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Case No: IHQ/12/0864

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 20/06/2013

Before :

THE HONOURABLE MR JUSTICE JEREMY BAKER

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Between :

WORCESTERSHIRE COUNTY COUNCIL	**First Claimant**
WORCESTERSHIRE SAFEGUARDING CHILDREN BOARD	**Second Claimant**
- and -	
HM CORONER FOR THE COUNTY OF WORCESTERSHIRE	**Defendant**

- -
- -

Mr Bernard Thorogood (instructed by **Browne Jacobson LLP**) for the **Claimants**
Mr Jonathan Hough (instructed by **Withers LLP**) for the **Defendant**

Hearing date: 2nd May 2013

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Judgment

Mr Justice Jeremy Baker :

1. On the afternoon of 3.3.11, 16 year old Dana Baker, was found hanging from a tree near a traffic island in Kidderminster. Despite the efforts of the police and paramedics who attended at the scene, she was pronounced dead.

2. Dana had had a troubled life. There were allegations that she had been sexually abused as a young child by a friend of the family, but this did not result in criminal proceedings. However further allegations of sexual abuse when she was older eventually resulted in criminal proceedings being commenced against her karate instructor. These proceedings were current at the time of her death and subsequently resulted in his conviction and imprisonment.

3. Dana had a difficult relationship with her parents and from a relatively early age had expressed suicidal thoughts. She self harmed and on the 6.5.09 was admitted to hospital, having taken an overdose of prescribed drugs. On 22.5.09 she was transferred to an adolescent mental health unit where she remained until 8.9.09. At that time the psychiatrist's opinion was that Dana posed a serious long term risk of suicide. It was also recognised that Dana made strong emotional attachments to individuals and reacted dramatically if those came to an end.

4. During this period Dana made it clear that she did not wish to return to live with her parents and they agreed (S.20 of the Children Act 1989) that she would be accommodated with foster carers by Worcestershire County Council Children's Services ("Children's Services").

5. On her discharge from the unit Dana went to live with a foster carer. This was arranged through an independent fostering agency, Child Care Bureau Limited ("the Independent Fostering Agency"), as no suitable in-house foster carers were available. Whilst living with that foster carer Dana continued to self harm and the foster carer reported that she was having difficulties with the arrangement, such that respite carers were identified by the Independent Fostering Agency and Dana moved into live with them on 30.11.09.

6. Although it was originally envisaged that these foster carers would only provide temporary respite care, it became clear that the arrangement with the original foster carer had broken down, and Dana remained living with these new foster carers.

7. Whilst living with these foster carers, Dana progressed well at school. However, the criminal proceedings against the karate instructor became enmeshed in delay and there were changes of social workers both from Children's Services and the Independent Fostering Agency. There were periods of stress and moments of crisis in the arrangements with the new foster carers and Dana continued to self harm. She also disclosed suicidal thoughts, including giving serious consideration to hanging herself.

8. On 27.2.11 an incident took place between Dana and her foster carers as a result of which Dana expressed a desire to leave them. Respite care was offered to Dana but declined. Instead an arrangement was made that she would stay with the parents of a friend of Dana's on a temporary basis. She went to stay with them on 1.3.11 and indeed remained living there up until her death 2 days later.

9. On 1.3.11 Dana expressed a desire to return to her foster carers. However her foster carers decided that they could no longer look after Dana.

10. On 2.3.11 Dana was told of the foster carers' decision. She became distraught and ran to their home. An emotional scene ensued. Dana talked of killing herself and she was taken to see a GP. However at that stage Dana denied any suicidal thoughts and she was eventually persuaded to return to her temporary carers.

11. On 3.3.11 Dana was visited by a Children's Services social worker and it was apparent that she had been self harming. The social worker confirmed that Dana could not return to her previous foster carers. Dana again became extremely upset, but agreed to remain with her temporary carers. During the course of the day Dana made a number of phone calls and sent texts to the current and previous social workers employed by the Independent Fostering Agency. These were communicated to Children's Services.

12. At about 4.30pm one of her temporary carers dropped Dana off in Kidderminster so that she could meet up with her boyfriend. At about 5pm these carers received a text message from Dana stating that, "I'm so sorry, I didn't ever want to lie to you but I promised I would not do anything at your house. Thank you for everything u have done for me. I love u always and I am so sorry. Dana xx." The Independent Fostering Agency also received a phone call from Dana in which she said that, "I just want to tell you that all I wanted was my family and you have taken that away from me and so I am calling to say goodbye, so goodbye." It was shortly after this text and call that Dana was found near a traffic island, together with a hand written note which appeared to indicate a desire to take her own life.

