BRIEFING

INQUESTS

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INTRODUCTION

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There have been a number of recent developments of interest to those who practice in the coroners' courts. As a result the 1 Chancery Lane Personal Injury and Clinical Negligence groups have joined forces to provide an update for your assistance.

Henk Soede considers the recent Supreme Court decision of *R (on the application of Maughan) v Her Majesty's Senior Coroner for Oxfordshire* [2020] UKSC 46, which is required reading for all inquest practitioners, altering the burden of proof to be applied to the short form conclusions of suicide and unlawful killing.

David Thomson discusses the Chief Coroner's Revised Guidance No 5 on Reports to Prevent Future Deaths, both identifying the changes and also providing a wide ranging explanation of the guidance in general.

Dominique Smith identifies the key points in the interesting costs decision of *Greater Manchester Fire and Rescue Service v Veevers* [2020] EWHC 2550 (Comm), which provides some welcome clarification about the recoverability of the costs of an inquest in subsequent civil proceedings.

Members of 1 Chancery Lane regularly act for both bereaved families and other interested persons and organisations in inquest proceedings. Members of Chambers are also currently instructed in the Manchester Arena Inquiry and the Grenfell Inquiry. We offer a wealth of experience in this area and are happy to assist with any of your queries or needs.

R (ON THE APPLICATION OF MAUGHAN) V HER MAJESTY'S SENIOR CORONER FOR OXFORDSHIRE [2020] UKSC 46

HENK SOEDE

In *Maughan*, the Supreme Court was asked to consider the standard of proof, or degree of conclusivity, required when answering the question of whether the deceased committed suicide. The Supreme Court held (by a 3:2 majority) that for all forms of conclusions at an inquest the standard of proof is the balance of probabilities. As practitioners in the field will know, this marks a significant change not only in cases where suicide is in issue, but also unlawful killing.

Factual background

The appeal arose out of the death on 11 July 2016 of the appellant's brother, James Maughan, at HMP Bullingdon. At the inquest the coroner decided that the jury could not safely reach a short form conclusion of suicide to the criminal standard of proof. However, the coroner also considered that the jury should be able to make a narrative statement of the circumstances of Mr Maughan's death applying the civil standard of proof. The jury considered that, on the balance of probabilities, Mr Maughan intended fatally to hang himself and that his death could not have been avoided by increased vigilance. Thus, whilst there was no *short* form conclusion of suicide, the narrative findings showed that the two elements of suicide (i.e., (1) that the deceased took his own life and (2) that he intended to kill himself) had been made out.

The Supreme Court was tasked with addressing the logical difficulty that arose in situations such as this where the narrative findings were suicide but there was no short form conclusion of suicide. The key issue, which was the source of that difficulty, was whether the standard of proof for those conclusions should be uniform.

The Majority View

Lady Arden (with whom Lord Wilson agreed) gave the lead judgment of the majority, and Lord Carnwath gave a brief concurring judgment. Lady Arden's analysis can be deconstructed as follows.

The legislative uncertainty

The Coroners and Justice Act 2009 is silent about whether the burden of proof in short form conclusions and narrative conclusions is the same. Similarly, under the Coroners (Inquests) Rules 2013 (SI 2013/1616) (the "2013 Regulations"), which were made for the purpose of "regulating the practice and procedure at or in connection with inquests", there is no regulation addressing the standard of proof that applied. There is, however, a provision described as "Note (iii)" in the Form for recording the results of an inquest prescribed by the Regulations, which provides as follows:

> "The standard of proof required for the short form conclusions of 'unlawful killing' and 'suicide' is the criminal standard of proof. For all other short form conclusions and a narrative statement the standard of proof is the civil standard of proof."

As the standard of proof was a matter of "practice and procedure", it was open to the 2013 Regulations (per the empowering provision at section 45 of the 2009 Act) to prescribe the standard of proof. Accordingly, Lady Arden was first required to consider the status of Note (iii) – was it a statutory statement of the standard of proof or something else entirely?

The status of Note (iii)

Lady Arden started by analysing the public consultation that precipitated the introduction of the 2013 Regulations. The consultation made clear that the Ministry of Justice proposed to retain the standard already established by case law and had also decided that the 2013 Rules could not change the law [26]-[27]. The essential point to be deducted from the Ministry of Justice's response document was that, there being a common law rule in place to regulate the standard of proof for the conclusion of suicide, it would be outside the enabling power in section 45 to make a rule to substitute for a common law rule which was in place [31]. The words "we cannot take forward a change in the [case] law through secondary legislation" made that

clear. Lady Arden considered this exchange to be a valuable aid to the interpretation of Note (iii) and the identification of its status [31].

