Case No: CO/1512/2014

Neutral Citation Number: [2015] EWHC 31 (Admin)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT (MANCHESTER)

Date: 14/01/2015

Before :

LORD JUSTICE BEAN
THE CHIEF CORONER (HIS HONOUR JUDGE PETER THORNTON QC)

- -

Between :

MISS REBECCA CHAMBERS (BY HER MOTHER AND LITIGATION FRIEND MRS DEBORAH CHAMBERS)	**Claimant**
- and -	
HM CORONER FOR PRESTON AND WEST LANCASHIRE	**Defendant**
-and-	
(1) NATIONAL OFFENDER MANAGEMENT SERVICE FOR HM PRISONS	**Interested Parties**
(2) MRS PAULINE CHAMBERS	

- -

Matthew Stockwell (instructed by **Birchall Blackburn Law**) for the **Claimant**
Bridget Dolan (instructed by **HM Coroner for Preston and West Lancashire**) for the **Defendant**
Thomas Leeper (instructed by the Treasury Solicitor) for the **First Interested Party**
The Second Interested Party did not appear and was not represented.

Hearing dates: 16 December 2014

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Judgment

Lord Justice Bean :

This is the judgment of the court to which we have both contributed.

1. On 26th January 2004 Stephen Chambers was found hanging in his cell at HMP Preston. On 14th May 2007 an inquest was held before HM Coroner, Dr James Adeley and a jury. The jury returned, and the Coroner recorded, a verdict that Mr Chambers died:-

    a) "between 09:30am and 10:12am on 26th January 2004 at HMP Preston in Cell C2-31; and that this was

    b) from hanging which caused his death. Among the contributing factors were his family problems and bullying. There is not enough evidence to suggest that the prison were aware of this bullying."

2. Since the claimant was less than three years old when her father died we may safely infer that it is her mother and litigation friend Mrs Deborah Chambers who is the real driving force behind this litigation. Mrs Chambers was neither present nor represented at the inquest. Her solicitors had asked to be notified of the date of the inquest but because of an oversight they were not so notified. Mrs Chambers is dissatisfied with the verdict reached at the 2007 inquest on the grounds both of an irregularity in the proceedings (namely the failure to notify her or her solicitors) that it was to take place and insufficiency of inquiry, to which we shall return in detail later in this judgment. She applied for the *fiat* of the Attorney General under Section 13 of the Coroners Act 1988 authorising an application to the High Court for an order quashing the original inquest and directing the holding of a fresh one. The then Solicitor General, Oliver Heald QC MP, gave such authorisation on 24th February 2014.

3. Mr Chambers had been in prison on a number of occasions, including from January 2001 to early 2003. For a substantial part of that time there was an open F2052 SH (self harm at risk) form in respect of him. During his time in custody in the year 2001 he attempted to hang himself on five occasions.

4. In July 2003 he committed a further offence and on 9 September 2003 was sentenced to 11 months imprisonment. On arrival that day at HMP Preston he was again subject to an open form F2052. He informed medical officers that his mother had recently died. This was untrue: his mother Pauline, the second Interested Party, was and is still alive. He expressed feelings of depression because of his mother's alleged death but also because he was going through divorce proceedings, as well as his claimed innocence of the charge. He told staff that he intended to kill himself before the end of his sentence.

5. During his first two weeks in custody there were some signs that his state of mind was improving. However, he reported being bullied to a prison listener and a security information report indicated that another named prisoner might be threatening him. In early October 2003 he was transferred to the poor copers' wing. An F2052 form was again opened because of concerns over his state of mind and expressed thoughts of suicide. He was reviewed by a prison doctor, Dr Seddon-Smith on 7th October 2003 and mentioned thoughts of suicide. On the same day he was assaulted by his

cellmate. Two days later on 9th October he was found hanging from the window bars of his cell but was conscious and largely unharmed. He said that his principal stresses were due to family problems but added that he was being bullied by two inmates, whom he did not name.