13. As a result of Dana's death, HM Coroner for the County of Worcestershire ("HM Coroner") opened and adjourned an inquest into her death, and the Worcestershire Safeguarding Children Board ("The Board") undertook a Serious Case Review ("SCR"). In the course of this review The Board obtained 10 Individual Management Reviews ("IMRs") and 6 Information Reports ("IRs"), and produced an SCR Overview Report, which is in draft form pending the outcome of the inquest.

14. HM Coroner requested to be provided with a copy of the draft overview report together with copies of the IMRs and IRs. Although initially resistant to the disclosure of the overview report, The Board have provided a copy of the draft overview report to him, but have declined to provide him with any of the IMRs or IRs.

15. As a result on the 15.11.12 HM Coroner applied to The High Court for permission to issue witness summonses requiring The Board and Worcestershire County Council ("The Council") to produce these and other documents to him, pursuant to CPR 34.3(2)(c) and CPR 34.4(1). That permission was granted by Master Cook on 15.11.12. On 5.12.12 The Board and The Council applied to set aside these witness summonses on the basis that their contents are protected by public interest immunity and/or their disclosure is unnecessary, pursuant to CPR 34.4(2).

16. In the course of the hearing of this matter on 2.5.13, it became clear that as the IMRs and IRs are in the possession and control of The Board, it was unnecessary for the witness summons to be pursued against The Council, and so that application has been withdrawn. Moreover, it was clarified that the only documentation which HM

Coroner now seeks from The Board is the IMRs and IRs, as no other potentially relevant documentation is in their possession.

The Board's submissions

17. Mr Thorogood commenced his submissions by indicating that The Board was anxious to give all proper assistance to HM Coroner and effectively sought the guidance of the court as to the proper approach to be taken by it in these circumstances.

18. However, he pointed out that the purpose of an SCR was not to enquire into how a child has died, but for the contributing agencies to identify and learn lessons to improve the way in which they work individually and together to better safeguard and promote the welfare of children. In doing so, it relied upon IMRs which are undertaken by the various contributing agencies with a view to looking openly and critically at individual and organisational practice. He submitted that in order to facilitate and promote candour on behalf of those contributing to the IMRs, it was necessary that they should be assured that their contributions would not be made public, but be confined to those undertaking the SCR.

19. He submitted that in those circumstances there was a clear public interest in protecting IMRs from disclosure and accordingly disclosure of the IMRs and IRs in this case should not be ordered.

20. He went on to submit that if the party who sought disclosure requested the court to inspect the IMRs and IRs, with a view to undertaking the balancing exercise between protecting their confidential nature against the public interest in providing sufficient information for the purposes of the inquest, then there was a duty upon that party to satisfy the court that there were sufficient grounds for expecting to find material of real importance to him in those documents. He submitted, now that The Board had disclosed the draft overview report, that HM Coroner could not satisfy the court of this matter. Indeed, although he conceded that the content of the IMRs and IRs contained potentially relevant material, it was not necessary for disclosure of these documents to be made to HM Coroner, as he had sufficient information for the purposes of the inquest as a result of the disclosure of the draft overview report.

21. There was a further concern raised, namely, that if disclosure of the IMRs and IRs was made to HM Coroner, there was at least a possibility that in turn, he would consider that some or all parts of that material would be required to be disclosed to the interested parties to the inquest.

HM Coroner's submissions

22. Mr Hough commenced his submissions by indicating that HM Coroner respected the position of The Board.

23. However he indicated that HM Coroner only sought disclosure of the IMRs and IRs in order to fulfil his statutory function of making proper inquiries into Dana's death. In this regard it was the belief of HM Coroner that these documents would assist him in determining the scope of the inquest by identifying the factors underlying her death, the identity of the relevant witnesses, the identity of the relevant documents and the lines of inquiry which it would be necessary to pursue with those witnesses. He

indicated that HM Coroner understood the rationale which lay behind The Board's opposition to his request for disclosure, and indicated that HM Coroner would not consider disclosure of any part of these documents without a hearing at which The Board and any of the contributing agencies would be able to make representations concerning public interest immunity.