Lady Arden then addressed the line of authority arising from *Attorney General v Lamplugh* [1878] 3 Ex D 214 and culminating in *Hunt v RM Douglas (Roofing) Ltd* [1990] 1 AC 398. The general principle arrived at in those cases was that a schedule to an Act of Parliament or a footnote in such an Act forms part of that Act and must therefore be considered as such. In theory, the same would apply to Note (iii). However, Lady Arden considered that unlike in those cases, there was no debate or notice about the potential effects of Note (iii), which was especially peculiar given it would usurp the common law position. Given the absence of any notice about the change that Note (iii) would potentially initiate, Lady Arden considered that Note (iii) should be interpreted as having an effect that accords with the (current) common law position [42]. Lady Arden concluded by stating that this conclusion should not be read as departing from the "strong presumption that every provision of an enactment has legislative force". The interpretation was justified solely due to the unusual background to Note (iii).

Lady Arden also found that an intention to codify a new statutory rule regarding the standard of proof was not borne out by the overall structure of the 2013 Regulations – there was, quite simply, no provision to that effect in the body of the Regulations themselves [45]. Had such a change been intended, it should have been brought to the attention of parliament and there was no indication that this was done [46]. Another important point was that Note (iii) used the present tense, not the future tense, and that this suggested that "the provision does not have the effect of ruling out any further change in the common law" [51]. The correct conclusion was that Note (iii) was merely speaking as to the state of the law as at the date on which the 2013 Regulations came into effect [51].

Should the standard of proof for short form conclusions of suicide and narrative conclusions of suicide be the same?

Having held that Note (iii) did not take away the power of the courts to develop the common law relating to the standard of proof [56], Lady Arden went on to analyse whether the standard of proof for all conclusions should be the civil standard.

The key points were four-fold:

First, inquests were civil proceedings and there was no cogent reason for disapplying the general rule that the standard of proof should be the balance of probabilities. Earlier cases in which the standard of proof for suicide was deemed to be the criminal standard seemed to be based on a) the links between coronial proceedings and criminal proceedings; b) the serious consequences of suicide; and c) the prevailing social norms attaching stigma to suicide [70]. Not only were those cases not binding on the Supreme court, but on Lady Arden's analysis the factors relied upon did not justify a departure from the general rule in civil proceedings.

Secondly, applying the criminal standard may lead to suicides being under-recorded and to lessons not being learnt. It was clearly in the public interest for the civil standard to apply [74].

Thirdly, historically suicide was a crime, but it ceased to be so in 1961. The role of inquests has also changed – inquests are concerned today not with criminal justice but with the investigation of deaths [81].

Finally, other commonwealth jurisdictions also applied the civil standard of proof to suicide conclusions in inquests. This supported the position.

Unlawful killing

Lady Arden concluded that the civil standard of proof also applies to determination of unlawful killing. The essential reasoning was that "a common standard applying to both unlawful killing and suicide is more consistent with principle and removes an inherent inconsistency in the determinations made at an inquest" [96].

The Minority View

Lord Kerr (with whom Lord Reed agreed) gave the lead judgment of the minority.

The proper interpretation of Note (iii)

Lord Kerr alighted, firstly, on two preliminary points of significance – 1) there were nine possible short-form conclusions outlined in Note (i) and only unlawful killing and suicide are identified as those to which the criminal standard applied; 2) the use of the word 'is' clearly denotes that a verdict of suicide or unlawful killing may only be reached if the jury or coroner consider it is beyond reasonable doubt that such a verdict is warranted [114]. The framing of this note, on Lord Kerr's view, was deliberate – there was a clear distinction between suicide and unlawful killing and the other possible verdicts, which is why the criminal standard applied. The criminal standard reflected the fact that short-form verdicts of suicide or unlawful killings were intended to have clear resonances beyond those of other short form conclusions [115].

It was also felt that there was no logical incongruity in cases where the jury finds suicide is made out in the narrative statement, but no such finding is made in the short-form conclusion. At [116]: "The clear distinction (in cases of unlawful killing and suicide) between a short-form conclusion (verdict) and a narrative statement (recital of the relevant testimony and transitory conclusions) should be recognised". It was quite right that a different standard of proof applied to the short-form verdict.

Lord Kerr then took a textual approach to Note (iii). Note (iii) forms part of an enactment and that it is therefore no less binding than a provision contained in a section of the Regulations itself [119]. The fact it was merely described as a note was immaterial and Lord Kerr affirmed the analysis in *Hunt* on a similar point [119]. It was also considered that use of the word "required" in Note (iii) had a straightforward meaning – it meant that the standard of proof that must be observed is the criminal standard [120]. As for Lady Arden's view that the intention behind Note (iii) was to reflect the common law position at the time but not to prevent the future development of that law, Lord Kerr disagreed. It would be extremely unusual if that were the case, as the meaning of the note would thus be required to shift and change to reflect future developments [122].

