5 ESSEX COURT

INSIGHT

INQUESTS AND INQUIRIES

IN THIS ISSUE

Welcome from the Editors

Samantha Leek QC
& Jonathan Dixey

Welcome to the second issue of 5 Essex Court's publication, *Insight: Inquests and Inquiries.*

In this edition we draw upon the vast experience of 5 Essex Court's barristers, who share practical insights and legal developments arising from some of 2018's most significant inquests and public inquiries.

Francesca Whitelaw and David Messling consider ***R (Thomas Maughan) v Her Majesty's Senior Coroner for Oxfordshire*** [2018] EWHC 1955 (Admin) and address the issue: *"What is the Standard of Proof for Suicide… and where does that leave Unlawful Killing?"* Francesca and David summarise by presenting their key messages for practitioners.

In his article *"It's been a privilege, but Worcestershire may be more attractive…"* Barney Branston considers the delicate issue of how to resolve the conflict between making appropriate disclosure to a coroner whilst not conceding any possible defence in civil proceedings.

5 Essex Court had an exciting 2018 and we were very pleased to welcome Bilal Rawat, Rob Harland and Saara Idelbi to Chambers. In this edition Rob shares his insights on *"The Perpetrator Issue: the appeal in Hambleton is allowed"* and addresses whether a coroner should be required to consider who the actual perpetrator of a homicide was if a criminal investigation fails to decide?

Samantha Leek QC writes about *"Hospital Deaths and Article 2."* In the context of ***R (Parkinson) v HM Senior Coroner Kent*** **[2018] EWHC 1501.** Samantha points to the *"clear analysis of the application of Article 2"* provided by the Divisional Court and offers detailed conclusions for the practitioner.

Our LinkedIn Group, Inquests and Inquiries: Insight from 5 Essex Court, received a question from a solicitor about what our top tips were. We thought this would make a great feature for our publication, and this edition finishes up with practical advice from six of our field leading barristers.

If you haven't already, please join our LinkedIn group which aims to provide a forum for debate and sharing views on key issues relating to inquests and inquiries.

We hope you find this edition of Insight informative and please send any questions, thoughts or suggestions to **inquestsandinquiries@5essexcourt.co.uk**

5 Essex Court's barristers have been instructed in the majority of high profile public inquiries including: *the Grenfell Tower Inquiry; the Independent Inquiry into Child Sexual Abuse; the Anthony Grainger Inquiry; the Renewable Heat Incentive Inquiry;* and *the Undercover Policing Inquiry*. Recent and ongoing high-profile inquests in which members of 5 Essex Court have appeared or are currently instructed include: *the London Bridge Attack; the Westminster Terror Attack; Perepilichnyy; Deepcut; the Birmingham Pub Bombings;* and *Poppi Worthington*.

"5 Essex Court has developed an enviable team for inquests and public inquiries work"

Chambers UK

Francesca Whitelaw & David Messling (pupil)

What is the Standard of Proof for Suicide… and where does that leave Unlawful Killing?

What standard of proof is required for an inquest to reach a conclusion of suicide? This was the question recently considered in *R (Thomas Maughan) v Her Majesty's Senior Coroner for Oxfordshire* [2018] EWHC 1955 (Admin). Overturning previous judgments of the High Court, a Divisional Court comprised of Leggatt LJ and Nicol J held that the civil standard, and not the criminal, ought to apply.

The case arose from an inquest held into the death of the claimant's brother, who was found hanged in his prison cell in HMP Bullingdon. At the conclusion of the inquest in October 2017, the Senior Coroner determined that there was insufficient evidence for the jury to be sure that the deceased had intended to kill himself. He therefore decided that a short-form conclusion of suicide was not open to the jury. Instead, he invited the jury to record a narrative conclusion which addressed five key questions, including whether the deceased had deliberately hanged himself and whether he intended the outcome to be fatal. The coroner advised the jury that the standard of proof to apply when considering these five questions was the balance of probabilities.

The jury concluded that the deceased had deliberately tied the ligature, that he had deliberately suspended himself, and that it was more than likely than not that he intended the hanging to be fatal. As the Divisional Court subsequently acknowledged, by determining that the deceased had deliberately acted to end his own life intending the outcome to be fatal, the jury had effectively reached a conclusion of suicide, whether or not the term 'suicide' was used. It was, said the court, "sophistry" to say the conclusion was not one of suicide.

