Inquests & Inquiries

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Inquests : Agenda

- Chief Coroner's guidance notes
- Inquests in the last 6 months
- Case law
- Costs of inquest

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Guidance Notes 34/37

- GN34 was controversial as it was interpreted by some to suggest that Coroners should not be investigating any workplace related COV19 deaths
- GN 37 states

"There are therefore some instances in which a COVID-19 death may be reported to the coroner, such as where the virus may have been contracted in the workplace setting. This may include frontline NHS staff as well as others (e.g. public transport employees, care home workers, emergency services personnel)."

"If the medical cause of death is COVID-19 and there is no reason to suspect that any culpable human failure contributed to the particular death, there will usually be no requirement for an investigation to be opened. The coroner may carry out reasonable pre-investigation enquiries under s1(7) to determine if there is any basis for opening an investigation"

Guidance Note 37

- *A death must be investigated and must usually be the subject of an inquest if the coroner has "reason to suspect that… the deceased died… [an] unnatural death". In this context, the words "reason to suspect" reflect a low threshold test; lower even than a prima facie case and requiring only grounds for surmise. However, 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. A death may be "unnatural" where it has resulted from the effects of a naturally occurring condition or disease process but where some human error contributed to death.*

Guidance Note 37

- *Accordingly, a death which is believed to be due to COVID-19 may require a coroner's investigation and inquest in some circumstances. For instance, 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. If the coroner decides to open an investigation, then he or she may need to consider whether any failures of precautions in a particular workplace caused the deceased to contract the virus and so contributed to death. Also, if there were reason to suspect that some failure of clinical care of the person in their final illness contributed to death, it may be necessary to have an inquest and consider the clinical care. If the person died in state detention (e.g. in prison or secure mental health ward), an inquest would have to take place.*

Guidance Note 38

- GN38 – Remote participation
- *"(a) It is permissible to hold a partially remote hearing;*
- *(b) It is unlawful to livestream any proceedings from a coroner's court;*
- *(c) It is permissible to use live video to hear evidence from witnesses and/or for*
- *participation by interested persons;*
- *(d) It is permissible to use audio only lines to enable public and/or press*
- *participation, as long as the coroner has expressly disapplied s9 of the Contempt of Court Act 1981 and given a warning as to recording etc;*
- *(e) The coroner must him/herself physically be present in the court when conducting any hearing."*

Guidance Notes 39/40

- GN 39 – Recovery from the Pandemic (written pre 'second wave')

  "The coroner service in England and Wales should now be moving towards routinely conducting hearings again."

  Juries – can a lower number of jurors be used – 8/9 in "short jury cases"?

- GN 40 – Counsel to the Inquest

Inquests in the last 6 months

- Hardly any
- Backlog must be very significant
- Certainly no jury inquests (although some have recently resumed)
- COV19 means more inquests too
  - Workplace/PPE arguments
  - Deaths in custody
  - Deaths in care homes – PPE/protection arguments – particularly DOLS cases

Ex parte Dyer [2019] EWHC 2987

- Application for police officers involved in death in custody to give evidence behind screens. Opposed by family.
- Anonymity orders granted, but concerns about officers' identities becoming known.
- HMC held that officers were not to be seen by family, only HMC, staff and legal reps.
- Per Jefford J, partially overturning HMC's decision:
- *(i) There is nothing unlawful per se in the use of screens but there is, as I have*
- *already concluded above, a balancing exercise to be undertaken.*
- *(ii) Amongst the factors in that balancing exercise is the fundamental importance of open justice. That is why the provision of screens should only be ordered where necessary and to the extent necessary.*

Ex parte Maguire [2020] EWCA Civ 738

- Article 2 duties do not arise simply because person under DOLS dies from natural causes
- There was no basis for thinking the deceased had died because of a breach of the state's operational duties
- Lopes de Sousa (decision of the Grand Chambers of the European Court of Human Rights) adopted:
- It confirmed that in cases involving alleged medical negligence the State's positive obligations were regulatory, "including necessary measures to ensure implementation, including supervision and enforcement" (para.189). It continued by noting that in "very exceptional circumstances" a state may be responsible under the substantive limb of article 2. It enumerated those circumstances between paras 191 and 196.
- First, "a specific situation where an individual patient's life is knowingly put in danger by denial of access to life-saving emergency treatment. It does not extend to circumstances where a patient is considered to have received deficient, incorrect or delayed treatment" (para. 191).
- Secondly "where a systemic or structural dysfunction in hospital services results in a patient being deprived of access to life-saving treatment and the authorities knew or ought to have known about the risk and failed to undertake the necessary measures to prevent the risk from materialising, thus putting the patients' lives, including the life of the particular patient concerned, in danger" (para. 192).