6. On 16th October 2003 his appeal against sentence to the Crown Court was dismissed. During this period he was subject to weekly F2052 self harm reviews attended by the prison chaplain, the Reverend Browne, Prison Officer Hugh and a probation officer, Lindsay Bailey. On each occasion he made reference to depression and thoughts of self harm. On 18th November 2003 he was allocated to the Visits Cleaning Party, a job which improved his self esteem. At the weekly self harm review on 2nd December 2003 he reported news of his divorce progressing. At the weekly review on 9th December he was recorded as seeming in a brighter mood, but on 11th December he told staff that he was feeling low and gave them a towel which he had ripped into lengths, apparently to form a ligature. At the weekly self-harm review on 16th December 2003 the F2052 form was closed. This was a unanimous decision of Reverend Browne, PO Hugh and Ms Bailey and was supported by Mr Chambers himself. The form recorded that his attitude was much more positive, that he was facing up to the issues in his life and that he was happy for the form to be closed on the understanding that he knew how to ask for help should he need it.

7. In January 2004 a security information report stated concerns that Mr Chambers could be in debt to other prisoners as a result of drug purchases. He was suspended from his job as a Visits Cleaner because of the suspicions, but did not seem greatly troubled. He wrote to his brother on 23rd January requesting money to pay his debts to others in the prison. At the inquest evidence was received from some inmates that he was being bullied as a result of his unpaid debts.

8. On 26th January 2004 Mr Chambers' cell was unlocked at 07:50. Other inmates gave evidence that he appeared normal that morning. A prison officer went to his cell at 08:30 and saw no reason for concern. Two other officers went to the cell at 09:30 to collect his cellmate for a drug test but found Mr Chambers absent. At around 09:40 another inmate walked past the door of Mr Chambers' cell and saw him standing and smiling. At about 09:50 two officers went to the cell to collect Mr Chambers for a drug test. One of them, PO Starkie, saw through the observation window that Mr Chambers was hanging from a window bar by a ligature made from torn sheets. Mr Starkie immediately called for assistance, entered the cell and supported Mr Chambers' weight. Despite prompt medical attendance he could not be resuscitated. It was confirmed at 10:12 that there was no sign of life.

Irregularity of proceedings

9. The claimant's divorce from Deborah Chambers had been made absolute 11 days before his death. On 12th May 2004 Birchall Blackburn, solicitors, wrote to the Coroner then in office on behalf of Mrs Chambers notifying him of her interest; this letter was acknowledged on 24th May 2004. There was then no further correspondence until 17th January 2006 when the solicitors wrote to ask about listing of the inquest. The Coroner replied indicating that he intended to hold a pre-inquest review hearing in the first half of 2006 and to list the inquest itself in late 2006 or early 2007.

10. Mr Chambers' mother and brother instructed a different firm of solicitors, Farleys, who wrote regularly to the Coroner's office in the period leading up to the inquest. Farleys described themselves as acting for "the family of Mr Chambers", although they made clear that their instructions came from his mother and brother. The Coroner's office corresponded with Farleys about arrangements for pre-inquest reviews, disclosure and the inquest hearing itself. Counsel instructed by Farleys represented Mr Chambers' mother and brother at the inquest: counsel announced himself at the start of the inquest as "representing the deceased's family".

11. On 31st August 2007, three and a half months after the verdict, Birchall Blackburn wrote to the Coroner's office for the first time since January 2006 to enquire about the inquest. The response was that the inquest had already taken place. The Coroner's office had plainly believed that Farleys were representing the family as a whole and had overlooked the earlier correspondence from Birchall Blackburn. Dr Adeley writes, and we accept, that he would have given notice to Birchall Blackburn if he had thought that Miss Chambers wished to be represented at the inquest separately from the deceased's mother and brother. Despite her young age, she was an interested person within the Coroners Rules. The failure to inform her solicitors of the hearing date after they had registered her interest with the Coroner's office was an irregularity. However, it does not follow automatically that it was a material irregularity which must lead to the inquisition being quashed.

