Neutral Citation Number: [2015] EWHC 2106 (Admin)

Case No: CO/376/2015

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
DIVISIONAL COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: Monday 20th July 2015

Before :

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

- -

Between :

DORIS SHAFI	**Claimant**
- v -	
HER MAJESTY'S SENIOR CORONER FOR EAST LONDON	**Defendant**

(Transcript of the Handed Down Judgment of
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Official Shorthand Writers to the Court)

John Lofthouse (instructed by **Imran Khan and Partners)** for **the Claimant**
Debra Powell (instructed by **The Solicitor, London Borough of Waltham Forest**) for the **Defendant**

Hearing date : 7 July 2015
Judgment
As Approved by the Court

Lord Justice Bean :

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

Introduction

1. This is an application by Doris Shafi, brought with the *fiat* of the Solicitor General under section 13 of the Coroners Act 1988 (as amended), to quash the inquest into the death of her son Lee Bradley Brown ('Lee') and to order a fresh investigation and inquest.

2. Lee died in custody at a police station prison in Dubai, United Arab Emirates, on 12 April 2011. At the inquest held on 10 October 2013 the coroner, the then senior coroner for the coroner area of East London, recorded an open conclusion with the medical cause of death described as 'unascertained'.

3. The applicant, represented by Mr Lofthouse of counsel, submits that the application should be granted in the interests of justice because there was insufficiency of inquiry by the coroner in the collection of evidence, in calling a limited number of witnesses and in the questioning of witnesses who were called. He also submits that there was irregularity in the proceedings by virtue of the coroner's decision to conduct the inquest without a jury and in admitting some written evidence from Dubai.

4. We are grateful to Mr Lofthouse and his instructing solicitor, Ms Kestler, who both appeared *pro bono* on the claimant's behalf. As is usual in this kind of proceedings, the defendant coroner was represented by counsel, Ms Debra Powell, who assisted the court while adopting a neutral stance.

A summary of the facts

5. In view of our conclusion that a fresh inquest should be held (see below), it would not be appropriate for us to do more than summarise the facts of the case.

6. Lee was a British national, born on 18 June 1971. He arrived in Dubai on 7 April 2011 apparently as a tourist. He booked into a room on the sixth floor of the well-known Burj al Arab Hotel.

7. On the same day Lee had an argument with a chambermaid. There is a dispute as to what happened. She and other hotel staff allege that he attacked her in his room, dragged her out and tried to throw her over the sixth floor balcony. He, on the other hand, denied this account. He told the Dubai police authorities that he had believed she was in his room for the purpose of stealing from him. Although he had been abusive to her and had pushed her out of the room he had not assaulted her as alleged.

8. The local police arrested Lee and took him to Bur Dubai Police Station and subsequently to the attached prison. He was interviewed by the Public Prosecutor.

9. Various witnesses in the Public Prosecutor's file, which was disclosed to the coroner, refer to unusual behaviour by Lee, such as taking his clothes off and exposing himself as well as attempts to escape and fight with other prisoners. The GP notes in England refer to a time in 2002 when he was 'mentally disturbed' but nothing since.

10. In due course Lee was placed in a cell in solitary confinement. He died in that cell some five days after his arrest. According to the Dubai authorities Lee was found dead in his cell some time late in the evening of 12 April 2011.

The medical cause of death

11. A number of rumours circulated after Lee's death suggesting that he had been 'beaten to death' in prison while in solitary confinement. Mrs Susan Gibbons, Lee's sister-in-law, gave evidence before the coroner that she received telephone calls around the time of his death from inmates of the prison who were worried about Lee because he had been beaten badly by the Dubai police 'with blood around his face and chest'. These were clearly matters of considerable concern for the family in England.

12. But the medical evidence, both from Dubai and England, showed otherwise.

13. A 'medical examiner' in Dubai, Dr Yosri Fathi Habib, in a report dated 14 April 2011, found only minor injuries which had been caused four or five days before death and which bore 'no relationship to the death'.