The claimant sought judicial review. He argued that the coroner had been wrong to advise the jury to apply the civil standard of proof for the narrative conclusion's questions, as this was inconsistent with requiring the criminal standard of proof for a short-form verdict of suicide. The claimant pointed to the stigma associated with suicide in some communities, including amongst the deceased's own family who were devout Roman Catholics. He contended that a conclusion of suicide, whether in short-form or in a narrative statement, should only be based on the criminal standard. The defendant coroner explained that his directions had followed the guidance from the Chief Coroner and the examples given in The Coroner Bench Book but took a neutral position as to whether such directions were ultimately lawful.

> "Suicide must be proved by evidence, and if it is not proved by evidence, it is the duty of the coroner not to find suicide but to find an open verdict."

In its judgment, the Divisional Court noted that there was no requirement in the body of the Coroners (Inquest) Rules 2013 for the criminal standard to be used. The only such requirement was to be found in Note (iii) to Form 2 (the required form for recording the record of the inquest), which stated that the standard of proof required for short-form conclusions of unlawful killing or suicide was the criminal standard. The Court rejected the argument that Note (iii) had statutory authority, concluding that if the intention had been to make a rule about the standard of proof, the appropriate place was in the body of the rules, not in a prescribed form. It did, however, accept that the power to make coroners' rules, contained in section 45 of the Coroners and Justice Act 2009, was sufficiently broad to enable such a rule to be made.

The Court then turned to the common law position, eliciting several key points. Firstly, it emphasised that there is a consistent principle that a finding of suicide must have an evidential basis and is only justified if the possibility of an unexplained accident can be excluded. The Court cited the statement of Lord Widgery CJ in *R v City of London Coroner, ex parte Barber* [1975] 1 WLR 1310 that

> "Suicide must be proved by evidence, and if it is not proved by evidence, it is the duty of the coroner not to find suicide but to find an open verdict".

However, secondly, the Court explained that this principle did not preclude suicide from being inferred from available evidence, nor did it provide a justification for applying the criminal standard of proof. It disagreed with the decision taken in *R v West London Coroner ex parte Gray* [1988] QB

Francesca Whitelaw & David Messling (pupil)

What is the Standard of Proof for Suicide… and where does that leave Unlawful Killing? (continued)

407, which had read *ex parte Barber* as requiring the criminal standard for suicide. Lord Widgery CJ, said the Court, had not been considering the standard of proof at all, but merely the point that suicide must never be presumed and must always be proved.

Thirdly, the Court noted that *ex parte Gray* had made no reference to the question of criminal offences in civil proceedings, in which it was the civil and not the criminal standard which applied. There was, it said, *"no attempt to explain why a different principle should apply in relation to a coroner's inquest"*. The Court emphasised that the modern inquest is a fact-finding exercise. It no longer has the power to commit for a criminal trial and its conclusions have no direct effect on legal rights. The Court also observed that the Supreme Court had disapproved of the views expressed about the standard of proof for suicide in *ex parte Gray in Braganza v BP Shipping Ltd* [2015] UKSC 17, as had courts in both Canada and New Zealand.

Finally, the Court addressed the judgment of Lang J in *R (Evandro Lagos) v HM Coroner for the City of London* [2013] EWHC 423 (Admin), which upheld a coroner's decision to apply the criminal standard. Relying on *ex parte Gray*, Lang J had explained that applying the criminal standard reflected the seriousness of a suicide finding and the inherent complexities of human psychology.

The Divisional Court rejected both these arguments (although it emphasised that Lang J, sitting alone, had been more constrained by the decision in *ex parte Gray* than a Divisional Court would have been). It said that there was no reason in principle why the serious nature of suicide justified a departure from the usual rule in civil proceedings, noting that many civil matters resulted in life changing and potentially devastating conclusions, but did not apply the criminal standard of proof. The requisite intention for suicide might be difficult to determine in practice, but this was not a reason to alter the standard of proof itself.

It is significant that the Divisional Court did not explicitly make a finding regarding the standard of proof required for a conclusion of unlawful killing; and there is binding Court of Appeal authority *(R v Wolverhampton Coroner, ex parte McCurbin* [1990] 1 WLR 719) that the criminal standard applies.