12. In *Jordan v United Kingdom* (2003) 37 EHRR 2 the European Court of Human Rights laid down the necessary features of an investigation into a death involving agents of the state in order to comply with Article 2. The investigation must be independent; it must be effective; it must be reasonably prompt; there must be a sufficient element of public scrutiny and the next of kind must be involved to the appropriate extent.

13. Mr Matthew Stockwell for the claimant also referred us to the decision of the House of Lords in *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653. This was another death in custody case but on very different facts from the present one. The deceased, while serving a custodial sentence in a young offender institution, was murdered by his cellmate who had a history of violent and racist behaviour. The Director General of the Prison Service wrote to the family of the deceased accepting responsibility for the death. An inquest was opened, but adjourned when the cellmate was charged with murder and not resumed after he was convicted. No prosecution was brought against the prison service. The Commission for Racial Equality conducted an investigation into racial discrimination in the Prison Service with the circumstances of the deceased's death as one of the terms of reference, but declined, save to a minimal extent, to hold the hearings in public or to permit the family to participate. The Secretary of State refused the family's request for a public inquiry. That decision was challenged by judicial review. Hooper J granted a declaration that in order to satisfy the procedural duty of the state under Article 2 of the ECHR to investigate the deceased's death in custody an independent public investigation should be held with the family of the deceased legally represented, provided with the relevant material and able to cross-examine the principal witnesses.

14. This order was set aside by the Court of Appeal, but restored by the House of Lords. The House held that the state's duty to take steps to protect the lives of prisoners in custody from the criminal acts of others and, where death occurred, the state's procedural obligation to carry out an effective investigation of the circumstances

required as a minimum standard of review (whatever mode of inquiry was adopted) sufficient public scrutiny to secure accountability and an appropriate level of participation by the next of kin to safeguard their legitimate interests. Lord Bingham of Cornhill said at paragraph 21:-

> "… while any deliberate killing by state agents is bound to arouse very grave disquiet, such an event is likely to be rare and the state's main task is to establish the facts and prosecute the culprits; a systemic failure to protect the lives of persons detained may well call for even more anxious consideration and raise even more intractable problems."

15. There are obvious differences between *Amin* and the present case. In *Amin* there had been no real public scrutiny at all of whether the State had discharged its duty towards the deceased. The only public hearing had been the murder trial in which the issues were plainly different and the family were not represented. In the present case there was an inquest at which witnesses were called and at which Mr Chambers' mother and brother were represented by counsel.

16. We consider that in this case the irregularity of Birchall Blackburn not being notified of the hearing cannot be a ground for quashing the inquisition. Either the Claimant makes out her case on insufficiency of inquiry or she does not. If she does not, the fact that through oversight she and her mother and their solicitors were not notified of the inquest is unfortunate but does not vitiate the proceedings. We observe that it is now considered good practice for coroners to hold pre-inquest review hearings more promptly than was done in this case. In addition rule 9(3) of the Coroners (Inquests) Rules 2013 imposes the requirement for details of the date, time and place of all forthcoming hearings including inquests to be made publicly available in advance of any hearing. It is good practice to place these and other details on the coroner's website or the local authority's website (where available): see Chief Coroner's Guidance No.9 on Opening Inquests at paragraphs 40-41.

Insufficiency of inquiry

17. The Coroner did not leave to the jury the possibility of returning a finding of neglect. Mr Stockwell accepts that as the evidence stood when the jury were sent out to consider their verdict there was insufficient evidence for such a conclusion to have been returned. But that was, he submits, because of the Coroner's failure to hold a sufficiently wide-ranging and appropriately focussed investigation: although there was a proper inquiry into whether domestic problems, bullying in prison or both may have contributed to Mr Chambers' death, there was insufficient inquiry into the extent to which the Prison Service did or did not discharge their duty of care towards Mr Chambers.

