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Albion Chambers INQUEST TEAM NEWSLETTER

Reports to prevent future deaths

On 14 January 2014, the Chief Coroner's Office began publishing, on the Judiciary website, PFD (preventing future deaths) reports made by coroners under paragraph 7, schedule 5 of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. This marked the first time that the public have had access to such reports online, and the reports are now to be routinely published.

Every year, somewhere in the region of 600 PFD reports (previously known as Rule 43 reports) are made by coroners in England and Wales, covering topics ranging from speed limits on particular roads to changes in military equipment used in Helmand Province, Afghanistan. Since July 2013, all PFD reports and responses have to be sent to the Chief Coroner, HHJ Peter Thornton QC, who, in September of last year, created a new template form for the reports and issued specific written guidance for coroners on PFD reports, 'Guidance No. 5'.

The Guidance starts by emphasising the importance placed by Parliament on the reports, which have been upgraded from a rule to part of the 2009 Act. Further, coroners are now under a duty to make a report where a concern is identified. Previously, coroners had discretion to make a report. However, whilst emphasising that PFD reports are important, the Guidance reminds coroners that the reports are ancillary to the inquest procedure and not its mainspring.

The coroner's duty

The Guidance states that the coroner's duty arises in the following circumstances:

(1) The coroner has been conducting an investigation into a person's death;

(2) Something revealed by the investigation (including evidence at the inquest) gives rise to a concern – which is said to be a relatively low threshold;

(3) The concern is that circumstances creating a risk of further deaths will occur, or will continue to exist in the future. It is a concern of a risk to life caused by present or future circumstances;

(4) In the coroner's opinion, action should be taken to prevent those circumstances happening again or to reduce the risk of death created by them

Pre-condition to making a report

Unlike the previous Rule 43 reports, the coroner is not restricted to matters revealed in evidence at the inquest. Now, the coroner's concern may arise from 'anything revealed by the investigation' (including the inquest). However, the Guidance emphasises the wording of regulation 28(3) that before making a report, it is a pre-condition that "the coroner has considered all the documents, evidence and information that in the opinion of the coroner is relevant to the investigation".

Timing of the report

Whilst normally the investigation will be complete, with the inquest concluded, the Guidance explains that this will not necessarily be the case. The wording of paragraph 7 of schedule 5 permits a report to be made before an inquest is heard so long as the pre-condition is complied with. Thus, where a coroner concludes that there is an urgent need for action, he or she may report with a view to action being taken without delay and the pre-condition may be satisfied during the investigation but before the inquest where a coroner takes the view that there is unlikely to be more material to come on the matter of concern.

Procedure

Coroners are entitled to hear and give weight to representations by interested persons as they see fit. However, whilst acknowledging that sometimes it might be appropriate to hear some evidence which may be relevant for the purpose of making a report, the Guidance tells coroners that adding to an inquest with lengthy, additional evidence or conducting a separate lengthy, additional hearing should be avoided.

The nature of the report and the coroner's concerns

Perhaps the most useful parts of the Guidance for coroners and legal representatives are those dealing with the coroner's concerns and the nature of the report, in particular paragraphs 5, 17-20, 23-28 and 31-34.

Reports need not be restricted to matters causative or potentially causative of the death in question. Nor does the report have to relate to a death in similar circumstances to that in respect of which the inquest is being held.

PFDs should not be unduly general in their content and sweeping generalisations should be avoided. Although in some cases the action to be taken following the coroner's concern will be obvious, the Guidance makes it clear that it is not for the coroner to express precisely what action should be taken. A PFD is a recommendation that action should be taken, but not what that action should be.

The essence of a report is that the coroner should express clearly, simply and 'in neutral and non-contentious terms' the factual basis for each concern. The coroner should be careful to base their report on clear evidence at the inquest or clear information during the investigation, to express clearly and simply what that information or evidence is, and to ensure that a bereaved family's expectations are not raised unrealistically.

Reports should not apportion blame and paragraph 27 reminds coroners that they should not make any other observations of any kind, however, well intentioned, outside the scope of the report. In a paragraph (para.28) that is perhaps meant to be of wider application than PFD reports, the

Guidance goes onto state that:

"In the past some coroners have from time to time expressed themselves in public with forceful language. Phrases such as 'I am appalled' or 'I am disgusted' or 'shame on you' have been used. They should not be used. Coroners should at all times use moderate, neutral, well-tempered language, befitting the holder of a judicial office…"

There are currently in the region of 70 reports available online and the website states that the Chief Coroner's officer is in the process of making available all reports made since 25 July 2013.