14. In England, an experienced forensic pathologist, Dr Ben Swift, concluded that there were 'no significant traumatic injuries'. In his report dated 27 April 2011, following his post-mortem examination, Dr Swift found that there were no injuries, internally or externally, which could account for Lee's death. He repeated that conclusion in evidence: 'Injuries present on the deceased were all relatively minor; there were no injuries present either externally or internally that could account for his death.' Nor was there evidence of compression of the neck.

15. The doctors did, however, disagree on the cause of death. Dr Habib concluded that the cause of death was 'asphyxiation due to vomit leaking into the airways'. Dr Swift could not agree. Vomit in the airways could be seen as a post-mortem change. He was unable, however, to find a cause of death, natural or unnatural, hence his finding, which was adopted by the coroner, that the medical cause of death was 'unascertained'.

The jurisdiction of the coroner

16. The coroner assumed jurisdiction to inquire into the death as soon as Lee's body was brought back to within the East London coroner's area. Since the decision of the Court of Appeal in 1982 in *R v West Yorkshire Coroner, ex parte Smith* [1983] QB 335 (the case of Helen Smith) coroners in England and Wales have been under a duty to investigate a death which occurred overseas if the body is returned to the coroner's district and the circumstances are such that an investigation would have been conducted if the death had occurred in England and Wales.

17. In this case the coroner was obliged by section 1(2)(b) of the Coroners and Justice Act 2009 to conduct an investigation into the death because he had reason to suspect that the cause of death was 'unknown'. Under section 6 of the 2009 Act a coroner who conducts an investigation into a death is under a duty to hold an inquest. Accordingly the coroner opened and adjourned the inquest into Lee's death for further inquiries.

Requests for information

18. As part of those inquiries the coroner sought relevant information from the Dubai authorities. As is usual in such cases he did so through the good offices of the Consular Division of the Foreign and Commonwealth Office ('FCO').

19. In a formal letter of request dated 27 October 2011 the coroner asked the authorities in Dubai for copies of the autopsy and toxicology reports, the death certificate, witness statements and 'details of any CCTV footage from the scenes'. All items were forthcoming from the Public Prosecutor in Dubai except the details of CCTV footage.

20. It appears that the Public Prosecutor had expected CCTV footage to be available because various orders were made by him which included retrieval of video recordings from the hotel, the Public Prosecutor's office and the police station prison. Nevertheless, no CCTV footage or stills was ever produced for the coroner.

The CCTV footage

21. It is on this issue of the CCTV that the applicant makes complaint of insufficiency of inquiry. Mr Lofthouse submits that the coroner did not do enough to obtain this material and should therefore not have proceeded to inquest without further inquiry.

22. We do not agree. In our judgment the coroner did enough to try and obtain the CCTV evidence. We are not saying that he might not have done more, in view of the repeated concerns of the family about this material. He might have been wise to have done more, and we shall return to this later. But sufficient steps were taken in all the circumstances to comply with his legal duties.

23. The applicant's helpful chronology shows that, in addition to the formal request of 27 October 2011 (paragraph 19 above), the coroner's officer made 'about eight documented instances of….requesting CCTV footage', that the FCO had also requested footage and with a number of 'chasers' (follow up requests), but all to no avail.

24. In due course the applicant's solicitors asked the coroner to make another formal request for the CCTV but he declined. By email dated 21 August 2013 the coroner's officer provided the solicitors with an extract from an email from the Emirati Ministry of Foreign Affairs (received via the FCO) confirming that the coroner's initial requests had been complied with 'but not the CCTV footage' and that 'the legal authority … claimed that [was] all the information they have .. and [we] are not expecting any farther information from the legal authority because they already provided everything they have'.

25. On that information the coroner decided on 21 August 2013 that the CCTV would not be forthcoming and that the inquest would proceed in October.

Difficulties in obtaining information; when to proceed

26. We do not criticise the coroner for this approach. There is only so much that a coroner can do to obtain evidence from a foreign state, however friendly. The coroner has no power to investigate overseas, send investigators overseas or require police to investigate overseas. Nor can the coroner compel the disclosure of documentation from the overseas country or compel witnesses from the country to attend to give evidence.