Maguire continued

- The Grand Chamber devised a strict test to determine whether the exceptional circumstances were satisfied in any given case. It identified four cumulative factors: (a) The acts or omissions of the health care providers "must go beyond mere error or medical negligence, in so far as the health care professionals, in breach of their professional obligations, deny a patient emergency medical treatment despite being fully aware that the person's life is at risk if that treatment is not given" (para. 194); (b) The dysfunction "must be objectively and genuinely identifiable as systemic or structural in order to be attributable to the state authorities, and must not merely comprise individual instances where something may have been dysfunctional in the sense of going wrong or functioning badly" (para. 195); (c) There must be "a link between the dysfunction complained of and the harm which the patient sustained (para. 196); (d) "The dysfunction in issue must have resulted from the failure of the state to meet its obligations to provide a regulatory framework ..." (para. 196).

- "The Court would emphasise at the outset that different considerations arise in certain other contexts, in particular with regard to medical treatment of persons deprived of their liberty or of particularly vulnerable persons under the care of the state, where the state has direct responsibility for the welfare of these individuals. Such circumstances are not in issue in the present case."

Ex parte Iroko [2020] EWHC 1753

- Follows Maguire
- Distinction between ordinary negligence cases and cases of systemic failures.
- Allegations of individual fault must not be dressed up as systemic failures
- On the facts there were not systemic failings.
- Commentary on neglect

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Ex parte Lewis [2020] EWHC 471

- Deceased detained under authority of state pursuant to mental health legislation and died from malnutrition
- Neglect finding withheld from jury
- Helpful comment that Coroner should give decision on whether he was leaving it before summing up
- Reminder that for neglect to arise there should be a gross failure to provide adequate nourishment or basic medical attention.
- There is no such thing as gross neglect and neglect should not be equated with negligence.

Ex parte Maughan [2019] EWCA Civ 809

- Unlawful killing has its own special status as a conclusion
- Conclusions of unlawful killing are restricted to homicide (murder, manslaughter and infanticide)
- The criminal standard of proof should be applied to unlawful killing because of the criminal connotations
- Suicide should attract the civil standard of proof, in both short form and narrative conclusions.

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Ex parte Ketcher – [2020] NICA 31

- Northern Irish Court of Appeal decision on expert evidence
- HMC ordered a party to disclose an expert's medical report obtained for the purposes of the inquest.
- Litigation Privilege did not bite as it applies to adversarial proceedings
- CA were clearly reluctantly driven to this view
- CA then considered the public interest in the disclosure of the report and concluded that the balance was highly likely to favour the view that a requirement to disclose was not reasonable
- Would outcome have been the same if it were a public body trying to suppress?

Government protocol on behaviour

- Where a Government department has interested person status to an inquest, the Government and the lawyers it instructs at inquests will adopt the following principles:
- Remain committed to supporting the inquisitorial approach and assisting the coroner to find the facts of what happened and learn lessons for the future.
- Approach the inquest with openness and honesty, including supporting the disclosure of all relevant and disclosable information to the coroner.
- Communicate with the bereaved in a sensitive and empathetic way which acknowledges and respects their loss.
- Keep in mind that the bereaved should:
  (1) Be at the heart of the inquest process;
  (2) Feel confident that the inquest will get to the facts of what happened; (3) Feel properly involved throughout and listened to.
- Challenge the evidence of other interested persons or witnesses sensitively, where it is necessary to do so.
- Consider a formal acknowledgement to the bereaved to recognise when the death of their loved one happened whilst in the care of the state.
- Consider the number of lawyers instructed bearing in mind the commitment to support an inquisitorial approach.
- This protocol applies to all Government departments represented at inquests and is designed to make sure that the consideration of families and loved ones are fully taken into account. We consider it stands as a model of behaviour that others who are interested persons in inquests or send representation to inquests should adopt.