The public consultation

Lord Kerr then addressed the public consultation that Lady Arden relied on in support of her interpretation. Lady Arden considered that the response to the consultation (see [123]) indicated that the Ministry of Justice had decided that the 2013 Regulations could not make a change in the law. Whilst Lord Kerr considered that interpretation was correct, he found that it was not "outside the power in section 45 to make rules for coronial proceedings" which replaced a common law rule. Note (iii) forms part of an enactment and, similarly to the footnote in *Hunt*, it must have the effect of creating binding law. Although the note did not purport to change the law, it did confirm the existing law [125]. The plain effect of Note (iii), on Lord Kerr's view, was to give statutory expression to the existing common law rule.

Conclusion on Note (iii)

For all of those reasons, Lord Kerr found that Note (iii) of Form 2 "admits of no interpretation other than that the prescribed short form conclusion in inquests involving questions of "unlawful killing" or "suicide" can only be reached by applying the criminal standard of proof" [127].

Standard of proof required to establish a criminal offence in civil proceedings

Lord Kerr then went on to address the numerous authorities in which it had been found that the criminal standard of proof could apply in quasi-criminal cases (e.g., *B v Chief Constable of Avon and Somerset Constabulary* [2001] 1 WLR 340). What those cases illustrated was that the characterisation of proceedings as civil or criminal will not automatically predetermine the standard of proof to be applied [134]. Accordingly, the fact an inquest was a civil proceeding did not by itself justify the application of a civil burden of proof, particularly in inquests where "the proposition which is sought to be established is sufficiently grave or carries significant consequences for those whom it will affect" [134]. As for the gravity of suicide, Lord Kerr considered there was no doubt that there was a need to distinguish it from other causes of death in terms of

the level of proof required to establish it [138].

Lord Kerr also cast doubt on Lady Arden's characterisation of all inquests as civil proceedings. It would not be appropriate "to consider that the civil standard of proof should apply to all matters which fall to be decided in an inquest. Given the unique nature of inquests, it is not surprising that some issues should be susceptible to differing standards of proof." [142].

Conclusion

The decision in *Maugham* is clearly of huge importance to inquest practitioners. The standard of proof for all forms of conclusions in inquests will now be the civil standard of proof. The decision can be commended for resolving the logical difficulty arising from two different standards of proof being applied to reach what is effectively the same conclusion. Similarly, one would imagine that this new system will be much easier to explain to the jury and to family members of the deceased.

COMMENTARY ON REPORTS TO PREVENT FUTURE DEATHS (PFD)

DAVID THOMSON

Introduction

On 3 November 2020 the Chief Coroner, HHJ Mark Ludcraft QC, gave revised Guidance on the matter of coroners making Reports to Prevent Further Deaths (known as Prevention of Future Deaths or PFDs). As the law on PFDs remains the same much is unchanged: the obligation on the coroner to issue a PFD where in his or her opinion action should be taken to prevent future deaths; PFDs are restricted to matters which were causative or potentially causative of the death; the restriction remains that the coroner's role is to identify areas of concern rather than specifying particular solutions; the timetable and the list of required recipients are unchanged. There are however a number of key developments that may have an impact on the approach that involved parties take to the evidence that is provided to the coroner. These are:

- The guidance now contains more information about how the coroner should approach consideration of a PFD where the proposed recipient provides evidence that it has already taken action or has a clear plan of action in place to reduce the risk of future deaths.
- The guidance refers to 'local trends' and what assistance the coroner may take from them.
- The guidance clarifies how to challenge a perceived mistake in the PFD.
- Further guidance is given on the circumstances in which a coroner might decide to write a letter rather than producing a PFD.
- More examples of PFDs are provided.

These present times certainly throw the matter of advice on prevention into clear relief from Novichok to SARS-Cov2 pandemics. This article summarises the guidance in its present form and provides some suggestions on good practice for interested persons or organisations.

What is a Report to Prevent Future Deaths?

PFDs are important for all to learn from deaths. Coroners have a duty to decide how a person came by their death. They also have a statutory duty to report about deaths with a view to preventing future deaths. So a PFD may arguably benefit society. That said, most interested organisations would generally rather avoid a PFD, because they can highlight concerns, aired sometimes sensationally in public, about how their services were operating, which can lead to further onerous scrutiny from regulatory organisations such as the Care Quality Commission (CQC).

Paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009 Act, and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 set out, where an inquest gives rise to concern that future deaths will occur, and the investigating coroner is of the opinion that action should be taken to reduce the risk of death, then the coroner *must* make a report to

the person that she or he believes may have the power to take such action(s).

The Guidance states that Chief Coroner is "committed to learning from PFDs with a view to encouraging persons and organisations to make changes to try to prevent future deaths."

PFDs are intended to improve public health, welfare and safety. The previous Articles 28's were relatively few, but this has changed. Many more PFDs are being considered and made, so revised Guidance is necessary.

Clearly PFDs are important, but they are "ancillary to the inquest procedure and not its mainspring" (Re: Kelly (deceased) (1996) 161 JP 417). They are about learning about what did or did not happen and looking to the future.