However, the Court did conclude that there was *"no principled reason"* for adopting a different standard of proof in inquests than in civil proceedings, *"even if the facts found disclose the commission of a criminal offence"*. This creates a tension in the law which makes it likely that following *Maughan*, the application of the criminal standard to unlawful killing will come under scrutiny in the future. It would arguably be troubling if the civil standard were to apply to unlawful killing, given that such a conclusion is judgmental and not merely factual, and that it will be recorded on a public document.

Maughan is due to be considered on appeal in the next few months. As the law currently stands, the standard of proof for suicide is the civil standard, with unlawful killing being an outlier in requiring a higher standard of proof than other conclusions. However, that position may yet change…

The Key Messages for Practitioners

- Following *Maughan*, the standard of proof for a suicide conclusion at an inquest is now the balance of probabilities. However, be aware that *Maughan* is subject to appeal so keep an eye out for the appeal decision.
- *Maughan* has not changed the standard of proof for an unlawful killing conclusion, which remains the criminal standard (beyond reasonable doubt), given the binding Court of Appeal decision in *McCurbin*.
- However, if unlawful killing is likely to be a potential conclusion in an inquest in which you are acting, in particular on behalf of public bodies as Interested Persons, it is important to be prepared to deal with any arguments you may now face that the reasoning in *Maughan* reads across so that the civil standard ought to apply.

Barney Branston

It's been a privilege, but Worcestershire may be more attractive…

In most cases involving emanations of the state, the coroner's inquest is rarely the first investigation into the circumstances that led to the death. There will either have been an external body considering the material facts (for example the police, the Prison and Probation Ombudsman or the Independent Office for Police Conduct); or there will have been an internal investigation (such as a Serious Incident Review); or even a hybrid (such as a stakeholder's Individual Management Review that contributes to a wider Domestic Homicide Review).

The purposes of such other prior investigations are subtly but fundamentally different to those of an inquest; a report designed to establish whether or not there has been misconduct by a police officer or whether there are "lessons to be learnt from the death" is not primarily designed to address the questions of "who, how, when and where the deceased came by his or her death" as set out in section 5(1) of the Coroners and Justice Act 2009. Of course a coroner is perfectly entitled to draw on the product of an external body's investigation for their own investigative purpose - they provide a useful "way in" to the case and a starting point in the identification of material issues and witnesses, albeit such use must be very carefully considered so as not to usurp their or the jury's function (see *Re Siberry* [2008] NIQB 147 at paragraphs [72] – [76]) – but doing so is not always straightforward.

As a matter of principle, the more the purposes of such reports diverge from answering the four questions set out in s5(1) CJA 2009, the less "relevant" they become in an inquest; there is therefore greater validity in objecting to the same being disclosed to other interested persons.

That principle is not, however, absolute, because there is a wider dimension to the inquest process that goes beyond the factual interrogatives of section 5(1) CJA 2009, namely to consider the prospective issue of whether there are lessons to be learnt to prevent other deaths. Those who have lost a loved one of course want to understand how they came by their death, and, where appropriate, to see those who may have contributed to the same be held to account, but if there is any consolation in such a process it is usually in the hope that lessons may be learnt and that others may be spared such tragedy in future.

This prospective issue is enshrined in regulation 28 of the Coroners (Investigations) Regulations 2013 and paragraph 7 to Schedule 5 of the Coroners and Justice Act 2009, by which a coroner is under a duty to make a report to prevent other deaths if

> "anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future."

At first blush, the reports generated by these prior investigations may have a very obvious overlap with this issue: the primary purpose of a Root Cause Analysis or of a Serious Incident Review is to analyse the facts and determine what happened so that lessons can be learnt for the future. In NHS cases there is an expectation that all who participate in the production of such reports will comply with the "duty of candour"; such an expectation is rather at odds with contentious litigation and that difference in approach often creates difficulties, not least where the inquest process precedes a civil claim.

Another example is the Domestic Homicide Review. This was established by statute (the Domestic Violence, Crime and Victims Act 2004) and is a review that is expressly "held with a view to identifying the lessons to be learnt from the death". Such a review is enabled by the input of whichever stakeholders are relevant to the case, a process in respect of which there is Statutory Guidance, the "Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews" dated December 2016. The stakeholder will consider their part in the tragedy in what is termed an Individual Management Review, one of the aims of which is to:

> "allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training, etc.) to see whether the homicide indicates that practice needs to be changed or improved to support professionals to carry out their work to the highest standards.[1] "

[1] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews dated December 2016, Section 7, paragraph 61(a).