Greater Manchester Fire v Veevers [2020] HHJ Pearce

- (a) Inquest costs may be recoverable in so far as reasonable and proportionate, so long as they can properly be said to be incidental to the civil claim;
- (b) Such costs will not be recoverable if liability is no longer in issue between the parties, since the costs are simply not incidental to something in issue in the civil claim;
- (c) In determining whether liability is in issue, the court must look at all the circumstances of the case, but the central issue is likely to be whether the prospective defendant has admitted liability or otherwise indicated a willingness to satisfy the claim;
- (d) Liability will not be in issue if it has been admitted since such an admission is binding unless the court subsequently permits it to be withdrawn pursuant to CPR 14.1A.
- (e) However, the Costs Judge is entitled to look with care at anything less than an unqualified admission to see whether the prospective defendant's position is one from which it may resile or which leaves matter in issue between the parties.
- (f) In particular, if the defendant's position is not one of unqualified admission in circumstances where such an admission could have been made, the Costs Judge may be entitled to find that the failure to make an unqualified admission justified the conclusion that the defendant might exercise its right to resile from the admission and that therefore the costs of the inquest could properly be said to be incidental to the civil claim.
- (g) If the costs can be justified upon these principles, the mere fact that there are other reasons why the family of the deceased should wish to be represented at an inquest, most obviously to avoid the inequality of arms between unrepresented family members and a represented public body does not mean that the costs are not recoverable. It is enough that the attendance to secure relevant evidence in relation to matters in issues was a material purpose for the attendance.

Inquiries : outline of what we'll cover

- Overview
- Relevant legislation and law
- Practice and procedure
- Tactics and approach

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Inquiries : overview

- What is a Public Inquiry? Statutory vs non-statutory
- What is it for?
- Who establishes a Public Inquiry?
- Well-known past Inquiries: Ladbroke Grove rail crash, Hillsborough, Bloody Sunday, Chilcot (Iraq), Leveson (press and phone hacking), Shipman, Mid Staffs NHS Trust
- Current ones: Infected Blood Inquiry, Grenfell Tower, Manchester Arena Bombing, Child Sexual Abuse, Undercover Policing
- Future: … Covid?
- Not part of regular PI practice but we have the skills of client care, forensic analysis and advocacy
- Key points about the Infected Blood Inquiry

Inquiries : legislation and law

- The Inquiries Act 2005
  - s.1 convening the Inquiry, s.3 the Chair, s.11 assessors, s.5 terms of reference
  - s.2 liability
- The Inquiry Rules 2006
  - r.5 core participants, r.6 recognised legal representatives, rr.19-34 funding
- Determinations by the Chair
- Challenges by Judicial Review
- Criminal offence to withhold documents or obstruct the Inquiry's work (s.35)
- Criticisms, warning letters and "Maxwellisation" (rr.13-16)

Inquiries : practice and procedure

- Chair, Counsel to the Inquiry, Inquiry personnel, Core Participants, observers
- Inquisitorial, not adversarial
- Public hearings (s.18), evidence on oath (s.17), privilege (s.22), media reporting and confidentiality / restriction notices (s.19)
- Determinations as to Core Participant status (r.5)
- Determinations as to funding (r.19-34)
- Ability to require disclosure of documents and witness statements (s.21)
- Disclosure to Core Participants in advance of hearings
- Determinations as to timetabling, procedure, evidence, questioning
- Opening session - not the same as a trial!
- At the end: Report on findings and recommendations (s.24)

Inquiries : tactics and approach

- Different skills of advocacy and persuasion to advance your client's case
- Cooperation where possible
- Document management, document systems, transcripts
- Teamwork
- Media and publicity
- Benefits over litigation
- Length of the Inquiry process
- How to deal with litigation meanwhile
- Implementation of recommendations after the Inquiry
- Concluding thoughts …

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