24. He informed the court that although HM Coroner had not as yet decided whether it would be necessary to hold an Article 2 type inquest, this was a distinct possibility given the apparently serious defaults of a number of the contributing agencies in relation to this "looked after child" who was a known suicide risk, as was clear from the draft overview report. In any event he pointed out that it was the duty of any coroner to ensure that the relevant facts are "fully, fairly and fearlessly" investigated, and that it was likely that a Rule 43 report would be required. He submitted that the ambit of the inquiry was essentially a matter for HM Coroner.

25. He pointed out that the disclosure sought in this case was to HM Coroner, as distinct from a member of the public, who was charged with a statutory duty to inquire into deaths within his jurisdiction. In this regard HM Coroner had an inquisitorial role, such that there should be a margin of appreciation afforded as to what he considered to be relevant and necessary for his investigation. Moreover, as HM Coroner had jurisdiction to make determinations concerning disclosure, the question of the withholding of disclosure of admittedly potentially relevant documentation on the basis of public interest immunity should be determined by him.

26. He submitted that the draft overview report was just that, namely an overview which did not purport to describe in detail the actions or defaults of those who were involved. It was therefore highly likely that the IMRs and IRs would contain substantially more detail which was of potential relevance, over and above that which is contained in the draft overview report. This view being fortified by The Board's indication that there were over 600 pages of such documentation. It would also be of value to HM Coroner to understand, in a specialised field such as child protection, how each of the contributing agencies interpreted their own and others' fulfilment of their respective duties to D. In that regard the draft overview report, having a different function to that of the inquest, may have omitted matters which were of particular relevance to HM Coroner. Furthermore, it would be wrong for HM Coroner to abrogate his duty to consider what is potentially relevant to his inquiry to another body, such as The Board.

The role of The Board

27. Every local authority in England is under a statutory duty to establish a Local Safeguarding Children Board ("LSCB") for its area, pursuant to S.13 of The Children Act 2004, whose objective is, under S.14(1) of the 2004 Act,

> "(a) to co-ordinate what is done by each person or body represented on the Board…for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established; and
>
> (b) to ensure the effectiveness of what is done by each such person or body for those purposes."

28. Regulation 5(1)(e) of The Local Safeguarding Children Boards Regulations 2006, provides that the functions of an LSCB in relation to its objective include,

> "undertaking reviews of serious cases and advising the authority and their Board partners on lessons learned."

29. Regulation 5(2) provides that,

> "For the purposes of paragraph (1)(e) a serious case is one where -
>
> (a) abuse or neglect of a child is known or suspected; and
>
> (b) either – (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child."

30. Section 16(2) of the 2004 Act provides that every such local authority and each of their Board members must, in exercising their functions relating to a LSCB, have regard to any guidance given to them for the purpose by the Secretary of State.

31. The current guidance is that contained within "Working Together to Safeguard Children (2010)", which provides the following guidance:

32. Chapter 8.1,

> "The prime purpose of a Serious Case Review (SCR) is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children."

33. Chapter 8.5,

> "The purposes of SCRs carried out under this guidance are to: - establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children; - identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and – improve intra – and inter – agency working and better safeguard and promote the welfare of children."

34. Chapter 8.6,

> "SCRs are not inquiries into how a child died or was seriously harmed, or into who is culpable. These are matters for coroners and criminal courts, respectively, to determine as appropriate."

35. Chapter 8.7,

> "Nor are SCRs part of any disciplinary inquiry or process relating to individual practitioners….."

36. Chapter 8.20 provides that the Board's SCR sub-committee should consider the scope of an SCR and draw up clear terms of reference, which include,

> "How should the review process take account of a coroner's inquiry, any criminal investigations (if relevant), family or other civil court proceedings related to the case? How will it be best to liaise with the coroner and/or the Crown Prosecution Service (CPS) and to ensure that the relevant information can be shared without incurring any significant delay in the review process?"

37. No such terms of reference were made available to the court during the course of the hearing of this case. Although, what appears to be a nationally agreed document, "A guide for The Police, The Crown Prosecution Service, Local Safeguarding Children Boards to assist with liaison and the Exchange of information when there are simultaneous Chapter 8 Serious Case Reviews and Criminal Proceedings" dated April 2011 was provided. This states that where a senior investigating police officer has genuine reason to believe that the SCR is likely to have obtained relevant material, the LSCB Chair should (at Paragraph 7.16),

> "…treat favourably any request by the SIO for them or their disclosure officer to view the material which it is felt *may* be of relevance, so that an informed judgment on its *actual* relevance can be made….."