The Guidance states PFDs should:

- Contain a concise overview in a relatively short paragraph or two
- Not be unduly general in their content; sweeping generalisations should be avoided
- Be clear, brief and focused
- Be meaningful and, wherever possible, designed to have practical effect
- Make specific points of concern, raised by the coroner
- Focus on the current position

PFDs should not:

- Contain a detailed rehearsal of the facts of the death that has been the subject of investigation
- Contain the history of the inquest
- Contain personal information about the deceased, the family or others.

All PFDs must be copied to the Chief Coroner's office, as well as to persons or organisations who, in the particular coroner's opinion, should receive them.

Coroner's duty to make a PFD

Under the new guidance, when considering whether the coroner's duty requires her or him to make a PFD report, the coroner should focus on the current position. This will normally be the position at the end of the inquest unless, unusually, consideration is being given to making a PFD report before the resumed inquest.

Coroners should not be drawn into issuing PFDs about matters that have not been explored properly during investigation or the inquest.

In considering the current position, the coroner should consider evidence and information about relevant changes, if any, made since the death or plans to implement such changes.

If a potential PFD recipient, for example an NHS Trust, has already implemented appropriate action to address the risk of future fatalities, the coroner can decide not to make a PFD. However a report to, for example, a relevant national organisation to highlight the issues more widely, may still be appropriate, *provided* the evidence persuades the coroner that the risk of future fatalities may arise nationally and the coroner believes that national action should be taken.

Of course, action to reduce risks may not yet have been fully implemented by the potential PFD recipient, such action may be ongoing or a decision likely made to take specific action in the near future. The need to take action may only have arisen from the evidence at the inquest. Whether a PFD report is required in these cases will depend on the circumstances.

The Guidance explains relevant matters could be:

- The nature of the commitment to take action
- Evidence in support of taking action
- The coroner's assessment of the organisation's understanding of the area of concern
- The coroner's assessment of the organisation's commitment to addressing the area of concern
- The coroner's consideration of the potential recipient in the context of any other PFDs sent to that individual or organisation
- Local trends

It is for the coroner to decide whether the duty to make a PFD arises in any particular instance, having

considered all the circumstances and the matter as a whole and hear representations if there are any.

The specific mention of "local trends" in the Guidance is a new emphasis or clarity. Coroners have always been aware of particular local circumstances, organisations, past investigations and Inquests, however trends or trending is possibly going to be a more open and articulated matter. Further such trend evidence will be more open to adequate consideration and evaluation. So, be prepared, if it is not the first time a particular concern has been raised with an organisation and/or if they have been slow to implement change previously, a coroner may be more likely to issue a PFD in a current case.

The template documents for making a PFD should be used by coroners. The templates should not be amended or altered. If possible the template documents should be uploaded onto coroners' systems.

The Guidance sets out some specific circumstances engaging the Coroner's duty to make a PFD, however it emphasizes in many places that all the circumstance are to be taken into account.

For now the duty arises, taking each step in turn, when:

1. The coroner has been conducting an investigation into a person's death. Normally the investigation will be complete when the inquest is concluded, but not always so.

2. Something revealed by the investigation, including evidence at the inquest, gives rise to a concern about a risk of future deaths.

3. Note, the coroner is not restricted to matters revealed in evidence at the inquest. The matter "giving rise to concern" will normally be addressed by evidence at the inquest, but it may be something revealed at any stage of a coroner's investigation.

4. Also that "giving rise to a concern" is a relatively low threshold (Coroners Inquests into the London Bombings of 7 July 2005, per Hallett LJ, Assistant Deputy Coroner for Inner West London, 6 May 2011, transcript p15).

5.There is concern that the circumstance(s) creating a risk of further deaths will occur or will continue to exist into the future. So it is a concern of a risk to life caused by present or future circumstances.

6. Then, in the coroner's opinion, action should be taken to try to prevent those circumstances happening again and so to reduce the risk of death created by them.

7. If the above apply, the coroner has a duty to report ("must report") the matter to a person or organisation who the coroner believes may have power to take action.

It is a pre-condition to making a PFD that "the coroner has considered all the documents, evidence and information that in the opinion of the coroner is relevant to the investigation" (Regulation 28(3)).

Article 2 Inquests

In an Article 2 inquest the PFD may complete the state's duty to inquire fully (see *R (Lewis) v HM Coroner for the Mid and North Division of the County of Shropshire* [2009] EWCA Civ 1403).

However, remember a PFD is not mandatory simply because an inquest is an Article 2 inquest.

The coroner's procedural obligation under Article 2 is most effectively discharged if the coroner announces publicly not only her or his intention to make a PFD report, if that is the intention, but also in broad terms the substance of the report which she or he intends to make.

Timing of the PFD

Normally, the PFD will be made after the inquest is concluded, because of the evidential pre-condition to making a report provided by Regulation 28(3), above. However, the concern about risk may arise from "anything revealed by the investigation", including the inquest. So paragraph 7 of Schedule 5 permits a PFD to be made after investigation but before an inquest is heard, so long as the pre-condition is complied with.

