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Albion Chambers INQUEST TEAM NEWSLETTER

Preventing Rule 43 Reports at Inquests

An advocate representing an institution (such as a NHS trust, a prison, a police force) will be greatly helped by an early agreement as to what the institution is seeking to achieve. In particular:

- whether it is trying to avoid any particular verdict
- whether it is trying to avoid a Rule 43 report
- whether it is most concerned about damaging publicity.

Often an institution has to accept inevitability of a particular verdict, and will instead focus on preventing a damning Rule 43 report, aiming for a picture that 'we accept there were serious errors then, but everything has changed!'

Rule 43 of the Coroners Rules 1984 (which will be replaced by the similarly worded Schedule 5 (7) of the Coroners and Justice Act, which is not yet in force) is set out at: www.opsi.gov.uk/si/si2008/uksi_20081652_en_1. Coroners have a wide remit to make reports of concerns which they have, in order to prevent future deaths. The remit extends to all concerns which coroners have about situations which may lead to further deaths, and is not limited, as it used to be, to preventing similar deaths. This means, of course, that the coroner can investigate any wider problem which is identified in the course of the inquest, and make a report about it. You may therefore 'win' an argument about causation but still be open to criticism about failures even if they did not cause the death. For example where poor medical practice in dispensing medication is uncovered in the course of an inquest the coroner should now consider exploring the poor practice even if the medical evidence is that the deceased would have died in any event even without the overdose. The potential for damning publicity is high, not least as the Lord Chancellor may publish the report and response, or a summary of them.

If representing a body such as NHS trust, you will need to consider how to deal with possible Rule 43 issues long before the inquest begins.

There is clearly no ban on having conferences with witnesses before hand. If representing a trust, for example, you may wish to meet all of the trust's employees who are likely to be called to give oral evidence at the inquest. If any of those employees are 'interested persons' and have their own legal representation, it is not advisable to include them in a trust conference.

If there is a clash on the witness statements between two of 'your' witnesses who are not interested parties (e.g. you represent a mental health trust, and there is disagreement between psychiatrists as to whether correct procedure was followed), you are entitled to go through their evidence with them separately, to ensure you understand the basis for their conclusions. Although there is no clear guidance from authorities, it is not good practice to do anything which might taint their evidence; I would therefore not show one employee the witness statement of another employee whose evidence materially contradicts their own. There is a grey area in the middle where you may decide to 'test' their account in conference, and discuss other employees' evidence in general terms, in case there has been a genuine error or misunderstanding in one employee's account, which they wish to correct before the inquest.

At least as important as speaking to employees who are witnesses is to ensure that you are fully briefed by senior management. It is helpful if one senior manager is identified as a 'liaison' manager who can be spoken to at short notice by the legal team, and who will be available to give evidence if required.

In order to deal with Rule 43 problems, you will need to be briefed on the following standard issues:

i. Which policies were in force at the time, and what they meant in practice;
ii. Whether any policies appear to have been breached by employees;
iii. If so, whether there was a culture of such breaches (lack of such a culture can sometimes be demonstrated by departmental monitoring reports etc);
iv. Whether the individual failings could have stemmed from lack of training; you will need full details of training procedure and content;
v. Whether individual failings were part of a pattern of failings by that individual which should have been noticed (demonstrate this was not the case by obtaining individual compliance rates from spot-checks etc);
vi. Whether disciplinary proccedings were taken, and the findings (although this shouldn't be in any statement);
vii. What policies/procedures/practices have changed.

You should identify the most appropriate witness from senior management, giving consideration to who will be a good witness in court. As well as dealing with any of the above issues which become relevant, that witness will need to be very clear about what failings are accepted by the trust/body.

Let the coroner know at the pre-inquest review that you will have a senior manager lined up to address policy issues at the end of the inquest, if that will assist the coroner. If possible, it is usually advisable to obtain a draft statement from that manager at an early stage, but not to disclose it; you can then amend that statement if needs be as the inquest proceeds. Some issues will take a far greater significance during proceedings that they did on paper, and will therefore need to be addressed in greater depth in the manager's statement. If there are new policy documents to be ▸

shown to the coroner, to demonstrate that shortcomings in policy have been rectified, it is advisable to append them, paginated, to the manager's statement. Copying the manager's statement to the coroner and all parties at a relatively late stage in the inquest is likely to put the institution in the most favourable position.