27. As Lord Lane CJ said in the *Smith* case more than 30 years ago ([1983] QB 335 at 355, see paragraph 16 above):

> "Inevitably a coroner conducting an inquisition into a death abroad will be faced with difficulties of evidence and so on, but that must have been so ever since the statute of George II … Coroners re well experienced [in] dealing with such problems."

That remains true today. The coroner will make all reasonable efforts to obtain sufficient relevant evidence, with the purpose of holding a full inquiry. That is all the more important in the case of a death in custody overseas.

28. The coroner will then decide in the exercise of his judicial discretion when to hold the inquest. It will be held when the coroner considers that either there is sufficient information available or further requests for information are not likely to be productive.

29. Some families will be disappointed when information is not in their view sufficiently forthcoming from the overseas country. They may expect the coroner to do more.

30. But experience shows that there must come a time when coroners have to be realistic and when no useful purpose would be served in deferring the hearing of the inquest further. At that stage the coroner must proceed with the inquest on the basis of the material (even if limited) before him, so long as he is satisfied that it would be in the interests of justice to do so.

31. The coroner's discretion as to whether to proceed must be exercised therefore in the light of all the information available, being fair to all concerned. This process must involve a careful assessment of all the circumstances, including consideration of any submissions made by interested persons, especially the family of the deceased.

32. It is not in the public interest for requests by coroners for information or further information to remain outstanding for an indefinite period of time just in the hope that more information may be forthcoming.

33. In the inquest itself there must always be sufficient inquiry by the coroner, but what is sufficient will depend on the circumstances of the individual case.

34. In these cases involving deaths overseas, where questions about evidence are raised and there are issues to be decided such as whether a jury should be summoned, the coroner should usually hold a pre-inquest review hearing. We shall return to this later.

35. The applicant also complains that the coroner failed to request other material from the Dubai authorities. In view of our conclusion in this case we do not need to address this point.

Written evidence: Rule 23

36. The applicant further submits that the coroner wrongly admitted written evidence under Rule 23 of the Coroners (Inquests) Rules 2013. Mr Lofthouse places his submissions on this point under both the headings of insufficiency of inquiry and of irregularity of proceedings.

37. The coroner's approach to evidence at the inquest was to call the English pathologist, Dr Swift, and Mrs Gibbons, Lee's sister-in-law (see paragraph 11 above), to give live evidence. In addition the written statements of two toxicologists from England and the GP were admitted in evidence without objection because their evidence was not in dispute.

38. The rest of the evidence, which was brief, was from Dubai. No witnesses from Dubai were called to give live evidence. The evidence was admitted by the coroner in written form and was read out by him. It included a brief extract from the report of the Chief Prosecutor, Mr Sami Al-Shamsi, and the reports of the medical examiner, Dr Habib, and the toxicologist, Hoda Saeed.

39. At the beginning of the inquest the coroner announced that he would be admitting evidence by way of written statements under Rule 23, naming the witnesses from Dubai and the nature of the evidence they would give. He gave his reasons:

> "Written evidence in this case is going to be admitted because there is good and sufficient reason to believe the maker of the written evidence will not attend the inquest hearing and that's on a basis of the discussions we have had with some of the Dubai authorities and the very basic fact that they are not compellable, they can't be made to come … I then need to set out that any Interested Person may object to the admission of any such written evidence, I can record the objection and consider it but the final decision will be mine …"

40. Mr Lofthouse, for the family, then objected to the admissibility of the Dubai evidence in its entirety. He submitted that the coroner should disclose the nature of the discussions with people in Dubai and that he should see 'whether there is anything that could be done to get anybody here who could actually say what happened'. He made further submissions about the absence of the CCTV and other evidence (which we need not repeat) and argued that it would be premature for the inquest to go ahead.