Where, for example, the coroner concludes that there

is an urgent need for action, she or he may make a PFD with a view to action being taken without delay. The Regulation 28(3) pre-condition may be satisfied during the investigation, but before the inquest, if the coroner takes the view that there is unlikely to be more evidence to come on the matter of concern.

It was not the intention of the 2009 Act that inquests may be lengthened or their scope widened for the purpose of hearing representations on PFDs. The Chief Coroner has emphasized that, although a report may become an important aspect of the outcome of an investigation, it is essentially ancillary to the primary purpose of an inquest, which is to make the statutory determinations, findings and conclusions relating to the death as recorded in the Record of Inquest (section 10 of the Coroners Act, Rule 34 and Schedule Form 2 of the Coroners Rules).

Whilst this lack of intention to cause lengthening of increased scope is clear in the Guidance, it seems to us that this is a hopeful assertion. There will be the need for investigation, assessment, response and submissions. However, what seems more likely is that this will be more tailored to the Guidance and consideration and making of PFDs.

Evidence concerning a PFD

Coroners may hear and give weight to representations by interested persons at the inquest as they see fit. Sometimes the coroner may find it helpful to hear some evidence which may be relevant for the purpose of making a PFD, but not strictly relevant to the outcome of the particular inquest. For example, a medical witness could, where appropriate, enlarge on her or his earlier evidence, even while the jury is deliberating and, for example, explain about actions developed post death.

When coroners take evidence relevant to PFD matters, particularly in the absence of the jury in this way, great care must be exercised to ensure that such evidence is strictly limited to post-death improvements and changes for PFD, and does not include substantive evidence about the death being investigated.

All relevant evidence regarding the death should be heard by the coroner and, if there is one, in front of the jury before the coroner sums up and directs on law.

The Guidance emphasizes again that adding to an inquest with matters regarding PFD with lengthy additional evidence or conducting a separate lengthy additional hearing should be avoided. We believe that will best be avoided by the early consideration of the issue of a PFD reasonably early in the investigation by the coroner and interested parties.

The substance of the PFD

Where a coroner's duty to report is engaged, the PFD must state the coroner's concerns and say that in the coroner's opinion action should be taken to prevent future deaths. The PFD must be sent to the person(s) or organisation(s) who the coroner believes has power to take such action (para.7(1)(c), Schedule 5 of the 2009 Act).

The PFD need not be restricted to matters causative (or potentially causative) of the death in question. Paragraph 7 is not so restricted, because Paragraph 7(1)(b) refers to "anything" revealed by the investigation which gives rise to concern that "circumstances creating a risk of other deaths will occur …"

A PFD does not have to relate to a death just in similar circumstances. The Guidance gives several examples which we do not repeat.

A coroner may shed light by taking evidence and making a PFD on a "system failure" that has regional or even national implications. However, coroners should not be drawn into reporting about matters that have not been explored properly at inquest (or investigation).

To be clear, the Guidance makes it clear that it is not a sufficient basis for a PFD, simply because it occurs to the coroner or an interested person that a certain matter might benefit from consideration, if it has not been *at all germane* to the death under investigation.

We believe that the evidential assessment (above) of "sometimes the coroner may find it helpful to hear some evidence which may be relevant for the purpose of making a PFD, but not strictly relevant to the outcome of the particular inquest" contrasts with the

issue of what is germane to the death and investigation, however these will be matters of fact and degree, so we will have to keep close attention to how this area develops.

The Guidance gives an illustration of where, say, the coroner hears evidence that an operation has resulted in death. The surgeon gives evidence at inquest that, as a result of this, there is now an addition to the sum of medical knowledge that could improve surgical outcomes in the future. It states "bringing this learning to trust, regional or national attention by way of a PFD may be entirely proper." However this is but one example and no doubt is going to be many more.

Note coroners should not include a confidentiality clause in a PFD. And it should not generally be necessary to send extraneous documents, such as the Record of Inquest or a recording, to the recipient, save for a narrative determination if one has been made. The intention is that the PFD report should be complete in itself.

The PFD should set out:

1. The coroner's concerns (box 5 of the template). The PFD will set out the details of the investigation (and inquest) and the circumstances of the death. It must then list the coroner's concerns. These are the concerns which the investigation has revealed, either at inquest or earlier during the investigation.

   This part is the essence of the PFD. The coroner should express clearly, simply and "in neutral and non-contentious terms" the factual basis for each concern (*R v Shrewsbury Coroner's Court, ex parte British Parachute Association* (1988) 152 JP 123).

   In some cases, the action to be taken following the coroner's expressed concern will be obvious, but it is not for the coroner to dictate precisely what action should be taken. Rather the PFD should raise issues and recommend that action should be taken, but not what that action should be.

