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# Inquests: Recent Developments

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# Outline

- Notification of death regs 2019
- Ketcher – Privilege
- Maguire – Art 2 & DOLS
- Smith [2020] – Conclusions
- Fullick – Costs
- COVID-19 Guidance

# Notification of Death Regulations

# Notification Of Death Regulations 2019

- Previously MCCD sent to registrar
- Now (1.10.2019), **Dr** must notify Snr Coroner if s/he “comes to know of the death” and:
  - Suspects [violent/ unnatural],
  - Unknown cause
  - In custody
  - Identity unknown, or
  - No-one to sign MCCD (14 days)
- **BUT** see Coronavirus Act 2020





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# Ketcher & Mitchell Privilege in expert reports

[2020] NICA 31

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# Ketcher - Issue

- Both deceased died by hanging at Albercorn Barracks.
- Mothers obtained psychiatric reports.
- Coroner required them to disclose. Appellants **and MOD** submitted that they were privileged.
- Principle basis:
  - *s. 17A and 17B of the Coroners Act (NI) 1959 imported litigation privilege into the inquest arena*
  - *Common law privilege.*

# Ketcher - Legislation

**Section 17A** – power to require evidence

**Section 17B** [...]

*(2) A person may not be required to give or produce any evidence or document under section 17A if—*

*(a) he could not be required to do so in civil proceedings in a court in Northern Ireland, or*

*(b) the requirement would be incompatible with an EU obligation.*

*(3) The rules of law under which evidence or documents are permitted or required to be withheld on grounds of public interest immunity apply in relation to an inquest as they apply in relation to civil proceedings in a court in Northern Ireland.”*

**Identical to CJA 2009 – Schedule 5 , para 1&2**

# Ketcher - Decision

- [13] *Although the principal argument... was that section 17B(2)(a)... imported litigation privilege ... the anterior question... is whether coronial proceedings... give rise in any event to litigation privilege.*
- [32]... *thrust of the case law since Three Rivers DC... inquests are fundamentally **inquisitorial** and **litigation privilege does not apply.***
  - So what about 17B(2)(a)?



# BUT – s17A

*(4) A claim by a person that—*

*(a) he is unable to comply with a notice under this section, or*

*(b) it is **not reasonable** in all the circumstances to require him to comply with such a notice,*

*is to be determined by the coroner, who may revoke or vary the notice on that ground.*

*(5) In deciding whether to revoke or vary a notice on the ground mentioned in subsection (4)(b), the coroner shall **consider the public interest** in the information in question being obtained for the purposes of the inquest, having regard to the likely importance of the information....*