41. The coroner rejected counsel's submissions and proceeded with the inquest.

42. Rule 23 of the Coroners (Inquests) Rules 2013 provides for the admission of written evidence in four different ways:

Written evidence

23.— (1) Written evidence as to who the deceased was and how, when and where the deceased came by his or her death is not admissible unless the coroner is satisfied that—

(a)it is not possible for the maker of the written evidence to give evidence at the inquest hearing at all, or within a reasonable time;

(b)there is a good and sufficient reason why the maker of the written evidence should not attend the inquest hearing;

(c)there is a good and sufficient reason to believe that the maker of the written evidence will not attend the inquest hearing; or

(d)the written evidence (including evidence in admission form) is unlikely to be disputed.

(2) Before admitting such written evidence the coroner must announce at the inquest hearing—

(a)what the nature of the written evidence to be admitted is;

(b)the full name of the maker of the written evidence to be admitted in evidence;

(c)that any interested person may object to the admission of any such written evidence; and

(d)that any interested person is entitled to see a copy of any written evidence if he or she so wishes.

(3) A coroner must admit as evidence at an inquest hearing any document made by a deceased person if the coroner is of the opinion that the contents of the document are relevant to the purposes of the inquest.

(4) A coroner may direct that all or parts only of any written evidence submitted under this rule may be read aloud at the inquest hearing.

43. The coroner relied on Rule 23(1)(c), namely that there was good and sufficient reason to believe that the witnesses would not attend the hearing to give evidence. He did not explain what the 'good and sufficient reason' was other than to say that it was 'on a basis of the discussions we have had with some of the Dubai authorities' (see paragraph 39 above). He did not explain who had held the discussions nor with whom, nor what was said. He did not explain, for example, whether any relevant witnesses were unwilling to attend or whether the overseas state did not wish them to attend.

44. The word 'attend' in Rule 23(1)(c) (also used in Rule 23(1)(b)) is not, in our judgment, restricted to attendance in person. In the modern age attendance at meetings is often effected in ways other than by attendance in person, for example by telephone or video

link or Skype and other similar software products which provide internet video calling. Much time, money and inconvenience are saved by making use of video and audio links.

45. Video links are now also a common feature of criminal and civil proceedings as well as coroner hearings. Rule 17 of the 2013 Rules provides for just this kind of attendance. A coroner may direct that a witness may give evidence at an inquest hearing through a live video link. We do not believe, at least for the purposes of coroner proceedings, that 'video link' should be restricted to a formal court link, court to court. It may also include other forms of link as long as they are by way of video so that the witness may be clearly seen and heard.

46. There are safeguards in Rule 17 so that video links are not used unfairly. But as the heading to Part 4 of the 2013 Rules suggests ('Management of the inquest hearing'), evidence by video link is a case management tool available for the benefit of the coroner process where appropriate. That will sometimes include facilitating evidence from witnesses overseas. One of the purposes of using a video link, as Rule 17(2) explains, is to 'allow the inquest to proceed more expediently'.

47. The coroner in this case had a number of options. He could have invited the key witnesses to attend in person. If they could not or would not, he could have invited them to 'attend' by video link. If they could not or would not, he could have considered whether their evidence, if available in writing, should be read, using the provisions of Rule 23.

48. In this case, it is not clear from the information provided that the coroner submitted himself to this process, certainly not from what was expressed clearly and openly to the deceased's family in correspondence or at court. There is nothing to suggest one way or the other that the witnesses had refused to attend either in person or by video link.

49. In our judgment this was a significant failure in due process. The coroner himself seems now to acknowledge that that may be the case. In his statement for these proceedings he writes:

> "I can confirm that I had formed the view that the makers of the reports in Dubai would not attend the inquest hearing. In addition, given the post mortem findings of Dr Swift and, in particular, his opinion that there was no evidence that a violent traumatic injury had played any part in the death, I did not consider that the evidence of any of the Dubai witnesses was needed live. <u>On mature reflection, that is a step that could have been explored further</u>**.**" [our emphasis]

50. The fact that there was no evidence of this being a violent death, either from the doctor in Dubai or the pathologist in London, did not mean that all questions had been answered. They were not. The medical cause of death and the mechanical cause of death (how the deceased came by his death) remained unexplained. All reasonable steps should have been taken to try and secure the 'attendance' of relevant witnesses to these issues. Mr Lofthouse's request to the coroner to see 'whether there is anything that could be done to

get anybody here who could actually say what happened' (see paragraph 40 above) was in the circumstances not without validity.