Simon Emslie

The Duggan inquest

What next?

The fatal shooting of Mark Duggan by police officers in the summer of 2011 was the catalyst for the biggest riots London had endured in years. What started as peaceful protests by those who believed Duggan's demise was enacted unlawfully led to widespread riots, violence, and looting which left five people dead and cost a staggering £200 million in damage.

After three months of evidence, 93 experts and seven days deliberation, a jury of seven men and three women returned their verdict on the 8 January. The verdict they were asked to deliver was complex, requiring that they address a diverging tree of six weighty questions (see a full copy on the Inquest website: http://dugganinquest.independent.gov.uk). But, in the end, their answers were not ambiguous: Mark Duggan did not have a gun in his hand when he was shot, but the police officer who fired at him believed, or may have believed, that he did. The killing was, accordingly, lawful.

Deborah Coles, co-director of INQUEST, stated: *"The jury's conclusion is both perverse and incomprehensible. We cannot have a situation where unarmed citizens are shot dead on the streets of London and no-one is held to account. The death of Mark Duggan is one of a number of fatal shootings by police that have raised profound concerns about operational planning and intelligence failings in firearms operations, where the use of lethal force has been disproportionate to the risks posed, and where the safety of the public was put at risk. Despite a pattern of cases raising similar issues there has been an institutional failure to implement the necessary learning to safeguard lives in the future"*.

INQUEST's view was expressed with consideration. Others reacted with hostility towards the jury who were subsequently given police protection and offered counselling. The perceived threat to the jury was so extreme that the coroner made a highly unusual ruling that the jurors' identities would remain hidden, and they would be known only by a number. Charged with a duty that they never asked for, the treatment that the jury received in the aftermath of their verdict was undeserved. Clear though it is that the they deserved no such treatment, it would be equally senseless to condemn the family.

However, now that Mark Duggan's family say that the jury's conclusion of lawful killing is not the end of the story, that they have been denied justice and want to challenge the outcome, what exactly are their options?

The reality is there are very few – and it boils down to whether or not there was a significant problem with the inquest itself.

There is no automatic right to appeal an inquest conclusion.

But families or other "interested parties" have three months to decide whether to try to judicially review the conclusions. If the family wants to judicially review the inquest's conclusion, they will have to convince the High Court that there was a fundamental flaw in the way HHJ Cutler managed the process. The jury themselves cannot be challenged because they are just a group of ordinary people doing their duty. Mr Duggan's family announced at the end of February 2014 that they are seeking leave for judicial review. Press reports suggest that they will argue that the coroner should have directed the jury that if Mr Duggan did not have a gun in his hand they could not return a verdict of lawful killing.

Deaths by police shooting are perhaps not as rare as might be thought in England and Wales. Statistics compiled by INQUEST show that there have been 43 deaths from police shooting in the last twenty years. Two police officers have stood trial in relation to those shootings but have not been convicted. There has been only one inquest into a police shooting which resulted in an unlawful killing verdict; the case of Harry Stanley. Very few inquests are successfully challenged – but the case of Harry Stanley did go through the courts – and the outcome there remains controversial to this day.

In 1999, armed police shot and killed Mr Stanley as he walked home carrying a table leg in a bag. Police thought it was a concealed shotgun. The first inquest concluded with an open verdict – but that was successfully challenged after a campaign by his family. A second inquest ended with a verdict of unlawful killing – which led to uproar among armed police officers. The officers challenged that and it too was quashed following Judicial review in May 2005.

One of the critical issues in the second challenge was the officers' evidence that they honestly believed Mr Stanley was turning around to shoot at them. The fact that the officers were mistaken, the judge ruled, did not mean that a jury should have been allowed to find they acted unlawfully.

The appeal relating to Mr Duggan appears likely to turn on a similar issue about what verdict is appropriate if police honestly believe that a person is more dangerous than they actually are.

Whatever happens in relation to any appeal, the coroner's work on the Duggan inquest is far from over. The Coroner has invited the Interested Persons to serve written submissions relating to the contents of any Report to Prevent Future Death, saying 'I do not want to be part of a justice system which in a case of this nature simply closes the file and moves on to the next'. The deadline for representations has been put back to the middle of March, but commentators speculate that his report is likely to raise questions about the way the police deal with the aftermath of a shooting – not least because this is not the first time critics have said officers should not be allowed to confer as they write up their notes. It seems that Scotland Yard has already accepted there must be some change. The Met's Commissioner, Sir Bernard Hogan Howe, says armed teams will soon be wearing personal video cameras - and he wants officers to be more open with independent investigators of future serious incidents. Given that the inquest jury found unanimously that the Serious and Organised Crime Agency could have done more to "gather and react" to intelligence and more to keep Duggan under surveillance, these failings may well inform the PFD report.