Barney Branston

It's been a privilege, but Worcestershire may be more attractive… (continued)

Such a laudable aim is achieved, in part, by a process which encourages and indeed relies on candour, not least where the Guidance also states that:

> "In all cases, the overview report and executive summary should be suitably anonymised and made publicly available. **IMRs should not be made publicly available**"[2]

The whole tenor of such a process is of co-operation and candour but with an expectation of confidentiality; it does not contemplate the publication of IMRs at all, still less in inquisitorial legal proceedings held in public. What can be done where a coroner seeks disclosure of such reports in the context of his or her inquest but where the disclosure of the same may well be detrimental to mounting a successful defence in litigation?

In the vast majority of cases an interested person should adopt the approach advocated in the Chief Coroner's Lawsheet No 3, the Worcestershire Case (*Worcestershire County Council and Worcestershire Safeguarding Children Board v HM Coroner for the County of Worcestershire* [2013] EWHC 1711 (QB)). This will enable the interested person to comply with their duty of disclosure to the coroner whilst still being able to make submissions regarding its wider disclosure in the inquest. Such submissions will usually be focussed on the narrow issue of "relevance", the touchstone by which a coroner can refuse (per rule 15(e) of the Coroners (Inquests) Rules 2013) an interested person's request to provide a document. When adopting this approach it is well worth reminding the coroner when disclosing such a document to them alone that they ought not to disclose the document more widely until they have considered submissions on the issue.

There will be some rare cases where an interested person wholly declines to disclose such a report to the coroner, even when specifically asked to do so. It is unusual for an interested person to adopt such a stance, not least because a coroner has a statutory power to compel disclosure by issuing an order pursuant to paragraph 1 of Schedule 5 of the Coroners and Justice Act 2009, a power to which is attached the formal penalty of a fine. In an appropriate case, there is a defence to such an order on the ground of Public Interest Immunity (as it applies in civil proceedings) or where there would be no requirement to do so in civil proceedings (see paragraph 2, Schedule 5, Coroners and Justice Act 2009).

One such example would include the claim of either litigation privilege or legal advice privilege. Whilst it is an authority from the criminal rather than the coronial jurisdiction, it is highly likely that the Court of Appeal's recent analysis of such privilege in *SFO v Eurasian Natural Resources Corp* [2018] EWCA Civ 2006 will have implications for such claims in future; the court will now look very carefully at the document in question and the circumstances behind its creation before according it such status.

Interested persons may therefore find that the approach advocated in the *Worcestershire* case is a more expedient way of resolving the conflict between making appropriate disclosure to a coroner whilst not conceding any possible defence in civil proceedings.

[2] ibid, Section 8, paragraph 80.

Rob Harland

The Perpetrator Issue: the appeal in Hambleton is allowed

Inquests that concern a death by homicide are generally adjourned pending any criminal investigation and trial.

But what happens if at the end of that investigation the accused are acquitted (or, as in the case of the Birmingham Six, their convictions are quashed many years later)? If a coroner resumes the inquest in such circumstances - as they likely will if, for example, there are 2 issues remaining to be explored - will he or she be required to consider who the actual perpetrator of the homicide was? There are competing interests at stake. On the one hand, the identity of the killer(s) may be of utmost importance to the family (and the public at large). They may, understandably, see it as being a central issue in investigating the "circumstances" of the death. On the other hand, the coroner might be mindful of the two prohibitions in the Coroners and Justice Act 2009: the first at s10(2), against determining criminal liability on the part of a named person, and the second at paragraph 8(5) of Schedule 1, against making a determination which is inconsistent with the outcome of the criminal proceedings. Given such restrictions, how can it be proportionate to try nonetheless to establish (but not name) who the killer was, when the police and prosecuting authorities have failed to do so, and the coroner does not have their resources to pour into a new investigation? In any event, is it desirable to turn a coroner's court into a quasi-criminal trial, albeit one which does not have the safeguards properly afforded to a criminal defendant such as "a clear statement in writing of the alleged wrongdoing… a right to call any relevant and admissible evidence and a right to address factual submissions to the tribunal of fact" (per Sir Thomas Bingham MR in *R v North Humberside Coroner, ex parte Jamieson* [1995] QB 1)

This was the issue in the case of Coroner for the *Birmingham Inquests v Hambleton and others* [2018] EWCA Civ 2081 in which Jeremy Johnson QC and Robert Cohen appeared for the interested party, and which relates to the re-opened inquests into the Birmingham pub bombing deaths. The families wanted to revisit the findings of the criminal trial, having the jury assess whether the Birmingham six and any other suspects were guilty or innocent of the bombings. The coroner declined to investigate this 'perpetrator' issue. The High Court quashed that decision and remitted it back to the coroner. Hot on the heels of the article on this case in the last issue of Insight, the Court of Appeal have allowed the Coroner's appeal and stated the law more clearly.

