fieldfisher

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THREE RAYMOND BUILDINGS
BARRISTERS

# HSLA Conference

## From Litvinenko to London Bridge: an insight into advising public authorities and enforcers in investigations, inquests and inquiries

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# Introduction

**INQUESTS**

In 2018:

- 541,589 deaths registered
- 220,600 deaths reported to the Coroner
- 30,700 inquests
- Westminster, London Bridge/Borough Market, Birmingham Pub Bombings, Deepcut, Perepilichny

# Introduction

**PUBLIC INQUIRIES**

- How many initiated between 2003 – 2007 (inclusive)? 10
- How many initiated between 2008- 2012 (inclusive)? 15
- How many initiated between 2013-2017 (inclusive)? 11
- IICSA, Contaminated Blood, Bloody Sunday, Litvinenko, Leveson.

# Introduction - TEST

- Go to slido.com
- Password B523

# Introduction - Test

- Most likely place to die in 2017?

# Introduction - TEST

- Least likely place to die 2017?

# Introduction - TEST

- How long was the longest public inquiry?

# Introduction

**Scale**

- How long was the longest public inquiry? 13 years 3 month; Hyponatraemia related deaths
- Baha Mousa Inquiry (2008): 10, 600 documents assessed by the Inquiry
- Hillsborough Inquests (2016): 1,026,167 pages were disclosed to IPs
- Baha Mousa Inquiry: 277 oral witnesses called
- Hillsborough: 620 oral witnesses called

# Inquest v Inquiry

**INQUEST v INQUIRY**

Difference in law:

- **Inquests** – To answer four statutory questions
  - s.5 Coroners and Justice Act 2009
  - Coroners (Inquests) Rules 2013 and Coroners (Investigations) Regulations 2015
- **Inquiry** – To investigate matters of public concern (s.1 Inquiries Act 2005)
  - Inquiries Act 2005 and Inquiry Regulations 2006

# Introduction

Other differences/similarities:

- Unpredictable - Coroner/Chair has wide discretion to manage their proceedings and determine relevance of issues
- Funding of legal representation at public expense more widely available in Inquiry (Section 40 of the Inquiries Act 2005).
- Examination of witnesses by other parties more common in inquests.
- Can address the Chair of an inquiry as to the facts (cf s.27 CJA 2005).

# 1. Early stages and preparation for the hearing

**IMMEDIATELY FOLLOWING 'THE EVENT'**

- Never too early to prepare
- Have procedures in place for this eventuality
- Planning for disclosure is key - Don't wait to be asked
- Keep staff informed - ensure they are aware of retention requirements
- Comms/PR – External/Internal; Proactive/Reactive.
- Work related deaths protocol/MOU between the Chief Coroner and the HSE

# 1. Early stages and preparation for the hearing

## INVOLVEMENT IN PROCEEDINGS

Whether to seek interested person or core participant status?

- Is it better to be involved than not?
- Will receive disclosure
- Can make opening/closing statement and ask questions (in inquests)
- Impact on your witnesses that may be called
- Potential reputational cost vs financial cost

# 1. Early stages and preparation for the hearing

## RESPONDING TO DISCLOSURE REQUESTS

- Disclosure is a key function of an inquest or inquiry
- Establish a robust process for responding to disclosure requests
- Discuss approach with Inquiry team/Coroner (or their team) at an early stage and keep engaged with them
- Ensure you provide regular updates on progress
- GDPR/DPA considerations (Section 21 Inquiries Act 2005 or Schedule 5 Coroners and Justice Act 2009)

# Disclosure

Duty of Candour

- Arising out of Hillsborough
  - Charter for Families Bereaved through Public Tragedy – Report of Bishop James Jones
  - Public Authority (Accountability) Bill – 'Hillsborough Law'

# 1. Early stages and preparation for the hearing

**EXPERTS**

- When are they needed?
- Whose expert?
- Engage with the coroner/inquiry as to its plans for expert evidence?

# 1. Early stages and preparation for the hearing

**FUNDING**

- Inquest vs Inquiry
  - Section 40 for Inquiries – All statutory inquiries will have a published costs protocol.
    - ➢ Not usually available for large organisations or individuals they support.
    - ➢ Funding for witnesses
  - Chief Coroner's recent annual report

# 2. The hearing

**WITNESSES**

- Representation
- Preparation
- Rule 23

# 2. The hearing

**WITNESSES**

- Compulsion
- Anonymity
- Questioning
- Support

# 2. The hearing

**SCOPE**

- Meaning?
- When to raise?
- When to determine?