**(Identical to CJA 2009 para 1(4) and (5))**

# 17A – balance against disclosure

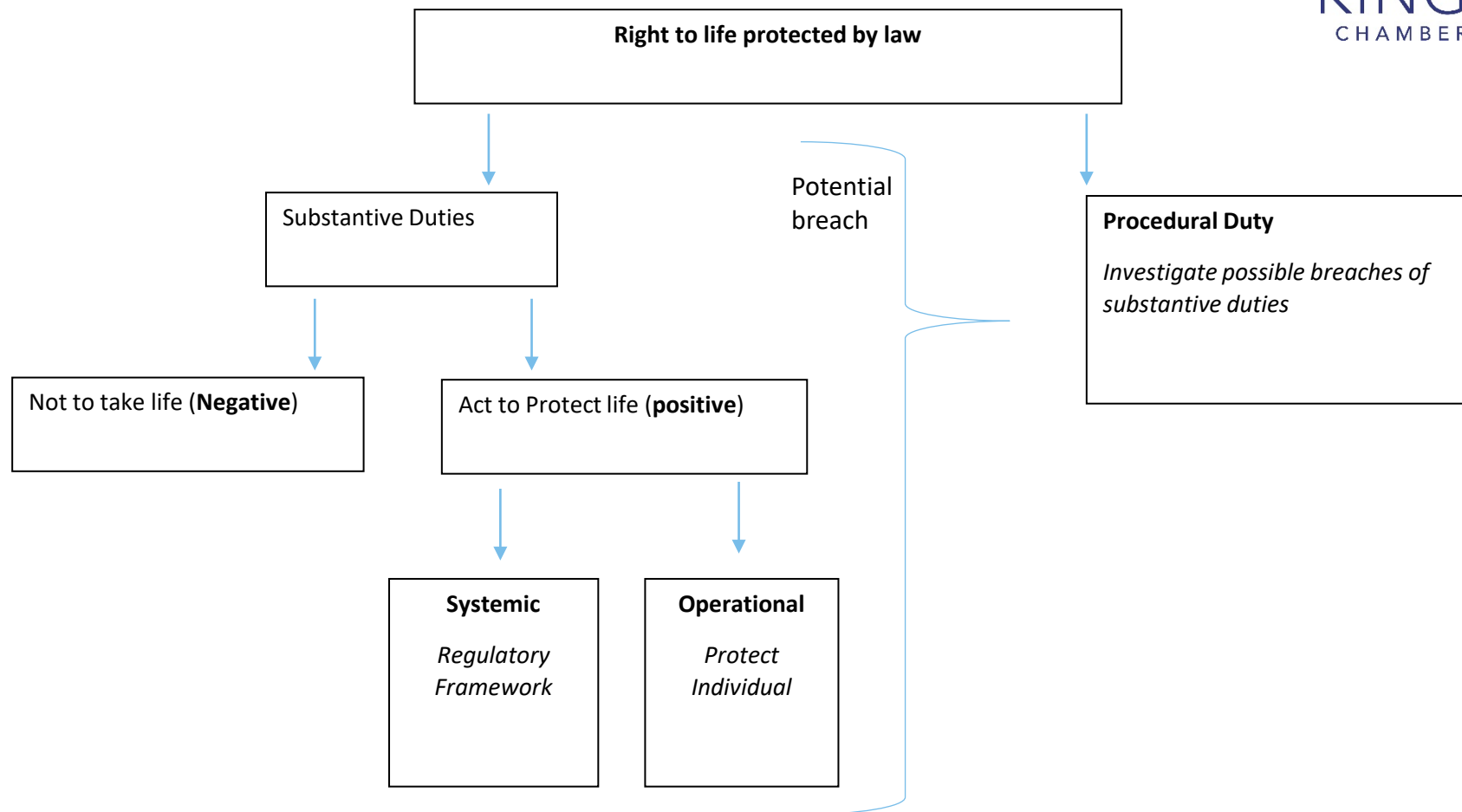
- Modest importance.
- In almost all cases any expert report ... would have been for the dominant purpose of the civil claim.
- In the vast majority of cases there would have been no power to require the production of such report.
- The interest of the family in preparing their case would normally outweigh the coroner's.
- Public Interest: Compulsory disclosure of such reports as a matter of course would be likely to **discourage such investigations.**

- What is the purpose of “could not be required to do so in civil proceedings”?
- Key points:
  - Ensure purpose of report (litigation) is clear on the instructions. This will prevent disclosure.
  - Bear in mind CJA 2009 Sched 5 1(4) & (5) and public Interest, if notice is issued.

# Maguire Art.2 & DOLS

[2020] EWCA civ 738

# Art 2



# Positive Obligation

- (a) the duty to provide a regulatory framework (systemic); and
- (b) the obligation to take preventive operational measures where the authorities know or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual (Operational)



# Systemic Duty

- effective criminal law provisions to deter the commission of offences against the person backed up by law-enforcement machinery ... (Osman v UK [115])
- “to take appropriate legislative and administrative steps to protect life, for example by the provision of a police force and criminal justice system” (Humberstone [21])
- Can include taking reasonable measures to ensure the safety of individuals in public places (Ciechońska v. Poland, [67]).