If the statement only refers to changes in policies and practice since the death, it is not relevant to the coroner or jury's consideration of how, where and when the deceased came by his death, and it is therefore evidence which shouldn't be heard in the fact-finding part of the inquest. Some coroners will hear such evidence after they have reached a verdict, or after a jury has reached a verdict, in order to decide whether they are going to make a Rule 43 report. Other coroners will hear such evidence during the body of the inquest. The timing of the manager's evidence is unlikely to make any significant difference to the institution.

Taking the above steps at an early stage is likely to place a trust/body in the strongest position to avoid critical Rule 43 reports and associated poor publicity.

Important inquest cases

These are central cases, which those who conduct inquests may wish to have available during proceedings, to deal with the most common issues which arise.

Scope of interest

R v North Humberside Coroner, ex p Jamieson [1995]
R (on the application of Keith Lewis) v HM Coroner for Shropshire [2010]

Admissability

R (on the application of Stanley) v Coroner for Inner North London [2003]
R (on the application of Butler) v HM Coroner for Black Country [2010]

Article 2

R (Middleton) v West Somerset Coroner [2004]
Secretary Of State For Defence (Appellant) v R (On The Application Of Catherine Smith) (Respondent) & Hm Assistant Deputy Coroner For Oxfordshire (Interested Party) & Equality & Human Rights Commission (Intervener) Sub Nom Sub Nom R (On The Application Of Smith) v Secretary Of State For Defence (2009)

Which verdicts to be left / causation

R(Bennett) v HM Coroner for IS London [2007]
R v Inner London Coroner, ex p Douglas-Williams [1999]
R (on the application of Keith Lewis) v HM Coroner for Shropshire [2010]

Kate Brunner

Coroners and Justice Act 2009

The Act received Royal Assent on 12.11.09, but as of the 1st May 2010, only sections 35 (appointment of Chief Coroner and Deputy Chief Coroners), 47 (definition of interested person) and 48 (general interpretation) are in force.

Without section 35 the new Act is essentially meaningless as the new position of Chief Coroner is the foundation of the new structure. The "competition" for the post is open (only High Court and Circuit judges need apply). The Ministry of Justice (www.justice.gov.uk) have set out a proposed timetable, as follows:

- Spring 2010, appointment of Chief Coroner and opening of consultation for views on policy details of the new system;
- Autumn 2010, appointment of National Medical Adviser to the Chief Coroner and appointment of a National Medical Examiner;
- April 2012, new system expected to go live. Appeals system will be piloted and rolled out nationally April 2013.

The Act is designed to bring the coronial system into the modern age by way of Statute. Many changes have occurred in the way the Coroners' system operates since the advent of the Human Rights Act 1988, most notably the stretching of Rule 36. Dr Shipman's activities also threw light on the inadequacies of the death certification system. The Government's stated aim was to continue with the localised structure of the coronial service but to superimpose a national framework of standards.

In line with this stated aim, is the creation of the office of Chief Coroner (sections 35-42 and schedule 8). One of the duties of the Chief Coroner is to give an annual report (section 36(1)) to the Lord Chancellor, which must include an assessment of consistency of standards between coroner areas and information about investigations that have taken over 12 months to complete. This latter point may cause some alarm amongst coroners' staff!

Continuing the theme of central control of the coroners' system, section 37 makes provisions for regulations about the training of coroners (it had to happen some time) and section 39 makes it a duty of inspectors of court administration to report on the operation of the coroner system.

After reading the Act, one may come to the conclusion that the aim is to provide central control of the system while passing the burden of the cost onto the respective local authority. This is most clearly seen in the appointment system, where the appointment of senior, area and assistant coroners must be approved by the Lord Chancellor and the Chief Coroner, but are paid by the local authority who also have to provide a pension.

Part 1 of the Corners and Justice Act 2009 applies to the coronial system (sections 1-51). The duty of a coroner is no longer expressed as a duty to hold an inquest in certain circumstances, but is termed as "investigations into deaths". This perhaps more aptly describes the role of the coroner rather than making any fundamental changes. There is still the duty to investigate death when the following applies (section 1):

- The deceased died a violent or unnatural death;
- The cause of death is unknown; or,
- The deceased dies while in custody or otherwise in state detention.

The major change comes in section 5(2), which puts into statutory form the extension to Rule 36:

- Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1988), the purpose mentioned in subsection 1(b) (who, how, when and where) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.