51. For this reason alone we are satisfied that there was insufficiency of inquiry within the meaning of section 13 of the 1988 Act. We conclude that more could have been done and should have been done to seek the attendance in one way or another of relevant witnesses from Dubai. The coroner was wrong to admit the written evidence from Dubai without making further inquiry.

Whether a jury was required

52. Section 7 of the Coroners and Justice Act 2009 provides, so far as material:

> "(1)An inquest into a death must be held without a jury unless subsection (2) or (3) applies."
>
> (2)An inquest into a death must be held with a jury if the senior coroner has reason to suspect—
>
> (a)that the deceased died while in custody or otherwise in state detention, and that either—
>
> (i)the death was a violent or unnatural one, or
>
> (ii)the cause of death is unknown,
>
> (b)that the death resulted from an act or omission of—
>
> (i)a police officer, or
>
> (ii)a member of a service police force, in the purported execution of the officer's or member's duty as such, or
>
> (c)that the death was caused by a notifiable accident, poisoning or disease.
>
> (3)An inquest into a death may be held with a jury if the senior coroner thinks that there is sufficient reason for doing so."

53. The provisions of section 7 of the 2009 Act on whether a jury is required for an inquest came into force in July 2013 and were therefore applicable at the time of the inquest in October 2013.

54. Section 7 has mandatory and discretionary provisions.

55. The applicant submits first that the mandatory provisions of section 7(2)(a) apply because this was a 'death in custody' and that phrase applies to deaths in custody in any country, secondly, in the alternative, that if the mandatory provisions do not apply the coroner should have exercised his discretion under section 7(3) to summon a jury because there was sufficient reason for doing so.

56. The applicant's solicitors had requested a jury by letter. The coroner ruled in writing on 8 October 2013 that the mandatory provisions did not apply because this death in custody was overseas. At the inquest hearing he stated that it was not a case for the exercise of discretion under section 7(3) to summon a jury. It was not, he said, a complex case and if the death had been in custody while in England there would have been no requirement for a jury because Dr Swift's conclusion of 'unascertained death' could easily mean 'unascertained natural cause' of death. We shall do no more than observe that when he gave evidence Dr Swift did not accept that his conclusion 'unascertained cause of death' meant 'unascertained natural death'. The death could have been natural or unnatural, hence his view that it was 'unascertained'.

57. There is no binding authority on the point. *Re Neal* (1995) 37 BMLR 164 was a case about a British tourist killed by carbon monoxide poisoning from a defective water heater in a rented apartment in Spain. An inquest was held by a coroner sitting without a jury at which an open verdict was returned. On an application to the High Court to quash the inquest and order a new one the deceased's parents contended *inter alia* that a jury had been required under section 8(3)(d) of the Coroners Act 1988 (repealed by the 2009 Act), since the death had occurred in circumstances the continuance or recurrence of which was prejudicial to health and safety. Staughton LJ said:

> "Then I turn to the fourth point: the fact that the coroner did not summon a jury. In the light of what I have just said this was a case which cried out for an inquiry into the possibility of repetition. It may well be that the coroner should have summoned a jury in this case. Nobody, in fact, suggested to him that he should do so. But it seems to me that he could very well have said to himself, 'There are circumstances here which point to a danger of repetition or recurrence,' and thought the case to be within section 8(3)(d).
>
> Mr Burnett, who appeared for the coroner, has argued that that passage in section 8 does not apply when the inquest is on a death that occurred abroad. We have been referred to some familiar cases about the territorial application of English statutes. I can quite see in section 8(3)(a), (b) and (c) that it may be that those paragraphs would not apply when the death occurred abroad. Those deal with death in prison, death in police custody and death from accident, poisoning or disease for which notification is required. The same reasoning does not apply to paragraph (d). It seems to me just as important that the section of the public who travel to Spain on holiday should be protected from dangerous gas heaters as the section of the public which stays at home. So I reject the argument that paragraph (d) does not apply when the death occurs abroad.
>
> As I have said, I consider that the coroner could well have summoned a jury in this case, and possibly that he should have done."