# Operational Duty

- Rabone [38]
  - a ‘real risk’ is “a substantial or significant risk and not a remote or fanciful one.”
  - Immediate is “... a risk which is present at the time of the alleged breach of duty and not a risk that will arise at some time in the future.”
- ‘a very high threshold’ (Van-Colle –v- Chief Constable of Hertfordshire Police [2009] 1 AC 225 para. 115)



# Maguire - Facts

- JM – Downs' Syndrome, care home, DoLS.
- 2 days' illness, seen by paramedics & GP
- Wouldn't co-operate with transfer to hospital
- Monitored overnight & Deteriorated
- Admitted & died following day.
- **Issues:**
  - failures in communication;
  - no advance plan was in place to get her to a hospital in the event that she refused to co-operate and admission was urgent.

# Maguire - Arguments

- Appellant:
  - Given vulnerability, lack of capacity, and detention, A2 engaged. Apply Rabone.
  - Systemic Duty engaged (Parkinson)
- Respondent –
  - Detention not connected to risk of death (unlike psychiatric). This is a medical case.
  - No systemic failure

# Lopes de Sousa (ECHR)

- A2 engaged in medical cases only in “very exceptional circumstances”:
  - Patient’s life is knowingly put in danger by denial of access to life-saving emergency treatment [191]. *Acts / omissions must go **beyond a mere error or medical negligence** [194]*
  - Systemic or **structural** dysfunction = patient deprived of access to life-saving emergency treatment [192] [195].
- BUT
  - different considerations arise in certain other contexts, in particular ... persons deprived of their liberty or of particularly vulnerable persons ...

# Maguire - Discussion

- Nencheva:
  - residential care home where 15 disabled children died.
  - The authorities were aware of the appalling conditions in the care home and of an increased mortality rate.
- Câmpeanu:
  - the domestic authorities knew that the facility in which the deceased was kept lacked proper heating and food, had a shortage of medical staff and resources and inadequate supplies of medication. That led to an increased mortality rate.

# Maguire - Discussion

- In ECHR cases *“the substantive article 2 duty owed to the people concerned was to protect from a type of harm entirely within the control of those who cared for them...”*



# Maguire - Discussion

- Natural causes death in custody did not engage A2 (Tyrell)
- Dumpe (ECHR)
  - was vulnerable and deprived of liberty (similar facts to Maguire),
  - A2 not engaged.
- indicated that an operational duty would not be owed to those in such a position seeking “*ordinary medical treatment*” [99].



# Decision – Vulnerability (100)

- Different to a psychiatric patient who is in hospital to guard against the risk of suicide.
- She was accommodated... because she was unable to look after herself...
- She was not there for medical treatment.
- If she needed medical treatment it was sought, in the usual way, from the NHS.

# Decision - Lopes

- “knowingly put in danger by a denial of access to life-saving emergency treatment.”
- Didn’t come close –
  - *“the collective judgement of the professionals was that JM was not in danger on the evening of 21 February 2017 and could be kept under observation at the home, even though it was preferable that she went to hospital”*



# Decision – Structural

- Lopes: “dysfunction.. must be... systemic or structural... not merely ... where something may have been dysfunctional in the sense of going wrong or functioning badly....”
- *“The making of plans in individual cases and the detail of guidance given to paramedics is far removed from what the [ECHR] describes...”*



# Maguire - Analysis

- Operational Duty
  - Vulnerability is not enough
  - State detention is not enough
  - Ordinary medical treatment unlikely to be enough
  - A link between the purpose of detention and the death (like in Rabone)
  - What about detention *for* ordinary medical treatment? (Hospital DOLS?)
- Systemic
  - Confirms what we know from de Sousa
  - Detail of guidelines is not enough