However, by placing this concept in statutory form, it is perhaps arguable that this will stop the increasing extension of the purpose of an inquest and in fact take that extension a notch backwards. Many coroners, particularly with the increased use of narrative verdicts, have extended the scope of an inquest regardless of whether Article 2 is engaged. The Act makes it clear, that it is only when Convention rights are in danger of being breached that the purpose of the inquest is extended to ascertaining in what circumstances death occurred. Most inquests will still have the traditional purpose. It will be interesting to

see whether the use of the narrative verdict will become less frequent.

The general rule is still that an inquest must be held without a jury; the exceptions are contained within section 7 (2) and (3). The Coroners Act 1988, required that a jury is summoned if the death occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public or any section of the public. The 2009 Act does not include this subsection, but in reality any such inquest would no doubt fall into subsection 3 (inquest may be held with a jury if the senior coroner thinks that there is sufficient reason for doing so).

An inquest jury will consist of 7-11 persons (section 8) and section 10 directs a jury to make a determination as to the questions in section 5 and any registration particulars required. Section 10(2) preserves Rule 42.

One area which, in the opinion of many lawyers needed overhauling, was the lack of a dedicated appeal system. Although the new system is unlikely to be with us until 2013, it provides a welcome change from the system of judicial review, which has been the only real source of redress for those aggrieved by the coronial system. Whilst not wishing to offend the judicial review specialists, the process is complicated and expensive. Many wrong inquest verdicts remain unchallenged because the person/body affected by the verdict is in no position to fund a review. In theory, the new system (section 40) should speed up the whole process although that may well depend on how many appeals are made. There is considerable provision for interlocutory appeals including an appeal against a refusal to be an interested party (section 40(5)). An appeal is to the Chief Coroner unless the person acting as coroner is a High Court or Circuit Judge, in which case the appeal is to the Court of Appeal or a High Court Judge.

Another welcome change included in the Act is the provision for a death to be investigated out of area (sections 2 and 3). This is mainly designed to counter the delay that has occurred in the inquests into the death of servicemen. Certain coronial areas have been over burdened by these deaths and delay may result in injustice and distress.

The most significant change made by the Act is in relation to certification of death (sections 18-21). The change will affect dramatically how the medical profession certifies death and should ensure that there are checks within the system. This article is no place for an analysis of the changes but I encourage you to read them.

We wait to see whether the Ministry of Justice timetable will be adhered to. In the near future a consultation should be launched. I encourage you to engage and hopefully we will be provided with a system that will better serve all those who come into contact with the coroners' system.

Fiona Elder

New style pre-inquest reviews and Article 2

Discussions after the recent Inquest Team Seminar showed that many pre-inquest reviews still follow a dated traditional format.

General overview

I suspect this is due to a combination of reasons; the first is that until we have been exposed to an advocate who seeks to make significant yards out of such hearings, we do not necessarily realise it can be and is done in a different way. Secondly, depending on our Coroner, it may well be that local custom and practice has lagged a little behind more contemporary approaches to such hearings.

I am in no doubt that with the 'professionalisation' of the role of Coroner, in essence, now being appointed as a judicial post, the pace of change and the pressure to milk the most progress out of pre-inquest reviews will increase. Therefore, it will be necessary to have in place, a game plan, an angle, a mission statement – call it what you will, from a very early stage in the proceedings, to help inform our decisions at PIRs. It will also be necessary to have prepared in the knowledge that that the advocacy at PIR, in shaping the case, may have a crucial impact when the verdicts are finally given. It of course raises the stakes in terms of mistakes, unpreparedness or lack of clarity in our instructions.

However, despite this increased demand on our preparation time and advocacy skills, this change does give us a window of opportunity. During the transfer phase from old to new, if we attend our PIR, ready to make forceful points as to the shape and style of the forthcoming inquest, those who are less prepared, those working under the 'old' style, may not be ready to challenge an advocate's polished submissions. The effect of such an imbalance in approach being that significant concessions may be extracted or potentially tricky avenues of examination put to bed at this early stage. This may be especially so if the Coroner is also working under the old style.

Article 2

The importance of being prepared to argue at PIRs has gained heightened importance when Article 2 issues may play a part in any eventual inquest. As the reader will be aware, Article 2, is addressed in Section 5, Coroners and Justice Act 2009.