The High Court's central criticism of the coroner was that he had failed to ask himself the right question in reaching his decision: namely "*whether the factual issue of the identity of the bomber was sufficiently closely connected to the deaths to form part of the circumstances of the death.*" The Court of Appeal stated that

> "we are unable to agree that the question formulated by the High Court was the one which the Coroner should have asked himself. It does not arise from the purposes of an inquest identified in section 5 of the 2009 Act. The Coroner was correct to consider the question of scope in the context of providing evidence to enable the jury to answer the four statutory questions. The scope of an inquest is not determined by looking at the broad circumstances of what occurred and requiring all matters touching those circumstances to be explored" (§51).

The Coroner's reasoning was therefore deemed correct.

It is right that the Court of Appeal (like the High Court) did not seek to lay down a black and white rule as to whether it would ever be appropriate to hear evidence about the identity of the person or persons thought responsible for a death (see §53). However, they were clear in relation to this case that they thought the coroner's decision clear cut:

> "it is difficult to criticise the coroner, still less to stigmatise as unlawful a decision to refuse to explore a distinct question which the jury is prohibited by statute from answering" (§56).

They identified that the distinctive nature of this case was that there had been a

> "comprehensive police investigation which has been unable satisfactorily to identify those responsible with a view to prosecution and it is being suggested that the inquest should independently conduct a fresh criminal investigation" (§53).

The Court supported the reasons given by the coroner for not investigating the perpetrator issue, including the practical difficulties which would lead to a piecemeal and incomplete investigation 43 years on from the deaths, an approach *"entirely unsuited to the inquest process and its limited resources [and]… disproportionate to the task in hand." The Court confirmed that the fact that a criminal investigation had not identified a guilty party did "not begin to establish that proper investigations had not been carried out"* such that there was a breach of 2 that the inquest should rectify. In any event, the appropriate remedy in such circumstances would normally be for a further police investigation or procedural review (§60).

Central to the Court's reasoning, and perhaps of wider importance outside the otherwise relatively niche facts of this case, was the observation that the families were wrong to characterise the perpetrator issue as being central to the 'circumstances' of the death in an Article 2 sense. The Court said in terms that

> "the identity of those responsible for the bombings is not a central issue in the inquests" (§54)

and distinguished the need under 2 to explain the circumstance in which the deceased came by their deaths with *"the broader circumstances of the deaths, which are not touched by the procedural obligation under article 2."* That is to say, that a Middleton investigation is to go as far, but no further, than the reach of 2.

Finally, the Court clarified that the test in judicial review as to the correctness of a Coroner's decision on scope remained a *Wednesbury* one. The High Court had wrongly considered that because it could be classified as a 'judgment' it was sufficient that they deemed it 'wrong'.

Samantha Leek QC

Hospital Deaths and Article 2

R (Parkinson) v HM Senior Coroner Kent [2018] EWHC 1501 (Admin). The Divisional Court in *Parkinson* gave a clear analysis of the application of 2 in relation to deaths following or during the course of medical treatment. It restated that the 2 investigative obligation will not be triggered if the treatment amounts to no more than clinical negligence.

The facts

91 year old Mrs Parkinson collapsed at home and was admitted to A&E. Dr Hijazi concluded that she was dying and that there was little that could be done to save her. Nevertheless he prescribed fluids and antibiotics. The Claimant, Mrs Parkinson's son, attempted to perform mouth to mouth resuscitation, despite the A&E staff advising him not to do this. He was abusive and obstructive towards Dr Hijazi. His mother deteriorated quickly after arrival at the hospital and died soon afterwards.

The Coroner found that the investigative obligation under 2 was not engaged. At the inquest he concluded that the cause of death was "bronchopneumonia combined possibly with right lung pulmonary thrombi" and returned a conclusion of natural causes. The Claimant had sought to persuade him that this was a case of unlawful killing by gross negligence.

