individuals in statutory public inquiries: PANEL principles and Trauma Informed Practice

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Introduction

Statutory public inquiries are established into matters of public concern where there has been large scale loss of life, serious health and safety issues, failure in regulation and other events of serious concern. As such, by their very nature, they are particularly important to those who have been directly affected by the matter being examined. When thinking about those who have been 'directly affected' we perhaps most commonly think about victims, survivors, the bereaved and families of those affected. Whilst the primary focus of this article, is on these groups, it is also important to recognise that other people can be affected including for example, first responders. It is essential therefore, that when reflecting on how public inquiries can better engage with affected people, an inclusive approach is taken to understand how different people may be affected.

In this article, I reflect on efforts being made to effectively engage with those directly affected and offer some suggestions about how this could be further improved through the adoption of PANEL principles and Trauma Informed Practice.

Efforts to engage

The purpose of an inquiry is to fulfil its terms of reference. They also have the potential to serve multiple purposes, including truth finding, accountability, learning lessons, restoring public confidence and for those affected – catharsis. For these aims to be achieved, it is important that inquiries meaningfully engage with the people directly affected.

Efforts are increasingly being made in this respect, for those with core participant status and for those without. For example, the Grenfell Tower Inquiry held regular community engagement sessions in the Notting Hill Methodist Church and undertook targeted outreach work with community leaders to understand community context, inform lines of enquiry and to identify witnesses. In addition to the inquiry formally opening with commemorative hearings, the module looking into the aftermath of the fire, opened with oral and written evidence from bereaved, survivors and residents to ensure that the lived experience was front and centre. The UK Covid-19 Inquiry has sought and received a substantial body of evidence from charities, NGOs and impacted groups dealing with inequalities and vulnerability issues arising from the pandemic. The 'Every Voice Matters'

listening project and display of impact films to open the substantive hearings are other means through which the UK Covid-19 Inquiry is seeking to ensure that those affected are meaningfully involved. Similarly, the Infected Blood Inquiry held a commemoration consisting of music, film, and poetry. In the context of inquests, the use of pen portrait material as a mechanism to put the life of the deceased at the heart of proceedings has been reaffirmed and encouraged.[11]

Concerns about engagement

Despite these efforts, recent inquiries have faced criticism that the level of engagement does not go far enough. These criticisms are often based on being refused core participant status[12] or if granted status, concerns around scope, decisions on witnesses to be called, lines of questioning, strict deadlines, provision of disclosure and who is permitted to ask questions.

To those on the outside looking in, inquiries may feel inaccessible, difficult to understand, unrepresentative and rigid. More practical considerations can lead to people feeling excluded, for example, because of the location of the hearings, how the hearing room is set up, lack of diversity in inquiry legal teams, accessibility in terms of physical and language needs and the availability of psychosocial support.

A culmination of these factors may result in a loss of confidence, trust, and willingness to engage. For some, this experience may reflect what has been described as a 'patronising disposition of unaccountable power' – a cultural condition, requiring a shift in attitude, culture, heart, and mind.[13]

A renewed approach

It is important that the work already being done to engage affected individuals is further developed and embedded into mainstream practice. Two frameworks that would help give effect to a more person-centred approach in inquiries are:

- Application of PANEL principles
- Adopting Trauma Informed Practice

There is already some recognition of these frameworks in the context of public inquiries,[14] however more work is required to ensure that the importance of these frameworks is widely understood, particularly by Counsel to the Inquiry and Solicitor to the Inquiry teams. This is important to ensure that public commitment to these principles' manifests in the substantive legal and evidential work of the inquiry.

PANEL principles

PANEL principles[15] (participation, accountability, non-discrimination, empowerment, legality) are widely recognised as a human rights approach putting people at the heart of policy and decision making. How might this approach apply to public inquiries? Application of some of the PANEL principles could include:

- Early expert training for Chairs, Panels, and inquiry teams on these principles and how they can be actualised in practice.
- Development of an Inquiry Engagement Protocol outlining how these principles will be considered and applied.
- Consultation on terms of reference and scope, open call for relevant evidence, commemorative evidence, human impact evidence and allocation of specific hearing time for this body of evidence.
- Active and early consideration of obligations under the Human Rights Act 1998.
- Active and early consideration of the Equality Act 2010 e.g., have relevant organisations complied with their Public Sector Equality Duty in respect of the policy being examined? Did the incident under examination have a disproportionate impact on a particular group of people?