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# R (Smith) Conclusions

[2020] EWHC 781

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# Conclusion: Middleton

- *“To meet the procedural requirement of art 2 an inquest ought ordinarily to culminate in an expression, however brief, of the jury's conclusion on the disputed factual issues at the heart of the case.”* (Middleton [20])
- *... in some cases, ...a traditional short form verdict will be quite satisfactory, but ...it must be for the coroner... to decide how best, in the particular case, to elicit the jury's conclusion on the central issue or issues... [including with a narrative] [36]*



# Conclusion: Middleton

- Amin: ‘unlawful killing’ did not deal with the major issue: The procedures which led in each case to the deceased and his killer sharing a cell.
- Helpful to consider “[*where when and how*]...*the defects in the system which contributed to the death; and any other factors which are relevant to the circumstances of the death*” [36]

# Content – Judgmental?

- Middleton: a “judgmental conclusion of a factual nature, directly relating to the circumstances of the death.”
- Permitted judgmental words include ‘inadequate’, ‘inappropriate’, ‘insufficient’, ‘lacking’, ‘unsuitable’, ‘unsatisfactory’, and ‘failure’ (CG17 at [52] – **not in Middleton**)

# Admitted Failings

Tainton (2016) at [73]

- Jury should be directed to record admitted failings which did not contribute to the death.
- BUT...

# R (Smith) (1)

- Suicide.
- RCA found “Inadequate medical cover for home treatment team patients”
- Highly critical expert report for inquest
- Criticisms in Coroner’s **findings** but not persuaded as to causation.
- Family - **Critical findings of fact ought to be in the conclusion**



# Proposed Conclusion

- Leah received inadequate care, below the level of basic medical care that a patient can expect to receive from a modern mental health service. Despite an urgent referral, she received no in-person consultation from a psychiatrist until 25 April.
- In the absence of such consultation, there was no opportunity to reach a proper diagnosis despite florid psychotic symptomatology, suggestive of psychotic depression.
- Medication (both anti-psychotic and antidepressant) given during much of this time was at a subtherapeutic dose, which risked side-effects. Furthermore, there was no appropriate monitoring of her medication.
- There were multiple opportunities prior to 25 March, for consultant psychiatrists to have seen Ms. Smith, and no adequate reason for this not to have occurred...

# Smith Judgment

- *“We cannot approve language of this sort for either Part 3 or Part 4 of the Record” [78]*
- *Middleton [37]:*
  - *The prohibition in rule 36(2) ...must continue to be respected*
  - *What Middleton envisages is conclusions of fact as opposed to expressions of opinion...”*
- *neither necessary nor convenient for [the failings] to be added ... it **would have been wrong**... [81]*
- *“The argument that [failings ought to be in the conclusion i.e. Tainton] ...is an argument of **form over substance**....” [77]*

# Non Causative Failings after Smith?

Tainton [73] :

*“such a statement would have completed the incomplete account of the circumstances in which Mr O’Neill met his death”*

Smith [77]

**Wrong, and “an argument of form over substance”**

- Non-causative failings not required, unless necessary to ‘complete the account of the circumstances’?

# Smith - Language

- Middleton says ‘judgmental conclusion’
- 4 questions (‘in what circumstances’)
- CCG says ‘inadequate’, ‘inappropriate’, ‘insufficient’... (not in Middleton)
- Smith ‘conclusions of fact not expressions of opinion’
- How do we square the circle?

# Language

Middleton proposed conclusion [37]:

- “The deceased took his own life, in part because the risk of his doing so was not recognised and appropriate precautions were not taken to prevent him doing so”
- *...this embodies a judgmental conclusion of a factual nature, directly relating to the circumstances of the death.”*

# Smith - Causation

- Approved Tainton:
- Standard of proof is on BOP
- Threshold is material contribution:
  - “event or conduct said to have caused the death must have “more than minimally, negligibly or trivially contributed to the death”
- Statistics – Chidlow – exercise caution in using statistics to establish causation

# Fullick v Met Inquest Costs

[2019] Cost L.R. 1231

# Fullick - Facts

- Death in custody – Claims for A2 breach, negligence, misfeasance.
- Inquest attended including 2 x PIRH
- Settled, without a letter of claim or particulars for £18,000.
- Costs bill of £122,000 was claimed including inquest.