Judicial Review

The Claimant challenged the Coroner's decisions on 5 grounds, namely that:

1. it was wrong in law to hold that the 2 enhanced investigative duty did not arise;
2. the finding regarding the medical cause of death was irrational;
3. the conclusion of "natural causes" did not discharge the Coroner's duties and / or was irrational;
4. it was irrational to find that the Claimant's conduct obstructed the care which would otherwise have been provided to his mother;
5. the Coroner was under a duty in this case to make a Prevention of Future Death ('PFD') Report.

Article 2 ECHR

Singh LJ, giving the judgment of the court, followed the recent statement of principles set out by the European Court in Fernandes v Portugal and summarised the relevant principles on 2 from the authorities as follows:

- Article 2 imposes substantive positive obligations on the state and procedural obligations.
- The primary substantive positive obligation is to have in place a regulatory framework compelling hospitals to adopt appropriate measures for the protection of patients' lives.
- The primary procedural obligation is to have a system of law by which individual failures can be the subject of an appropriate remedy, ie by having a criminal justice system, which can in principle hold to account a healthcare professional who causes a patient's death by gross negligence and a civil justice system, which makes available a possible civil claim for negligence.
- The enhanced duty to investigate, which requires the state initiate an effective and independent investigation, only arises in medical cases where there is an arguable breach of the state's own substantive obligations under 2.
- Where the state has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, matters such as an error of judgment on the part of a health professional or negligent coordination among health professionals in the treatment of a particular patient are not sufficient of themselves to call the state to account under 2.
- There may be exceptional cases which go beyond mere error or medical negligence, in which medical staff, in breach of their professional obligations, fail to provide emergency medical treatment despite being fully aware that a person's life would be put at risk if that treatment is not given. In those cases the failure would result from a dysfunction in the hospital's services and this will be a structural issue linked to the deficiencies in the regulatory framework.

Samantha Leek QC

Hospital Deaths and Article 2 (continued)

Conclusions

Systemic issues

The court found that the hospital had a system in place in the form of a policy which governed the triage system to be used when a patient comes into A&E. That was based on a nationally recognised system known as the Manchester Triage System. There was also a Resuscitation Policy. The argument that other wards of the hospital used a different system to classify medical emergencies found no favour with the court. The Coroner was entitled to reach the view that there was no systemic issue which arose – therefore there was no arguable breach of the substantive obligations in 2. Therefore there was no enhanced duty of investigation.

Factual challenges

The Claimant challenged the Coroner's findings on the medical cause of death; that no action that the hospital might have taken could have changed the outcome; and that the Claimant obstructed the examination of Mrs Parkinson. The Court reaffirmed that the issue was whether the Coroner's conclusions were ones which no reasonable coroner could have reached.

Despite the conflicting and complex evidence of numerous pathologists as to the cause of death, the court found that:

- there was sufficient evidence for the Coroner to have concluded that Mrs Parkinson was dying and that no treatment would have affected the outcome;
- there was sufficient evidence to find that the medical cause of death was "bronchopneumonia combined possibly with right lung pulmonary thrombi"; and that
- the Coroner was clearly entitled to reach the conclusion that Mr Parkinson had obstructed the doctor's examination of his mother. This was not an irrational conclusion.

PFD report

On the basis of the above conclusions, it was entirely reasonable for the Coroner to decide that there was no basis upon which he needed to make a report.

Costs

The Claimant was ordered to pay not only the costs of the Coroner, but also the costs incurred by each of the Interested Parties. The Court found that it was necessary in this case for the Coroner to defend his decisions and to take an active part in the proceedings. In the circumstances of this case each of the Interested Parties should be awarded their costs - the Claimant had made serious and separate allegations against the doctor and the NHS Trust, giving rise to separate interests which needed to be protected by separate representation.

The Coroner was entitled to reach the view that there was no systemic issue which arose – therefore there was no arguable breach of the substantive obligations in 2.

5 Essex Court

Top tips for inquests and inquiries

As it's a new year, we thought we would revisit one of the discussions we had in our LinkedIn group in 2018: what are our top tips for inquests and inquiries? The following is a selection of the tips offered, with some additional suggestions.