The guide states that any refusal to provide this material may result in the issuing of a witness summons. Moreover even if the material is disclosed to the SIO, in the absence of agreement by the Chair of the LSCB, any further disclosure of the material to the defence would require a PII hearing in the criminal proceedings.

38. Chapter 8.23 of the statutory guidance of 2010 envisages that SCRs should normally be completed within 6 months of the date of the decision to proceed with an SCR, albeit sometimes it may become apparent that this timetable cannot be achieved for a number of reasons including, "…(perhaps because of judicial proceedings)…"

39. Chapter 8.27,

> "The final SCR report, including the executive summary, should take full account of salient, new information which becomes available during the course of these proceedings and the facts, conclusions and recommendations should be revised accordingly."

40. Chapter 8.31,

> "The SCR panel, on behalf of the LSCB, should commission an overview report that brings together and analyses the findings

> of the various IMRs from organisations and others, and that makes recommendations for future action…."

41. Chapter 8.33,

> "The overview report should be commissioned from a person who is independent of all the local agencies and professionals involved and of the LSCB(s)…….Those conducting management reviews of individual services should not have been directly concerned with the child or family, or have been the immediate line manger of the practitioner(s) involved."

42. Chapter 8.34,

> "Once it is known that a case is being considered for review, each organisation should secure its records relating to the case to guard against loss or interference. Once it is decided that a SCR will be undertaken, individual organisations, having secured their case records promptly, should begin quickly to draw up a chronology of their involvement with the child of the family."

43. Chapter 8.35,

> "The aim of IMRs should be to look openly and critically at individual and organisational practice and at the context within which people were working to see whether the case indicates that improvements could and should be made and, if so, identify how those changes can be brought about….."

44. Chapter 8.39,

> "……It is important that the SCR process supports an open, just and learning culture and is not perceived as a disciplinary – type hearing which may intimidate and undermine the confidence of staff."

45. Chapters 8.39 and 8.40, respectively, outline the scope and format of IMRs and the SCR overview report. Essentially IMRs are required to provide, in addition to a comprehensive chronology of involvement of the particular agency and professional, a detailed analysis of its involvement with the child, (as supplemented in this case by the Written Guidance issued by The Board updated in August 2010). Whereas the SCR overview report, in addition to an integrated chronology, is designed to provide a summation of the IMRs.

46. In relation to publication of the various reports provided by the SCR process, there has been an alteration in the guidance provided by the Secretary of State which is set out in a letter from the Parliamentary Under Secretary of State for Children and Families dated 10.6.10; such that whereas previously only a suitably anonymised executive summary of the overview report was made public (Chapter 8.42, 8.44 and 8.50), since 10.6.10 the full anonymised SCR overview report is published. The

anonymised IMRs are to remain unpublished, save for their provision to Ofsted and other similar bodies.

47. In explaining the rationale behind these alterations, the Under Secretary of State explained that,

> "The key purpose of undertaking Serious Case Reviews is to enable lessons to be learned from cases where a child dies or is seriously harmed and abuse or neglect is known, or suspected, to be a factor. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each case, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. Only by publishing Serious Case Reviews will this greater level of transparency and accountability be achieved. Our aim in publishing SCR overview reports is to restore public confidence and improve transparency in the child protection system, and to ensure that the context in which the events occurred is properly understood so relevant lessons are learnt and applied as widely as possible."

The role of HM Coroner

48. Coroners are now appointed for particular districts under Section 1 of the Coroners Act 1988 and have a duty under Section 8(1)(e) The Coroners Act 1988 to hold an inquest where the coroner is informed that the body of a person is lying within his district and there is reasonable cause to suspect that the deceased, inter alia, "has died a violent or unnatural death."

49. The Coroners Rules 1984 provide at Rule 36 that,

> "(1) The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters, namely: (a) who the deceased was; (b) how, when and where the deceased came by his death; (c) the particulars for the time being required by the Registration Acts to be registered concerning the death.
>
> (2) Neither the coroner nor the jury shall express any opinion on any other matters."

50. By Rule 43(1) of the Coroners Rules 1984,

> "Where – (a) a coroner is holding an inquest into a person's death; (b) the evidence gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and (c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner

> may report the circumstances to a person who the coroner believes may have power to take such action."

The remainder of that rule goes onto to provide for the dissemination of any such report to, inter alia, the Lord Chancellor and any person who the coroner believes may find it useful. The former may decide to publish the report and the latter is under a duty to respond to it in writing.

51. Although Rule 57A of the Coroners Rules 1984 provides for the supply of information by a coroner to a LSCB, there is no provision for the supply of information by the LSCB to a coroner.