# Scope

- *Coroner for the Birmingham Inquests (1974) v Hambleton and others* [2018] EWCA Civ 2081 para 20, 57; Sir Peter Thornton:
  - *"18. The word 'scope' has no special meaning of its own. By 'scope' all that is generally meant is a list of the topics upon which the coroner, in the coroner's discretion, will call relevant evidence so as to be able to answer the four key statutory questions: Who died? How, when and where did they come by their death?*
  - *19. These questions and the answers to them, known as the determination, are provided by statute in Sections 5 and 10 of the Coroners and Justice Act 2009. They are the four central questions in every inquest. When decided the answers to them are recorded by the coroner or the jury, if there is one, in the statutory Record of Inquest."*

# Scope

Hambleton :

- *"A decision on scope represents a coroner's view about what is necessary, desirable and proportionate by way of investigation to enable the statutory functions to be discharged. These are not hard-edged questions. The decision on scope, just as a decision on which witnesses to call, and the breadth of evidence adduced, is for the coroner. A court exercising supervisory jurisdiction can interfere with such a decision only if it is infected with a public law failing. It has long been the case that a court exercising supervisory jurisdiction will be slow to disturb a decision of this sort (see Simon Brown LJ in Dallaglio at [155] cited in [21] above) and will do so only on what is described in omnibus terms as Wednesbury grounds…"* [para 48]

# Scope

## Hambleton:

- *"The authorities speak in terms of a discretion to set the bounds of an inquest. The Chief Coroner's Law Sheet No. 5 sets out references to cases where that principle has been stated. It is sufficient to note the observations of Lord Mance at [208] in R v Secretary of State for Defence, ex parte Smith [2011] 1 AC 1 that "[e]veryone agrees that coroners have a considerable discretion as to the scope of their inquiry"; and of Hallett LJ in R (Sreedharan) v HM Coroner for the County of Greater Manchester [2013] EWCA Civ 181, at [48] that "the Coroner has a broad discretion as to the nature and extent of the inquiry". The principle was recently restated in R (Maguire) v Assistant Coroner for West Yorkshire (Eastern Area) [2018] EWCA Civ 6, at [3*].." [para 50]

# 3. Conclusion of proceedings

**Inquests**

- Art 2

➢ automatically engaged:

(i) violent deaths in custody (including suicide)

(ii) violent death of a detained psychiatric patient (inc suicide)

(ii) deliberate killings by state agents.

# 3. Conclusion of proceedings

- Art 2

➢ also engaged where there is an arguable case that the state committed a breach of a substantive Art 2 duty in relation to the death: *R (Humberstone) v Legal Services Commission* [2011] 1 WLR 1460 at [52] – [68]

➢ In LB inquests, the Chief Coroner applied a test of "arguable breach" – a low test.

# 3. Conclusion of proceedings

- Art 2 Substantive duties

  (1) General duty to adopt laws and procedures suitable to safeguard life

  (2) Operational duties may be owed by state authorities and agents to avert particular threats to lives of individuals or the public.

# 3. Conclusion of proceedings

- What difference does Art 2 make?

➢ Has little, if any, effect upon the scope of inquiry or the conduct of the inquest hearing before the final determination is considered: *Sreedharan* at [18(vii)]

# 3. Conclusion of proceedings

- Narrative conclusions in Art 2 inquests:
  - Art 2 makes a difference to the scope of narrative conclusions
  - Art 2 narratives should express findings on key factual issues
  - May go beyond the immediate physical means of death and may include broader circumstances, as well as underlying and contributory factors
  - Cannot though make any findings that Art 2 was actually breached.

# 3. Conclusion of proceedings

- Art 2
  - if Art 2 is engaged by reference to the conduct of one state agent, the Court should scrutinise the conduct of all state agents and all others with the same intensity: *R (Sreedharan) v Manchester City Coroner* [2013] EWCA Civ 181 at [23]
  - London Bridge Inquests: Art 2 engaged by reference to:(i) the pre- attack investigation; and (ii) protective security systems.

# 3. Conclusion of proceedings

- Approach to Art 2 in London Bridge Inquests:
  - The effect of Art 2 being engaged should not be over-stated
  - The determinations addressed the circumstances as well as the means of death
  - Made common sense criticisms without determining that Art 2 had been breached
  - However, it was still concise

# 3. Conclusion of proceedings

- Short form/narrative:
  - Wherever possible coroners should conclude with a short-form conclusion: [26] of Chief Coroner's Guidance No.17
  - Civil standard of proof is to be applied to factual findings and determinations in inquests generally, including to findings of suicide (whether expressed in narrative or short-form): *R (Maughan) v Senior Coroner for Oxfordshire* [2019] EWCA Civ 809
  - Criminal standard of proof (exceptionally) to unlawful killing

# 3. Conclusion of proceedings

- Unlawful killing: all change after February?
  - Supreme Court will hear the appeal in *Maughan* in February
  - Hard to see that the Supreme Court will disagree with the Court of Appeal's conclusion in relation to suicide
  - Real interest for h & s lawyers in what the Supreme Court will determine about the coronial standard of proof for unlawful killing
  - Will it be changed to the civil standard of proof?