18. We should note at this stage that as the House of Lords observed in the leading case of *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182, neglect is a term of art in the law of inquests. In the case of a suicide, a finding of neglect is only permissible where there has been a gross failure to provide (for example) basic medical or psychiatric attention and a clear and direct causal connection between the neglect and the death. Where it is found that the deceased has taken his own life that is the appropriate verdict (conclusion), and only in the most extreme circumstances (going

well beyond ordinary negligence) can neglect be properly found to have contributed to that cause of death (see *R v North Humberside Coroner ex p. Jamieson* [1995] QB 1).

19. We do not think that, even with the benefit of the fresh evidence which has been placed before us, there would be now, or would have been in 2007, any prospect of a finding of neglect.

20. But that is not the end of the Claimant's case. As the House of Lords held in *Middleton*, a short-form verdict (conclusion) in the traditional form is not always adequate in a case involving the duty of the state under Article 2 of the ECHR. Indeed, the verdict of the jury in the present case went beyond a simple finding that the cause of death was hanging. The jury found that there was not enough evidence to suggest that the prison staff were aware that Mr Chambers was being bullied, and Mr Stockwell (realistically) does not seek to reopen that issue before us. He does, however, complain of the failure of the Coroner to obtain independent psychiatric evidence as to Mr Chambers' treatment or lack of treatment during the period between his admission to HMP Preston and his death; and also of the absence from the inquest of Dr Seddon-Smith, the prison doctor who had seen Mr Chambers on at least one occasion and prescribed depressants. The doctor's place was taken at the inquest by a locum with access to Dr Seddon-Smith's notes. We do not know why Dr Seddon-Smith was unable to attend, but it does not appear that objection was taken to the matter being dealt with as it was.

21. The Claimant's solicitors have obtained expert evidence from a consultant psychiatrist, Dr Peter Snowden, dated 2nd April 2014. This is described as a "desktop" report: Dr Snowden could not of course examine Mr Chambers, but has had access to his medical records. He writes:-

> "From the evidence available to me it is clear that Stephen Chambers was a vulnerable individual, at times a fantasist (his account that his mother had died was not true) who at times, and in response to (usually) family issues, but also to issues (perhaps bullying) in the prison presented with serious self-harm behaviour. The records suggest that in a prison environment he was a significant risk of harm through hanging. There appear to have been since 1991 5 hanging incidents in prison, prior to the event that led to his death.
>
> I have no information about him in the community. There is no evidence of any contact between the prison service (healthcare) with his general practitioner in the community to identify if there was any mental health history in the community which would have been of relevance. In the setting of his history of self-harm this would have been a normal practice in my view.
>
> I cannot find any evidence that when he was seen by mental health nurses or when he was seen by doctors (and I have presumed that all his medical contacts were with prison doctors) he was given a formal medical illness diagnosis. However he was being treated with antidepressants, this

> indicates that he must have been thought to be suffering from a depressive disorder (in the International Classification of Mental Disorders ICD10 this is defined in F32). Apart from sleep disturbance at times and depressed mood there is no evidence from the notes of the symptom profile that one would expect to find in a depressive disorder. I therefore cannot give any support to a formal mental health depressive disorder diagnosis. Nevertheless he was clearly thought to have had an abnormal mental state/illness by the prison doctor, which required medication rather than support.
>
> Finally in the setting of serious self-harm, he should in my view have been assessed by a psychiatrist, and this was not done at any stage during his period in prison. HMP Preston would have had visiting psychiatrist availability. A psychiatric detailed assessment of diagnosis and risk could then have been undertaken. This was never triggered, and should have been in the setting of his history.
>
> It is also of concern that a F2052SH process initiated for self-harm (of which there was an extensive history) could be closed by staff who would not have had any specialist understanding or training in mental health assessments or risk."

22. Dr Snowden continues:-

> "I believe he was not suitably reviewed. If one considers the concept of equivalence – that a person in prison should receive the same quality of healthcare available in the community – then there were omissions. There was at no stage a psychiatric assessment, and this could have been easily accessed. Such an assessment would have allowed a better understanding of diagnosis and risk. If he had presented with same self-harm behaviour in the community, he would have been assessed in a casualty department and probably admitted for a period for psychiatric assessment.
>
> The input from mental health professionals appears to have been nurse led. Whilst this is not a criticism, at some point a psychiatrist should have been asked to see the prisoner. But, the decisions to take him off active F2052SH monitoring was taken by non-mental health professionals. In the setting of his history of risk, and the fact that he was being treated with antidepressant medication, this all suggests that mental health expertise should have been brought into the decision making process."