# Deputy Master

- PIRHs *“were instrumental in a number of different ways in getting [the claimant’s] own pathology evidence heard at the inquest, in compelling certain police witnesses to attend”.*
- *“inquest... went a lot further than evidence gathering... settlement was... reached without... civil proceedings...”*
- “artificial to say that work done and preparation for the inquest in taking those steps that somehow is not part of the civil claim.”

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# Slade J – Appeal

- The authorities emphasise the need to identify the issues raised in the civil claim and the relevance of matters in other proceedings...
- Once the threshold of relevance has been passed, the costs judge will decide whether the costs... were proportionate to the matters in issue in the civil proceedings.



# Slade - Recoverability

- The conclusion identified defaults on the part of the defendant that were relevant to civil proceedings:
  - inadequate policies, procedures and training.
- Unlikely to be proportionate or reasonable for a receiving party to attend a pre-hearing review to deal with agreed matters
- First PIRH – “first opportunity to engage with the issues”: Correct to say “*remiss in pursuing this claim not to be there*”
- Second PIRH – “*getting questions to*” the expert. Allowed.

# Slade – Proportionality

- £18,000 claim but acknowledged by D that the claim was not just about money.
- [48] Roach - the inquests in those cases in practice seemed to have the effect of causing the civil proceedings thereafter relatively speedily to be compromised.
- The value of the assistance gained in civil proceedings should be weighed against the cost of pursuing that particular point in the inquest.
- *“It... would be prudent to stand back to consider whether the total costs of participation in the inquest are proportionate to its **utility and relevance** to outstanding issues in the civil claim.”*

# COVID-19 Guidance



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# Hearings (35 & 38)

- CCG 35 – Hearings
  - “absent a coroner, it is not a court”
  - Only urgent matters proceeding
- CCG 38 – remote participation
  - Coroner must be present.
  - Parties and others can be remote (inc. witnesses)
  - Courts can be used in line with social distancing
  - Can stream to another court room but NOT online
- Are we seeing these?

# CCG 37 – Workplace COVID

- COVID is a notifiable disease BUT – s.30 CA 2020 – no jury.
- 12. it is a matter for the coroner’s judgement in each case whether the facts and evidence in the particular case provide “reason to suspect” that the death was unnatural
- 13...if there were reason to suspect that some human failure contributed to the person being infected with the virus, an investigation and inquest may be required.
- 15. it is a matter of judgment for the individual coroner to decide on the scope of each investigation.



# CCG 37 Workplace COVID

- R (Smith) v Oxfordshire Asst. Deputy Coroner [2011] 1 AC 1:
  - Lord Phillips observed that an inquest could properly consider whether a soldier had died because a flak jacket had been pierced by a sniper's bullet, but would not *"be a satisfactory tribunal for investigating whether more effective flak jackets could and should have been supplied"*

# CCG 37 – Workplace COVID

- Coroners can consider these issues
- Art 2 clearly engaged by COVID / pandemics
  - Planning inc PPE
- Breach? Will depend on the circumstances
- Smith
  - Doesn't prevent considering availability of PPE as it relates to the individual death
  - May limit scope in terms of national planning
  - Not at a local level

# Other cases

- Maughan (CA)
  - Balance of Probs for suicide
  - BRD for unlawful killing.
  - UKSC February 2020 – Judgment?
- Lee [2019] EWHC 3227 (Admin): Rabone in the community – perhaps?
- Dyer [2019] EWHC 2897 (Admin): Screens
- Birmingham Bombings: Anonymity guidance
- Deepcut: Propensity / Bad Character (applied s.100 CJA2003)





# Questions?

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