11 Chief Coroner Guidance No.41 available at: *https://www.judiciary.uk/wp-content/uploads/2021/07/Chief-Coroners-Guidance-No-41-Use-of-Pen-Portrait-material.pdf*

12 See R *(EA and another) v Chairman of the Manchester Arena Inquiry* [2020] EWHC 2053 *(Admin)*

13 'The patronising disposition of unaccountable power' A report to ensure the pain and suffering of the Hillsborough families is not repeated, The Right Reverend James Jones KBE available at: *https://assets.publishing.service.gov.uk/media/5a82c1cce5274a2e8ab5931d/6_3860_HO_Hillsborough_Report_2017_FINAL_updated.pdf*

14 See for example: *https://covid19.public-inquiry.uk/wp-content/uploads/2023/07/06122912/2023-07-06-Equalities-and-Human-Rights-statement.pdf*

https://www.covid19inquiry.scot/sites/default/files/2023-10/Policy-Statement-HRBA-October-2023.pdf

https://www.equalityhumanrights.com/sites/default/files/consultation-response-covid-inquiry-tor-april-2022.docx

https://www.scottishhumanrights.com/media/1409/shrc_hrba_leaflet.pdf

15 *https://ennhri.org/about-nhris/human-rights-based-approach/*

- Where relevant, consider broader notions of vulnerability beyond protected characteristics for example: socio-economic status, pre-existing inequalities, and health vulnerabilities.

- Alternative processes for those not granted core participant status e.g., actively seeking witness evidence, representative panels, focus groups, community engagement programmes and listening projects.

- Adopting a culturally competent approach.[16]

- Venue: consider size, location, set up of the hearing room, remote participation, satellite locations, private areas and access to multi-faith and wellbeing facilities.

- Additional support: psychosocial support, adjust timings to accommodate particular needs e.g., prayer times and fasting periods.

- Accessibility: consider language, communication, mobility needs and expenses.

Trauma Informed Practice (TIP)

TIP is a model that is grounded in an understanding of the impact of trauma on people's lives and incorporating this into policy and service provision. The key principles of TIP are safety, trust, choice, collaboration, and empowerment. Whilst the model is more commonly applied in health and care contexts, there is an increasing awareness of the applicability of such principles in a legal context.[17] 'Trauma informed lawyering' is an emerging concept in the UK, particularly in criminal justice and youth justice.[18] However, the principles are equally transferable to the public inquiry context, given inquiries are often examining circumstances giving rise to widespread loss and suffering.[19]

A trauma informed approach in the inquiry context complements the PANEL framework and could consider the following questions:

- How can we prioritise the safety of those affected, by ensuring inquiry processes and decision making does not exacerbate existing trauma? At the very least, how can we seek to minimise this?

    - How can we build trust with affected individuals, in a way that will give them confidence to engage?

    - How can we ensure that those affected have agency through the inquiry process and feel that they have a voice?

    - How can we ensure that we are working collaboratively with affected individuals – working together, rather than making unilateral decisions without consultation?

Conclusion

It is important for legal representatives of those affected to have these considerations in mind, however it is equally important, for inquiry legal teams to actively consider these issues. Inquiry teams are responsible for the overarching infrastructure within which core participants and others must engage and contribute. Consideration and incorporation of these factors at an early stage, would set the tone for how an inquiry is to run and signal that affected individuals have an important voice, evidential value, and a vital role to play. It remains important for inquiry Chairs to have regard to these factors, whilst ensuring independence, the appearance of independence and fairness to all parties involved. Achieving this delicate balance would help ensure a robust process and effective participation for all. Whilst this article focuses on statutory public inquiries, the principles are equally applicable to non-statutory inquiries, inquests and other reviews and investigations.

16 See for example: *https://communities.lawsociety.org.uk/july-2021/culture-club/6001890.article*

17 See for example: *https://ehrac.org.uk/wp-content/uploads/2022/03/Trauma-Informed-Legal-Practice-Toolkit-2022.pdf*

18 See for example: *https://yjlc.uk/resources/legal-guides-and-toolkits/trauma-informed-lawyering*

19 *https://www.crestadvisory.com/post/a-trauma-informed-approach-to-public-inquiries*

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