One conclusion that can be unanimously drawn from the Duggan inquest though is the need to improve police relations with the public. In light of this inquest and other high profile incidents, not least "Plebgate', a consensus seems to be emerging that there is a growing lack of trust towards the police. The failings of the IPCC which were exposed in the Duggan inquest have led many to the view that the public is not being well served by

the regulatory body, and that it is incapable of holding the police to account in a robust and independent fashion.

Jason Taylor

Please note: since this article was submitted for publishing it has been announced that the Duggan family has been granted permission for a limited Judicial Review.

Coroners Guidance and law sheets

The appointment of HHJ Peter Thornton has seen a welcome move towards a more transparent and open coronial system. In the past, decisions of coroners' courts found their way into the public domain only if they were of interest to the local press or, anecdotally, if participants in an inquest recognised that it involved an important point of law or principle and made the effort to disseminate the information.

Bearing in mind the number of inquests that are held throughout England and Wales each year, it was apparent that there was a real risk that important issues of law were being determined without reference to any form of precedent.

This deficiency in the coronial system has now been addressed through the introduction of Reports to Prevent Future Deaths and Law sheets. Both of these resources are available through the Judiciary of England and Wales Web Site (http://www.judiciary.gov.uk/index)

Law Sheets

The Chief Coroner has produced three law sheets that set out a summary of the law that applies in three important areas; unlawful killing, leaving particular verdicts to a jury (the "Galbraith plus" test) and disclosure in the light of *Worcestershire County Council and Worcestershire Safeguarding Children Board v HM Coroner for the County of Worcestershire* [2013] EWHC 1711 (QB). It is likely that additional sheets will be added to take into account significant changes in the law.

1. Unlawful killing

This summarises the most important issues in this sensitive area. Perhaps the most useful subject covered is that which relates to driving cases. The conclusion of unlawful killing does not extend to the criminal offences of causing death by dangerous driving, or causing death by careless driving (or to Health and Safety Act offences where death results). No reference should be made in an inquest to any of these offences or the elements of the offences (except occasionally where it is necessary to acknowledge their existence and to dismiss them as irrelevant).

Bad-driving cases causing death may, therefore, only be regarded as unlawful killing for inquest purposes if they satisfy the ingredients for manslaughter (gross negligence manslaughter), or where a vehicle is used as a weapon of assault and deliberately driven at a person who dies (murder or manslaughter depending on the intent).

The sheet also emphasises that allegations of unlawful killing must be proved to the criminal standard. It also is one of the few publications that attempts to define what being sure actually means. Paragraph 32 struggles with defining the concept of certainty, but ultimately comes to the conclusion that *"Juries should just be told that they must be sure, or that they must be satisfied beyond reasonable doubt (which means the same thing). No other words should be used."*

It is, perhaps, somewhat debatable as to what this adds to existing jurisprudence.

2. "Galbraith plus"

This law sheet helpfully draws together the reasoning set out in the relevant authorities to clarify the principles that apply to a coroner's decision whether or not to leave a verdict to the jury. This is distilled into two questions: *"is there evidence on which a jury properly directed could properly convict?" and "would it be safe for the jury to convict on the evidence before it?"*

3. Disclosure

This is the most recent of the law sheets having been published on 31 January 2014. It is probably the most useful of them because it sets out with clarity how the disclosure regime now operates under Schedule 5 of the 2009 Act. In particular it summarises the important authority of *Worcestershire County Council and Worcestershire Safeguarding Children Board v HM Coroner for the County of Worcestershire* [2013] EWHC 1711 (QB). It emphasises the distinction between disclosure to the coroner and disclosure to the public and the two stage test that must be applied.

If the first stage disclosure is to the coroner alone, for the purpose of deciding the scope of the inquest and the witnesses to be called. There is no longer a need for an application to be made by summons to the High Court or County Court. It may now be made under the notice provisions in Schedule 5 of the 2009 Act. Once material is in possession of the coroner he must then move on to consider the second stage. In the second stage the coroner decides whether there can and should be onward disclosure to interested persons.