58. This passage (in an apparently unreserved judgment) is not easy to follow, since it does not distinguish clearly between mandatory and discretionary provisions about summoning a jury. In any event it is clearly *obiter* in what it says about deaths in custody.

59. Section 8(3)(d) of the 1988 Act was also considered in *R (Paul) v Deputy Coroner for the Queen's Household and Assistant Deputy Coroner for Surrey* [2008] QB 172, the case concerning the inquest into the deaths in Paris of Diana, Princess of Wales, and Dodi Al-Fayed. The Divisional Court held that section 8(3)(d) required the inquest to be held with a jury. Again this does not answer the question of whether a jury is required for an inquest into a death in custody abroad.

60. In our view the legislative policy underlying section 7(2)(a)-(b) of the 2009 Act is clear. Where a death occurs in custody or because of the act or omission of a police officer, the actions of agents of the State are under scrutiny; and the verdict at the inquest must be returned by a jury, as a body of people who are *and are perceived to be* wholly independent of the State. Similar policy reasons underlie section 69(1)(b) of the Senior Courts Act 1981, which preserves (subject to exceptions) the right to jury trial on the application of any party to a civil claim for malicious prosecution or false imprisonment. In neither case is Parliament saying that coroners or judges are unfit to make independent decisions: after all, they now sit alone in most of the cases they try. The policy is, we think, based on perception. But we do not consider that it applies with the same force where it is the agents of a foreign State whose acts or omissions are under scrutiny.

61. Ms Powell also points out that section 48 of the 2009 Act, the interpretation section, states that a person is in "state detention" for the purposes of the Act if he is compulsorily detained by a public authority within the meaning of section 6 of the Human Rights Act 1998. It also defines "service police force" as meaning the Royal Navy Police, Royal Military Police or Royal Air Force Police. These two definitions plainly refer to UK institutions. If Mr Lofthouse is right in his submissions about the circumstances in which section 7 requires a jury for an inquest into a death abroad, it would result in two striking anomalies. A jury would have to be summoned in all cases where the death occurred in prison anywhere in the world, and in all cases of compulsory detention on the grounds of mental illness in the UK only, but not in cases of compulsory detention on grounds of mental illness elsewhere. Similarly a jury would have to be summoned in all cases where the death occurred in civilian police custody anywhere in the world, and in all cases of death in service police custody in the UK, but not in cases of death in service police custody elsewhere. It seems highly improbable that Parliament should have intended to create such anomalies.

62. We do not, therefore, consider that section 7(2)(a) of the 2009 Act requires a coroner to summon a jury in every case of a death in custody abroad.

63. It should be noted that the precise words 'the deceased died while in custody or otherwise in state detention' in section 7(2)(a) of the 2009 Act are also to be found in section 1(2)(c) of the Act.

64. Section 1 provides for the circumstances in which a coroner has a duty to investigate a death. Once the coroner is made aware that the body of a deceased person is within the

coroner's area, the coroner has a duty under section 1(2) to investigate the death if the coroner has reason to suspect that

(a) the deceased died a violent or unnatural death,
(b) the cause of death is unknown, or
(c)the deceased died while in custody or otherwise in state detention. [our emphasis]

65. In our judgment there is nothing in the wording or structure of the 2009 Act to suggest that Parliament intended the words 'while in custody or otherwise in state detention' in section 1(2) to have any different meaning from the same words in the jury section, section 7. We emphasise that the point was not raised or argued before us, but we are firmly of the view for the reasons set out above that they have the same meaning.

66. For the purposes of section 1 this means that the duty to investigate a death in custody (or otherwise in state detention) overseas, assuming the body has been repatriated to the coroner's area for burial or cremation, does not arise *per se* but only where the coroner has reason to suspect under section 1(2)(a) that the deceased had died a violent or unnatural death or under section 1(2)(b) that the cause of death was unknown.