23. Mr Stockwell submitted that where a death in custody occurs and there is evidence that medical or psychiatric issues may have contributed to the death, an effective and independent investigation requires the obtaining of independent expert evidence. He cited two authorities in support of this argument.

24. *R (Wright) v Secretary of State for the Home Department* [2002] HRLR 1 concerned a prisoner with a long history of serious asthma who died in custody as a result of a severe asthma attack. His family attended the inquest but in the absence of legal aid had no advocate to represent them. The deceased's cellmate was not called to give evidence and a written witness statement from him was excluded as inadmissible. The doctor who primarily dealt with his treatment was similarly not called to give evidence. The jury returned a verdict of death by natural causes. It was later discovered by the claimants that the doctor in question had been banned from sole practice and had been held responsible for the death of two elderly patients through neglect. Mr Wright's family brought a claim under the Fatal Accidents Act 1976: the defendant admitted liability before the trial, so there was no public hearing in the civil courts. A request for a public independent investigation was refused.

25. Jackson J granted the family's application for judicial review of that refusal. He held that it was arguable that the Prison Service had breached Article 2 or Article 3 because of the negligent medical treatment of Mr Wright, both over a period of months during 1996 and in the minutes leading up to his death. Jackson J held that the inquest did not constitute an effective investigation for five reasons: (1) the failure to call the cellmate as a witness although he was available and willing to attend, (2) the failure to consider the shortcomings in the medical treatment given to Mr Wright and the fact that no independent expert reviewed the adequacy of this treatment, (3) the failure of the Prison Service to disclose the restrictions under which the prison doctor was practising and the lack of investigation as to whether he had played an excessive and unsupervised role in Mr Wrights treatment, (4) the lack of representation for the claimants at the inquest and (5) the non-compliance by reasons of factors 1-4 with the requirement enumerated by the European Court of Human Rights in *Jordan v UK*. He observed at paragraph 63 that "our courts have always recognised the particular need for a thorough inquest when a person dies in custody".

26. Mr Stockwell also relied on *R (Warren) v HM Assistant Coroner for Northamptonshire* [2008] Inquest LR 65; [2008] EWHC 966 (Admin). In that case Michael Bailey had committed suicide in the segregation unit of HMP Rye Hill. Prior to the period shortly before his death there was no history of any mental illness and no psychotic episodes. But for about a week before his death he was behaving very bizarrely and out of character. Four days before his death he stripped naked and walked around the exercise yard at the prison, reciting the Lord's Prayer and saying that he was ready to die. He had clearly become significantly mentally disturbed.

27. Three prison officers were charged with the manslaughter of Mr Bailey through gross neglect and another was charged with conspiracy to pervert the course of justice. The trial judge in the Crown Court accepted submissions that each defendant had no case to answer and each was thus acquitted. Arrangements were then made for an inquest which was due to last four weeks and to involve the calling of forty witnesses. The prosecution in the criminal proceedings had obtained a report from a registered nurse and trained investigator, Ms Frances. She prepared a report which was very critical of the suicide and self harm policy at the prison. This was made available to the Prisons and Probation Ombudsman who published a 66 page report on the case in July 2007. He concluded that the circumstances surrounding Mr Bailey's death were among the most disturbing he had come across in almost 300 cases of self-inflicted deaths that

had been investigated, and said that there had been "individual and systemic failures of disturbing proportions".