# 3. Conclusion of proceedings

- Regulation 28 on action to Prevent Future Deaths ("PFD")
  - The Coroner must make a report if he forms the view that a risk of future death can be seen and that preventive action ought to be taken: Schedule 5 to the CJA, paragraph 7(1)
  - The jurisdiction to make PFD Reports is not limited to reporting circumstances and risks which were causally relevant to the particular deaths under investigation: Chief Coroner's Guidance No. 5 [17]

# 3. Conclusion of proceedings

- **PFDs**:
  - A Coroner may properly decide not to make a PFD Report on an issue on the basis that he is not satisfied that further action is necessary
  - For example, if it appears that a risk or issue has been addressed by action of some kind, or if circumstances have changed substantially since the death in question
  - Need to have PFD evidence

# 3. Conclusion of proceedings

- Approach to PFDs in London Bridge Inquests:
  - Witness statements addressed what action had been taken since the attack
  - Sequential written submissions made after the evidence had concluded
  - Bereaved families provided submissions first
  - Organisations then had an opportunity to respond.

# 3. Conclusion of proceedings

- Chief Coroner's PFD report in London Bridge Inquests made on 1.11.19:
  - Matter of Concern 3 – addressed to the Secretary of State for the Home Department: suggests that consideration be given either:

    (a) to introducing legislation governing the duties of public authorities (including highway authorities) regarding protective security; or

    (b) to produce guidance indicating what existing legal duties require of public authorities re assessment of sites.

# 3. Conclusion of proceedings

**INQUIRIES**

- Warning letters
  - No duty on an inquiry to serve a warning letter: rule 13(1) of 2006 Rules
  - BUT panel may not include criticism of a person in a report unless such a letter has been sent to the persons concerned and they have been given a reasonable opportunity to respond to the warning letter: rule 13(3).

# 3. Conclusion of proceedings

- **Warning letters**
  - 2006 Rules do not require that a person be given a warning letter before giving evidence
  - Prohibition on criticising a person relates to the time of publication of the report, not at the time a witness gives evidence
  - Although Rule 13 drafted sufficiently widely that an inquiry can issue letters to witnesses both before they give evidence and before final report

# 3. Conclusion of proceedings

- **Inquiry report publication**
  - Section 24 of the 2005 Act places a duty on the chairman of an inquiry to deliver the inquiry's report to the minister
  - After delivery to the minister, the chairman is required to provide a copy to each CP: rule 17 of Inquiry Rules 2006
  - Individuals receiving a copy under rule 17 are under an actionable duty of confidentiality until after the chairman has published the report: rule 17(2) and (3)

# 3. Conclusion of proceedings

- **Recommendations of an Inquiry:**
  - Where the inquiry's terms of reference require that it make recommendations, these must be set out in the inquiry report: s24(1)(b) 2005 Act
  - No legal obligations on the Government or public authorities to implement the recommendations of an inquiry

# Resources

- Coroners and Justice Act 2009
- The Coroners (Inquests) Rules 2013
- The Coroners (Investigations) Regulations 2013
- Inquiries Act 2005

# Resources

- Chief Coroners Guidance esp.
  - No. 4 PFD
  - No. 17 Conclusions
  - No. 22 PIRs
  - No. 25 The Media
  - No. 29 Rule 23 inquests

# Resources

- **Chief Coroner Guidance**
  - LS 1 Unlawful killing
  - LS 2 *Galbraith* plus
  - LS 3 Disclosure
  - LS 4 Hearsay
  - LS 5 Discretion

# Resources

- London Bridge/Borough Market Inquests

  https://londonbridgeinquests.independent.gov.uk/
- Westminster Bridge Inquests

  https://westminsterbridgeinquests.independent.gov.uk/

# Resources

- Litvinenko Public Inquiry

  https://webarchive.nationalarchives.gov.uk/20160613090305/https://www.litvinenkoinquiry.org/

- Hillsborough Inquests (not active pending criminal proceedings)

# Resources

- *Maughan R (Maughan) v Senior Coroner for Oxfordshire* [2019] EWCA Civ 809: suicide/unlawful killing standard
- *Coroner for the Birmingham Inquests (1974) v Hambleton and others* [2018] EWCA Civ 2081: scope
- *R (Sreedharan) v HM Coroner for the County of Greater Manchester [2013] EWCA Civ 181: scope*
- *R (Worthington) v Senior Coroner for Cumbria* [2018] EWHC 3386 (Admin) 11 December 2018: conclusion

# Resources

- *R (Fullick) -v- HM Senior Coroner for Inner North London* [2015] EWHC 3522 (Admin): jury
- *Worcestershire County Council -v- HM Coroner for the County of Worcestershire* [2013] EWHC 1711 (QB): disclosure
- *Mueller v Her Majesty's Area Coroner for Manchester West* [2017] EWHC 3000 (Admin): Rule 23

# The Chief Coroner in Conversation with 3RB

- 4 December 2019
- Sky Bar, Leonardo Royal Hotel, St Pauls
- From 6.30 pm
- Strictly RSVP to Katie.bowman@3rblaw.com by **27.11.2019**