The relevant matters to be ascertained are, or are phrased thus;

(1) The purpose of an investigation under this Part into a person's death is to ascertain:
(a) who the deceased was;
(b) how, when and where the deceased came by his or her death;
(c) the particulars (if any) required by the 1953 Act to be registered concerning the death.

Clarification is then given as follows;

(2) Where necessary in order to avoid a breach of any Convention rights…, the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.

Taking a look at the authorities that examine the area, one of the leading (and contemporary) cases which encapsulates the ethos of *R (Middleton) v West Somerset Coroner [2004]* is *R (on Application of Smith) v HM Asst Deputy Coroner and Another [2009]*. Arising from this case (and others), the following question is neatly posed;

"What does the Convention require of a properly conducted official investigation involving a possible breach of article 2?

It is clear that an uninformative, overly restrictive procedure is unlikely to satisfy the requirements of Article 2.

An example of this stance is *R (on application of Amin) v SSHD [2003]*; where the court stated that it is necessary that *"those who have lost their relative may at*

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Call 1987

Fiona Elder
Call 1988

John Livesey
Call 1990
Part-time Employment Judge

Michael Cullum
Call 1991 Recorder
Immigration Judge

Paul Cook
Call 1992

Jason Taylor
Call 1995

Kirsty Real
Call 1996

Kate Brunner
Call 1997

Richard Shepherd
Call 2001

Team Clerks Nick Jeanes and Michael Harding

least have the satisfaction of knowing that lessons learned from his death may save the lives of others".

Amin also reviewed a number of European authorities and drafted the following propositions to be borne in mind when deciding upon Article 2 inquiries/ inquests;

i. *Where a person in good health when detained is killed it is incumbent on the state to provide a plausible explanation of what occurred;*
ii. *Must be an effective official investigation which must ensure the accountability of the state agents or bodies… and the investigation must be capable of leading to a determination of whether any force used was justified;*
iii. *Must be an appropriate element of public scrutiny and the next of kin must be involved in the process;*
iv. *Independent, effective and reasonably prompt investigation.*

As the readers of this article can well appreciate, such propositions, if adopted, can lead to a very wide all-encompassing examination as to the circumstances of an individual's death.

Middleton, as referred to above, also highlighted the fact that where individual 'agents of the state' use lethal force, it is always a matter of extreme seriousness, and systematic failures (as per *Amin)* may also call for no less important or even more complex investigations.

The inclusive approach was maintained in *Smith*, as referred to above, where the family of a member of the Territorial Army, serving in Iraq sought an Article 2 inquiry/ inquest and argued that the usual 'in custody' Article 2 should be extended to include serving soldiers.

The Court, applying the following judgment in *R (on Application of JL) v SoS for Justice [2008]: "Plainly patients who have been detained because their health or safety demands that they should receive treatment in the hospital are vulnerable…, not only by reason of their illness which may affect their ability to look after themselves but also because they are under control of the hospital authorities. Like anyone else in detention they are vulnerable for exploitation abuse bullying and all the other potential dangers of closed institution."* decided that in the circumstances, an Article 2 inquest was appropriate.

Therefore it would seem that where the state is the puppet master, where it dictates where, when and how an individual should live, in essence, restraining an individual's liberty (used in the widest sense of the word), then an Article 2 inquest is likely to be required.

This assessment would seem to be borne out by a counter finding in the case of *Richard Rabone v Pennine Care NHS Trust (2009)* where a **voluntary** mental patient discharged herself and then committed suicide. No Article 2 obligations attached to the NHS trust in this case.

Conclusions

The above article is not intended to scare, deter or to put an individual off undertaking advocacy at the PIR. It is intended to explore the ramifications, or potential ramifications of decisions we make prior to and during the hearing. As stated above, this 'new style' presents opportunities as well as risks.

The thumbnail analysis of Article 2 above is an example of the depth of preparation now necessary before embarking upon PIRs. The way we prepare for those Pre-Inquest Reviews must be slicker and more robust, and we must be in a position to begin lobbying for 'our' verdict at this relatively early stage. We must be fully versed in Article 2 (and other areas outside the remit and word count of this article), bearing in mind its particularly wide application within the authorities. We must be on top of our brief, almost as if we were trial ready, in order to be able to properly shape a case from conception to verdict.

Richard Shepherd

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