4. Reports to prevent future deaths

Paragraph 7 of Schedule 5, Coroners and Justice Act 2009, provides coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths. It is intended that in due course these reports will become a database of coronial findings and recommendations that can be accessed by all. As of the beginning of March 2014 a total of 75 reports had been uploaded onto the web-site, and the current aim is to make available all reports made since 25 July 2013. The latest post, made on 14 January 2014, points towards police related deaths; regrettably, when that link is followed there are no reports yet uploaded!

The most recent substantive report was made following an inquest held in West Yorkshire into the death of a patient suffering from depression who was being treated by the Intensive home-based teatment team of the local NHS Trust. The deceased was found to have died as a result of a combination of an overdose of alcohol and gabapentin. She was found by a member of the public unconscious, in an apparently abandoned car. Attempts to resuscitate her failed and she was pronounced dead at the scene.

The coroner found that there was a period of four hours and 20 minutes when it was known that she was absent from her accommodation unit but that there was no signing in/out record that could have alerted those responsible for her care that she was absent. The coroner made the following recommendation to prevent future deaths:

"I consider that, although I did not find that Mrs Gabbitas' death would have been prevented by earlier attention to her absence, there is a risk that future deaths may occur in similar circumstances if no action is taken to record and monitor absence, albeit informally (in keeping with the nature of care in the SHARE unit), and to react appropriately to absences which appear to be inappropriate or particularly lengthy."

The relevant NHS trust was obliged to inform the coroner within 56 days of the action that they had taken i.e. by 5 February. Although the web-site does not disclose what action was taken, any practitioner involved in an inquest dealing with similar issues would be able to refer to the recommendation made in the report.

One issue that may well develop is the use of the recommendations in civil proceedings. One can readily envisage

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Call 1987

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recommendations being cited as evidence of good practice and the fact that they are available on-line would make it difficult for a potential defendant to deny knowledge of their existence.

5. Summary

The use of up to date technology to increase the understanding and awareness of the law and practice is to be commended. In time, Reports to Prevent Future Deaths will become a substantial repository of coronial decisions that can be referred to by all those who become involved in an inquest. The law sheets are likely to become the first port of call for any practitioner wishing to familiarise themselves with basic legal principles or to make sure that their knowledge is up to date. I would suggest that a visit to the web-site should now be regarded as an essential part of preparation for appearing in any inquest.

Stephen Mooney

Pre Inquest Reviews

National guidance

The Chief Coroner in a speech soon after his appointment spoke of his aim to achieve 'national consistency'. Practitioners writing a list of 'national inconsistencies' in the coronial system would be likely to have Pre-Inquest Reviews towards the top of the page, near 'disclosure' and 'verdict'.

The Chief Coroner has recently taken a further step towards consistency, using the case of *Brown v HM Coroner for Norfolk* [2014] EWHC 187 (Admin) to give powerful guidance about the conduct of Pre-Inquest Reviews. The case involved a thirty-one year old woman who was found dead at her home. The inquest proceeded on the basis that she may have injected herself with insulin. The expert pathologist was apparently unaware that blood samples taken by a paramedic from the deceased revealed normal levels of glucose. The resulting narrative verdict was set aside by the High Court, which explored accusations of bias and cover up.

The Chief Coroner gave the following guidance:

1. A written agenda should be issued in advance of the Pre-Inquest Review.

2. In complex inquests, the coroner should invite written responses to the agenda before the hearing.

3. A checklist for the agenda should include:

- list of interested persons;
- list of witnesses, identifying those who the coroner intends to call, and to read;
- the likely issues;
- the scope of the inquest;
- whether a jury is to be required;
- whether Article 2 is engaged;
- disclosure;
- date of the final hearing.

4. There should be 'sufficient disclosure' before the hearing to enable interested persons to address the agenda items. (In the Brown case it was said that the bereaved family who represented themselves had not been given the toxicology and pathology reports before the hearing, causing a 'significant disadvantage').

5. Coroners should neither prejudge issues nor give the impression that they have done so.

6. Coroners should be cautious about writing in over-familiar terms to interested persons or investigators who they have regular dealings with, such as local police officers. They should only write letters and emails 'which will stand the test of looking fair and unbiased if and when read out in court'.

The last remark is likely to be of particular importance to bereaved families who represent themselves, and whose sense of exclusion from the inquest process may be heightened by seeing correspondence which suggests favouritism. The guidance as a whole is likely to be of great significance to all who practice in this area, and who are all too familiar with attending Pre-Inquest Reviews with little idea of what issues to prepare for. National consistency in practice may be some way off, but we practitioners at least now have an authority to hand when we seek clarification of issues before the inquest begins.

Kate Brunner