67. We would expect all coroners to be particularly vigilant about any death in custody overseas. Any potential suicide, for example, would be investigated as a violent or unnatural death. Uncertainty about the cause of death, as in this case, would be investigated because the cause of death is unknown. But if, for example, the coroner were satisfied on credible evidence or information that the death was from natural causes, no inquest need be held.

68. Mr Lofthouse's alternative submission is that the coroner should have exercised his discretion to summon a jury under section 7(3) because there was sufficient reason for doing so. In view of our conclusion that there should be a fresh inquest, we do not rule on this submission. In many cases the coroner will exercise the discretion to summon a jury as if the death were in custody in England and Wales. Whether, however, there should be a jury in this case in the exercise of the coroner's discretion will be a matter for the new coroner.

69. No doubt the coroner will wish to consider, amongst other matters,

(1) the observation in *Paul* at [44] that a factor relevant (but not determinative) to the exercise of the coroner's discretion which ought to be taken into consideration is the wishes of the family;
(2) submissions made on behalf of the family (and any other Interested Person);
(3) the further observation in *Paul* at [45] that it is appropriate to 'consider whether the facts of the instant case bear any resemblance to the types of situation covered by the mandatory provisions';
(4) the uncertain circumstances of the death in custody;
(5) the uncertainties of the medical evidence; and
(6) whether any witnesses from Dubai will attend to give evidence in person or by video link, or whether written evidence from Dubai will be admitted.

70. It should also be noted that the Divisional Court in *Paul* at [42] advised that no decision on whether to summon a jury should be made until after the coroner had determined the

scope of the inquest. But we are not expressing a view on how the coroner will exercise her discretion. That will be entirely a matter for her.

No pre-inquest review hearing

71. We cannot leave this case without observing that the good management of this case demanded a pre-inquest review hearing (PIRH) to be held. Under Rule 6 of the 2013 Rules a coroner may at any time hold a pre-inquest review during the course of an investigation and before an inquest hearing. One should have been held in this case.

72. The Rules do not prescribe the circumstances in which a PIRH should be held. But a PIRH should usually be held in any case of complexity or difficulty or which raises issues which are best determined openly and fully at a public hearing. Deaths in custody (except where the death is from natural causes and there is no other issue) will always require a PIRH. Deaths overseas are very likely to require one, especially where, as here, there were issues of obtaining evidence from witnesses overseas, disclosure, scope of the inquest, timing of the inquest and whether a jury should be summoned.

73. These were all issues that were best raised, considered and decided in a public PIRH. This was, after all, a case where the family had considerable (and understandable) concerns about the death. The applicant's solicitors had asked for a PIRH on more than one occasion. There were, in our judgment, good reasons for holding one.

74. It is often better for important outstanding issues to be aired and resolved publicly before the inquest at a PIRH, with a written agenda in advance and brief written decisions afterwards.

75. In this case the issues of evidence and whether to summon a jury were not insignificant. From the family's point of view there was much to discuss. Suspicions needed to be raised, if not allayed. A hearing would have been better than correspondence.

76. A PIRH would also have given the coroner the opportunity to consider whether it might have been wise in all the circumstances to accede to the family's request and make one last formal attempt to obtain the CCTV footage.

77. In the end the inquest commenced with submissions from Mr Lofthouse on the outstanding issues, rather in the form of a PIRH but somewhat late in the day. It seems to us that this aspect of the hearing, taking up (at least in transcript pages) about one third of the hearing, was something of a distraction from the inquest itself. A separate PIRH would have been better.

78. We do not conclude that the failure to hold a PIRH was in itself an irregularity of proceedings but we are of the firm view that one should have been held well in advance of the inquest.

Conclusion

79. In conclusion we are satisfied that as a result of the insufficiency of inquiry in relation to the Dubai evidence it is necessary and desirable in the interests of justice that another investigation and inquest should be held.

80. We therefore quash the conclusions of the inquest held on 10 October 2013 into the death of Lee Bradley Brown and order a fresh investigation and inquest to be conducted by the new senior coroner for the East London coroner area.
81.