Mark Thomas

Get a grip of proceedings as soon as possible, including at the pre-inquest review (PIR) stage. Keep in mind the guidance for PIRs in *Brown v HM Coroner for Norfolk* [2014] EWHC 187 (Admin):

1. The coroner should ensure that all Interested Persons (IP) have sufficient notice of the matters to be discussed at the PIR.
2. The coroner should circulate a written agenda in advance, expressing provisional views so that agreement or opposition can be expressed.
3. In complex cases, the IPs should be invited to respond to the agenda in advance of the PIR.
4. The coroner should ensure that IPs, particularly unrepresented ones, have sufficient disclosure of statements and documents to play a proper role in the PIR.
5. The coroner should not give impression that the findings and conclusions of the inquest are pre-determined.
6. Coroners should take care when dealing with IPs not to give impression of bias.

"Remain compassionate. After days or weeks of evidence, camaraderie naturally develops in the courtroom."

Georgina Wolfe

Here are my top three tips:

1. Know the facts inside out. The coronial process tends to be fairly fluid with nebulous rules and more relaxed procedure. This means you can be surprised at any minute and the only way to prepare for that is to be on top of all the documents, evidence and facts. Try and be abreast of everything before the first PIR and you will give your client a significant advantage. Equally, if you have your disclosure well underway by that early stage, it shows you are taking the inquest seriously and you are likely to win favour with the court and other IPs.
2. Take a careful note of proceedings including time markings (i.e. '2pm Witness A examination… 3pm End of Witness A; submissions on conclusion…'). The inquests costs landscape is changing; there is no higher court decision clearly setting out the law. This means that when it comes to a costs argument in the course of a subsequent civil case, nothing is guaranteed. The indications from the costs courts (see *Lynch v Chief Constable of Warwickshire* [2014] Inquest LR 247 and *Douglas v Ministry of Justice* [2018] EWHC B2 (Costs), [2018] Inquest LR 71) are that the costs of attending the inquest are recoverable insofar as they relate to securing disclosure and witness evidence from defendants. That means that parts of the inquest that have no bearing on the civil claim – submissions on whether there should be a jury, reading witness statements aloud for the jury etc – are probably not recoverable. If you can show the times spent on these matters, you should be able to reduce the costs come detailed assessment.
3. Remain compassionate. After days or weeks of evidence, camaraderie naturally develops in the courtroom. But whatever happens, remember that at the heart of every inquest is the loss of someone's loved one. This is the family's opportunity to understand what happened. It is part of their grieving process. Always keep that in mind.

5 Essex Court

Top tips for inquests and inquiries (continued)

Jonathan Dixey

Identify and obtain evidence at the earliest possible opportunity. One of the key differences between inquests and civil proceedings is the bar on addressing the coroner and / or jury on the facts. Whilst that prohibition is not always strictly observed or enforced, it places greater emphasis on the witnesses to present their evidence and explain why that evidence is important and should be accepted. For that reason the identification of the issues to be explored at an inquest (or inquiry) at the earliest possible stage is of vital importance. That means identifying what evidence presently exists (documents and witness evidence) and if it doesn't exist, it is important to set about obtaining that evidence before memories fade, people leave the organisation etc. If disclosed early enough, it may be possible to persuade a coroner / chairperson to exclude from the scope / issues those matters which are adequately addressed in the evidence.

Anne Studd QC

Make sure your witness knows what the issues are in broad terms and has an opportunity to review the contemporary documentation. Obviously you can't coach your witness and you must not. However, making sure that they are aware of the scope of the inquest or inquiry, the issues involved and by ensuring that they have a document pack which includes any statement and contemporaneous notes and any other relevant document in good time for the hearing is vital.

Claire Palmer

It may seem obvious but ensure each witness you represent has re-read (where they exist) their statement(s), interview and contemporaneous notes. And make sure they do so again the day before giving evidence.

Samantha Leek QC

In high-profile inquests and inquiries there will often be requests by the media for copies of photographs, CCTV recordings and the like. These will usually only be made after the material has been adduced into evidence. It is worth considering – usually at a preliminary hearing or pre-inquest review – what actually needs to be used in court in order to prove the relevant facts. When acting for families who already find the inquiry / inquest process distressing, a key objective may well be to restrict how much sensitive or distressing information is put into the public domain.

If you haven't already, please do join the **Inquests and Inquiries: Insight from 5 Essex Court** LinkedIn group. Do join the discussion.

About 5 Essex Court

5 Essex Court is widely recognised as a top-tier set for inquests and public inquiries with an outstanding and comprehensive service.

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