   As stated by Hallett LJ: "However, it is neither necessary, nor appropriate, for a coroner making a report under rule 43 [the predecessor to para 7, Schedule 5 of the 2009 Act] to identify the necessary remedial action. As is apparent from the final words of rule 43(1), the coroner's function is to identify points of concern, not to prescribe solutions."

   The action to be taken is a matter for the person or organisation to whom the PFD report is directed to propose.

2. Coroners should be careful, particularly when reporting about something specific, to base their report on clear evidence at the inquest or on clear information during the investigation, and to express clearly and simply what that information or evidence is, and to "ensure that a bereaved family's expectations are not raised unrealistically."

3. The PFD should not apportion blame, be defamatory, prejudice law enforcement action or the administration of justice, affect national security, put anyone's safety at risk, or breach data protection, for example by naming children or breaching medical confidentiality.

4. Coroners should not make any other observations of any kind, however well intentioned, outside the scope of the PFD, because such observations are an expression of opinion wider than is permissible (under section 5(3) of the 2009 Act) and are therefore unlawful and to no effect (*R (Mowlem plc) v Avon Assistant Deputy Coroner* [2005] EWHC 1359 (Admin)).

5. The Guidance specifically comments 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" have been used. They should not be used. Coroners should at all times use moderate, neutral, well-tempered language, befitting a judge. This applies to public hearings as well as correspondence and reports.

6. The PFD must state that "in the coroner's opinion action should be taken" and that the coroner believes the person/organisation has "power to take such action" (paragraph 7(1) and box

6 of the template). Again the coroner should not recommend what precisely that action should be, but the coroner can highlight the area of concern and draw attention to it.

7. What about recommendations? In *Re Clegg (deceased)* (1996) 161 JP 521 (DC), Phillips LJ used the word "recommendations" in a general sense only: "…again my conclusion is that in a situation such as this a coroner cannot be expected to do more than to make general recommendations and that it must, at the end of the day, be for the National Health Service to give detailed consideration to how their recommendations should be implemented". In other words, the Guidance is that the coroner should identify the specific area of concern, raise it, but then allow the person/organisation to provide the remedy.

8. The coroner must send the report to "a person who the coroner believes may have power to take such action": paragraph 7(1). A "person" includes an organisation. Where a report is sent to an organisation, the coroner should seek to identify a relevant person in the organisation who is sufficiently senior to have the "power" to take action, if that is possible.

9. The PFD should be sent out either within 10 working days of the end of the inquest, or within 10 working days of the time before inquest when the matter of concern is revealed and considered during the course of the investigation.

10. Once a PFD has been sent, the coroner has no power to withdraw it. The appropriate remedy for correcting any mistake of fact in the report is by responding to it (as provided for in paragraph 7(1), Schedule 5 of the Coroners and Justice Act 2009 Act and *R (Siddiqui & Paeprer-Rohricht) v HM Assistant Coroner for East London* (28 September 2017) Admin Court CO/2892/2017).

A Letter from the Coroner instead of a PFD?

The Guidance is clear - where an investigation (including inquest) gives rise to a concern that future deaths will occur, the coroner should make a PFD report.

In *exceptional circumstances*, where the duty to make a report does not arise, but the coroner nevertheless wishes to draw attention to a matter of concern. The usual reason that no duty to make a PFD arises is because the matter does not relate to a risk of future deaths. In these circumstances, the coroner may write a letter expressing the concern to the relevant person or organisation.

This could be discussed with interested persons at inquest and the correspondence could be copied to them.

So this exceptional circumstance is where there is circumstance(s) where the coroner wants to raise or highlight a concern but the duty to make a PFD does not arise, usually because the matter does not relate to a risk of future deaths, in which case she or he could instead write a letter to the person or organisation.

The Guidance gives an example of the inquest into the death of Ian Tomlinson who died during protests at the G20 summit in London in April 2009. There was evidence, which in the end was excluded from the inquest hearing, about Police Service vetting arrangements. This evidence did not relate to the death or to future deaths, but it caused concern to the coroner who discussed it with counsel, corresponded with the Home Secretary about it, and disclosed the correspondence (with the Home Secretary's consent) to all interested persons. In due course the Home Secretary amended the vetting arrangements.

As with a PFD report, any letter must identify clearly the specific element of concern. Writing a letter instead of a report is an exceptional course of action. If the subject matter relates to the prevention of future deaths, writing a PFD report is the default position.

Note well that the matter raised in the PFD does not have to have been causative of the death under investigation. If there has been a serious failure in, say, a trust's investigative process, this could have an impact upon the ability to learn from one death and so avoid other deaths, and may therefore be included within a PFD.

Note also that, unlike a PFD, there is no mandatory copying of such a letter or a response.

The role of the Jury in PFDs

A jury is not permitted to make riders or recommendations (ex parte Middleton [2004] 2 AC 182). Coroners should not invite juries to make any kind of observation. Juries should be directed not to express an opinion on any matter other than the section 5 matters to be ascertained (who, how, when and where).