28. In the period between the PPO's report and the inquest Mr Bailey's family obtained a report from a consultant psychiatrist, Dr Trevor Turner. The Coroner rejected the family's request for Dr Turner to be called. The grounds for doing so were that all relevant medical and healthcare issues were dealt with adequately by the evidence of Ms Frances and the doctors at the prison; that "the hypothetical situation of how Mr Bailey would have been treated had he been in the community" was irrelevant; and that it would be inappropriate for Dr Turner "to give expert evidence concerning the role of a GP within the Prison Service".

29. The family of the deceased applied for judicial review of the Coroner's decision. In a judgment delivered on 29th April 2008, a week before the inquest was due to start, Foskett J granted judicial review. He declined to issue a mandatory order requiring the Coroner to call Dr Turner but said at paragraphs 42-44 that:-

> "[An] inquest in this particular case that does not have available to it evidence from an independent consultant psychiatrist and, I would add, an independent general practitioner, would not comply with Article 2 … I should emphasise that this decision is confined solely to the facts of this particular case. It does not necessarily follow that evidence of this kind will be required in every case of a suicide in prison."

Discussion and conclusion

30. Both *Wright* and *Warren* are cases with exceptional features. In *Wright* these included the fact that the shortcomings in the deceased's medical treatment were so clear that liability for negligence was admitted; that the prison doctor responsible for Mr Wright's treatment had been subject to restrictions on his practice; and yet he had not been called at the inquest, at which the family had no lawyer to represent them. In *Warren* there had been charges of manslaughter and perverting the course of justice brought against prison officers, and a finding by the Prison and Probation Ombudsman of "individual and systemic failures of disturbing proportions", yet the Coroner was declining to call a independent consultant psychiatrist who had prepared a report at the request of the family.

31. Both these decisions are clearly correct, but they do not assist in the present case. They do not support the Claimant's bold contention that independent psychiatric evidence must be called in every case of suicide in prison where there may be a mental health issue. Each case must be determined on its own facts. To suggest otherwise would be to fetter the discretion of the coroner. It is long-established law and practice that the coroner has a wide discretion in deciding which witnesses to call (see *Mack v HM Coroner for Birmingham* [2011] Inquest LR 17; [2011] EWCA Civ 712 at paragraph 9; *R (LePage) v HM Assistant Coroner for Inner South London* [2012] Inquest LR 31; [2012] EWHC 1485 (Admin) at paragraphs 44-54). This includes expert witnesses (see *R (Takoushis) v Inner North London Coroner* [2006] 1 WLR 461 at paragraph 61) such as psychiatrists (see, for example, *R (Warren) v HM Assistant Coroner for Northamptonshire* [2008] EWHC 966 (Admin) at paragraph 41).

32. Dr Snowden's report suggests at its highest that there was a potential need for a referral of Mr Chambers to a psychiatrist 'at some point'. In some cases that would have been the appropriate action. In this case it would not, for the reason quite simply that Dr Snowden, having reviewed the medical history of Mr Chambers, could not himself 'give any support to a formal mental health depressive disorder diagnosis'. Mr Chambers undoubtedly suffered from low mood and declared himself at times to have a depressed mood. But he was treated accordingly, under the care of the prison healthcare team, nurses and general practitioners. That team makes the decision when appropriate to refer a prisoner to a psychiatrist; no such decision was made in this case.

33. In those circumstances Dr Snowden adds little or nothing to the medical picture. He expresses the opinion that there should have been a psychiatric referral but finds nothing in the medical history to suggest that a psychiatrist, if the referral had been made, would have been likely to recommend any different treatment from that given by the healthcare team. In that sense he neither supports the Claimant's contention for 'insufficiency of inquiry', nor presents 'new facts or evidence' (section 13, Coroners Act 1988) of any substance.

34. Looking at the broader picture we are satisfied that there was sufficiency of inquiry in this case on all relevant issues. In particular there was sufficient inquiry into the management of the risk of suicide. Having reviewed the evidence which was called by the coroner, we observe that there was evidence before the jury on a range of relevant self harm issues: procedures relating to self-harm, general guidance, the 2052SH form process (including opening and closing of forms), the chronology of the use of forms in relation to Mr Chambers, the regular reviews of the forms in his case, and the specific decision to close the form on 16 December 2003.