The Guidance states that in the right case, the coroner has a discretion to leave to the jury, in addition to the direct or indirect causes or contributions to the death, facts that are relevant to the coroner's reporting power (under paragraph 7 of Schedule 5) particularly where those facts are disputed or uncertain. This is a discretion not a duty, and in general it is better for the coroner alone to deal with PFD matters, unless she or he specifically needs assistance from the jury on what occurred factually.

What case is the "right" case will depend on all the circumstances and appropriate restrain by the coroner.

Disputed facts

Even if facts are disputed, that does not prevent the making of a PFD. A matter raised in the PFD does not have to be demonstrated to have been causative of the death under investigation.

Responding to a PFD

A person or organisation served with a PFD must respond within 56 days, or longer if the coroner grants an extension (Regulation 29(4) and (5)).

A response must detail the action taken or to be taken, whether in response to the report or otherwise, and the timetable for it, or it must explain why no action is proposed (Regulation 29(3)).

The responder should also use the template form, which the Chief Coroner's office can provide.

The best way for persons or organisation is to provide robust evidence in the response template that actions have already been taken (or will be taken within a clear timeframe) to address any concerns.

Where proposed actions have not yet been fully implemented, for example actions are still ongoing or will be decided on in the near future, the factors for coroners to consider (as set out above) will include the nature of the commitment to take action and any evidence to support it.

The coroner will provide an assessment of the person or organisation's understanding of and commitment to addressing the concern raised.

This Guidance requiring the coroner to make and detail her is his assessment may avoid a PFD, in circumstance where the concerns are being addressed and so prove a very worthwhile aspect of the revised Guidance.

Mandatory recipients of the PFD

If made, the coroner must send a copy of the PFD to the Chief Coroner and also to all interested persons who in the coroner's opinion should receive it (Regulation 28(4)(a)) – see further interested persons below.

The coroner must send a copy of any response(s) to the Chief Coroner and to all interested persons who in the coroner's opinion should receive it (Regulation 29(6)).

The coroner may also send a copy of the report and/or the response to "any other person [other than interested persons] who the coroner believes may find it useful or of interest" (Regulations 28(4)(c) and 29(6)(c)). The coroner should consider requests for copies from "other persons" on a case by case basis. The Guidance states that coroners should err on the side of openness unless there is a very good reason for restricting access to these documents.

Interested persons

Obviously, who is an interested person will depend on all the circumstances of the investigation or inquest. The Guidance is that coroners should routinely send relevant PFDs to other organisations, such as the Department of Health and Social Care, the Health & Safety Investigation Branch, the Care Quality

Commission, or the Department of Transport, so that wider lessons can be learnt.

Where the deceased is believed to be under 18, a copy must also be sent to the Local Safeguarding Children Board (Regulation 28(4)(b)

All reports and responses about deaths in prisons and other detention centres should as a matter of good practice be sent to HM Inspectorate of Prisons in all cases. They should also be sent to the HM Prison and Probation Service and to the Independent Advisory Panel on Deaths in Custody.

Chief Coroner's Response

The Chief Coroner may publish a report or a response, or part of one or in a redacted or summarised form (Regulations 28(5)(a) and 29(7)(a)). 59. A person or organisation giving a response to a PFD may make representations to the coroner about the release or publication of their response (Regulation 29(8). Representations must be passed by the coroner to the Chief Coroner (Regulation 29(10)). The Chief Coroner may also send a copy of a report or a response to any other person the Chief Coroner believes may find it useful or of interest (Regulations 28(5)(b) and 29(7)(b)).

The Chief Coroner publishes on the coroner section of the public judiciary website as many PFDs as possible, subject to some limited redaction. As a matter of policy there is, subject to representations and exceptions, a presumption of publication.

The Guidance explains that it is implicit in the statutory framework that the Chief Coroner should have a role in taking some PFDs (and responses) even further. Therefore, from time to time the Chief Coroner will make assessment(s) of areas of concern, whether from single or multiple reports, and may advise action where appropriate. He may consult on areas of concern and where feasible recommend action, whether by way of advice to government or an organisation or individual, or where necessary by recommending a change in the law.

RECOVERING THE COSTS OF AN INQUEST: *GREATER MANCHESTER FIRE AND RESCUE SERVICE V SUSAN ANN VEEVERS* [2020] EWHC 2550 (COMM)

DOMINIQUE SMITH

The recent decision of *Greater Manchester Fire and Rescue Service v Susan Ann Veevers* provides welcome clarification on the recoverability of inquest costs in fatal accident claims. Specifically, it looked at situations where informal or equivocal concessions have been made and whether such concessions prevent inquest costs from being recovered.