35. Three reviews were conducted after Mr Chambers' death into the healthcare he had received. Two of the reviewers, Ms Rimmer and Dr Allen, gave evidence at the inquest. All concluded that the care provided was of a reasonable standard and equivalent to care which would have been provided in the community. Apart from suggesting that there should have been a psychiatric referral, Dr Snowden does not disagree. He does not criticise the treatment provided.

36. In the end the principal focus for the jury in this inquest was directed at the possible reasons for Mr Chambers taking his own life (the fact of which was never in dispute), namely family relationships and bullying in prison. These were the topics which emerged through the evidence as the central issues in the case. Hence the coroner focussed on these issues in his written questionnaire to the jury.

37. We have already referred to the fact that the jury concluded with a narrative verdict (conclusion). They did so having considered a number of questions which the coroner placed before them in writing. These questions had been discussed with counsel in advance of the coroner's summing up. They included questions, as the questionnaire stated in its preamble, on 'central factual matters', including matters which may potentially have caused or contributed to his death such as problems with family relationships and bullying in prison.

38. Although these matters were the primary focus of the questionnaire, the coroner did not exclude the jury from making findings on other facts, so long as they were central

facts. That approach was in our view correct. In *Middleton* above, at paragraph 45, the House of Lords stated:

> "By one means or another [by short-form conclusion, narrative conclusion or conclusion given in answer to the coroner's questions] the jury should, to meet the procedural obligation in article 2, have been permitted to express their conclusion on the central facts before them."

39. Hence the coroner's additional words to the jury in the written questionnaire: 'If you wish to comment upon other factual matters central to the circumstances surrounding the death of Stephen Chambers please do so …' It should be noted that the coroner had drawn the jury's attention in his summing up to the evidence of the medical care and the systems of suicide prevention. He had also addressed the question of findings on the prison's systems in the summing up. When introducing the questionnaire he directed the jury (at pages 71-72) :

> "These questions [on family problems and bullying], in my view, address central factual issues in the case. But, members of the Jury, what are the central issues in the case are a matter for you. If I have not addressed an issue which you think is an important issue you should record your findings on this point, whether this relates to an individual's conduct or a system operated by the prison. If you identify any actions by an individual or defects in any system operated you should go on to consider whether or not this problem may have caused or contributed to Stephen Chambers' death."

40. If the jury, having heard the evidence and followed the coroner's directions, had wanted to conclude that the risk assessment process was inadequate they were free to make findings accordingly. In their narrative conclusion, to which we have already referred, the jury did make findings about contributory factors, particularly family problems and bullying. It must therefore be presumed from their silence on any other issues that they either found that risk management issues were not central issues in the case or that, if they were, there was no good reason to make findings about them.

41. For these reasons we reject the submission that there was insufficiency of inquiry. In our judgment the scope of the coroner's inquiry was sufficiently full for the purposes of this particular case.

42. All prison death cases, especially self harm cases, must be given the most careful public scrutiny. As Lord Bingham said in *R (Amin) v Home Secretary* [2004] 1 AC 653 at paragraph 30: "The state owes a particular duty to those involuntarily in its custody." Lord Hope said in *R (Sacker) v West Yorkshire Coroner* [2004] 1 WLR 796 at paragraph 11: "So all the facts surrounding every suicide [in prison] must be thoroughly, impartially and carefully investigated." It is therefore the duty of the coroner, acting as an independent judicial officer, to ensure that the process of inquiry is rigorous and full. In our judgment, on the particular facts of this case, it was. To comply with the procedural obligation in Article 2 of the European Convention of Human Rights the investigation must be 'effective': see *Amin*, above, at paragraph 25. In our judgment it was.

43. It was for these reasons that at the conclusion of the oral hearing on 16 December we indicated, considering section 13 of the Coroners Act 1988 (as amended), that we were not satisfied that it was necessary or desirable in the interests of justice that another investigation should be held. We do not quash the inquisition of the inquest. The Claimant's application is therefore refused.