Factual Background

Mrs Veveers ("the Respondent") brought a claim against Greater Manchester Fire and Rescue Service ("the Appellant") and Paul's Hair World Limited, following the death of her son, Stephen Alan Hunt ("Mr Hunt"). Mr Hunt was sadly killed during the course of his employment as a firefighter at the premises of Paul's Hair World Limited, due to heat exhaustion and hypoxia. The claim was brought pursuant to the Law Reform (Miscellaneous Provisions) Act 1934 and the Fatal Accidents Act 1976, alleging that the Appellant failed to take reasonable care to ensure that Mr Hunt's use of breathing apparatus and full personal protective equipment did not exceed a maximum of 20 minutes and/or that a proper watch was kept on him when using such equipment.

Prior to the issue of proceedings, the Respondent had instructed solicitors to investigate the cause of Mr Hunt's death and an inquest was scheduled. Shortly before the inquest, the Appellant's solicitors wrote to Respondent's solicitors, stating:

> *"…Our clients are not in a position to consider an admission of liability… We write in open correspondence in order to advise that our clients are willing to compensate the estate and dependents of Stephen Hunt… for any loss which they may prove to be attributable to the incident on 13 July 2013 together with payment of their reasonable costs. It is*

not our client's intention to allege contributory negligence or to seek any reduction of damages in this regard. We confirm that our clients will deal with the claims on a full basis."

The Respondent's solicitors replied, inviting the Appellant to admit liability as "*the intention to pay compensation to the estate and dependents could be withdrawn at any time*". The Respondent's solicitors thereafter stated that they would continue to prepare for the inquest "*…until such time as liability is admitted or my client's claims are settled…*".

In a further exchange of correspondence, the Appellant's solicitors replied that there was no need to prepare a letter of claim and that the claims by the dependents or the estate would be met without reduction. Pertinently, the Appellant did not admit liability.

The Respondent proceeded to attend the inquest with legal representation, and thereafter issued the aforementioned proceedings. The Appellant served a defence, admitting liability to compensate the estate and dependents of the deceased for damages and consequential losses. The Respondent also agreed to pay the Appellant's reasonable costs, which were referred for assessment.

The matter came before Deputy District Judge Harris for assessment. A key issue between the parties during assessment was whether the Respondent was entitled to recover the costs of preparing for and attending the inquest. The Appellant argued that those costs were not of and incidental to the claim for damages, and in the alternative, could not be considered reasonable and proportionate. The Respondent, on the other hand, considered that the statements in the correspondence were ambiguous, such as to render preparation for and attendance at the inquest both a cost of and incidental to the civil claim.

Deputy District Judge Harris concluded that an admission of liability prior to an inquest was an important factor to be taken into account as to whether the costs of the inquest were recoverable and/or justifiable. However, when considering the correspondence between the parties, Deputy District Judge Harris found that there had been no admission of liability by the Appellant. He accepted that the Respondent perceived there was a risk that the Appellant might resile from their statement that they would compensate the estate and dependents of Mr Hunt and, in those circumstances, those costs were recoverable.

The Appellant subsequently appealed the decision, arguing that the costs of preparing for and attending the inquest were not properly recoverable. Even if they were, the Appellant argued in the alternative that they could not be considered reasonable or proportionate, in the light of communications between the parties.

The decision of the High Court

HHJ Pearce summarised the law in respect of recovery of costs in a civil claim for the preparation for and attendance at an inquest as follows:

a) Reasonable and proportionate inquest costs may be recoverable, 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;
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;
e) A Costs Judge is entitled to look 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 matters in issue between the parties;
f) If the defendant's position is not one of an 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 the inquest, such as to avoid the inequality of arms, 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.

HHJ Pearce concluded that there had been no error in the judgment of Deputy District Judge Harris. Whilst the Appellant had sought to draw parallels between this case and that of *The Bowbelle*, HHJ Pearce considered there were clear distinctions between the two cases. In *The Bowbelle*, it was noted that negligence "*had been conceded*', whereas negligence, and liability generally, had not been conceded in this case. In addition, the Appellant had further declined to admit liability when invited to do so by the Respondent. HHJ Pearce did not consider that the correspondence within the letters equated to an admission of liability, thus the Respondent could not have entered judgment based upon them, as had been suggested by the Appellant in submissions. Consequently, the appeal was dismissed.

What can we learn from the decision?

This decision is no doubt a welcome one for bereaved families. Where a fatal accident occurs and an inquest subsequently ensues, a claimant's reasonable and proportionate costs of attending the inquest will likely be recoverable in civil proceedings, even if an informal or equivocal concession has been made. They will not, however, be recoverable if a defendant makes a formal admission of liability.

The decision might be considered harsh by defendant practitioners but provides some welcome clarity at least and will no doubt serve its purpose in focussing minds at an early stage on whether a formal admission of liability should be made. Potential defendants should be aware that if they are going to make an admission pre-action the admission must comply with CPR 14 and be made in a timely manner, ideally prior to any costs being incurred in relation to the preparation for the inquest. Should a potential defendant fail to admit liability prior to proceedings being issued they will likely be ordered to pay the costs of the inquest as well as those of the civil proceedings.

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