52. However the Ministry of Justice has provided "Guidance for coroners and Local Safeguarding Children Boards on the supply of information concerning the death of children" which at Paragraph 3.5 states,

> "If any information comes to the attention of LSCBs which they believe should be drawn to the attention of the relevant coroner, then the LSCB should consider supplying it to the coroner as a matter of urgency."

53. As and when the relevant parts of the Coroners and Justice Act 2009 are brought into force, under S.32 and Schedule 5 Paragraph 1(2) to that Act,

> "A senior coroner who is conducting an investigation under this Part may by notice require a person, within such period as the senior coroner thinks reasonable – ….(b) to produce any documents in the custody or under the control of the person which relate to a matter that is relevant to the investigation……"

54. Schedule 5 Paragraph 1(4) will provide that,

> "A claim by a person that – ….(b) it is not reasonable in all the circumstances to require him or her to comply with such a notice, is to be determined by the senior coroner, who may revoke or vary the notice on that ground."

55. Schedule 5 Paragraph 1(5) will provide that,

> " In deciding whether to revoke or vary a notice on the ground mentioned in sub-paragraph (4)(b), the senior coroner must consider the public interest in the information in question being obtained for the purposes of the inquest or investigation, having regard to the likely importance of the information."

56. Furthermore Schedule 5 Paragraph 2 will provide that,

> "(1) A person may not be required to give, produce or provide any evidence or document under paragraph 1 if – (a) he or she could not be required to do so in civil proceedings in a court in England and Wales, or (b) the requirement would be

> incompatible with a Community obligation. (2) The rules of law under which evidence or documents are permitted or required to be withheld on grounds of public interest immunity apply in relation to an investigation or inquest under this Part as they apply in relation to civil proceedings in England and Wales."

Review of Authorities

Scope of Inquests

57. The general conclusions set out by Sir Thomas Bingham MR in the case of *Regina v HM Coroner for North Humberside and Scunthorpe ex-parte Jamieson [1995] QB 1* are familiar to those dealing with the scope of Coroner's inquests. However their importance has not diminished with time:

> "(1) An inquest is a fact finding inquiry conducted by a coroner, with or without a jury, to establish reliable answers to four important but limited factual questions. The first of these relates to the identity of the deceased, the second to the place of his death, the third to the time of death. In most cases these questions are not hard to answer but in a minority of cases the answer may be problematical. The fourth question, and that to which evidence and inquiry are most often and most closely directed, relates to how the deceased came by his death. Rule 36 requires that the proceedings and evidence shall be directed solely to ascertaining these matters and forbids any expression of opinion on any other matter.
>
> (2) Both in Section 11 (5) (b) (ii) of the Act of 1988 and in Rule 36 (1) (b) of the Rules of 1984, "how" is to be understood as meaning "by what means". It is noteworthy that the task is not to ascertain how the deceased died, which might raise general and far reaching issues, but "how…the deceased came by his death", a more limited question directed towards the means by which the deceased came by his death. …
>
> (14) it is the duty of the coroner as the public official responsible for the conduct of inquests, whether he is sitting with a jury or without, to ensure that the relevant facts are fully, fairly and fearlessly investigated. He is bound to recognise the acute public concern rightly aroused where deaths occur in custody. He must ensure that the relevant facts are exposed to public scrutiny, particularly if there is evidence of foul play, abuse or inhumanity. He fails in his duty if his investigation is superficial, slipshod or perfunctory. But the responsibility is his. He must set the bounds of the inquiry. He must rule on the procedure to be followed. His decisions, like those of any other judicial officer, must be respected unless and until they are varied or overruled."

58. In *Regina v Inner West London Coroner ex parte Dallaglio & Another [1994] 4 All ER 139*, Simon Brown LJ reflected upon those general conclusions and stated:

> "That, of course, was a Section 8 (3) (a) case, but its adaptability to a Section 8 (3) (d) context is obvious. It is, in short, for the individual coroner to recognise and resolve the tension existing between Sections 8 (3) and 11 (5) (b) of the 1988 Act and Rule 36. The inquiry is always bound to stretch wider than strictly required for the purposes of a verdict. How much wider is pre-eminently a matter for the coroner whose rulings upon the question will only exceptionally be susceptible to judicial review."

59. In *Regina v Inner South London Coroner, ex parte Douglas-Williams [1998] 1 All ER 334* Lord Woolf MR, having referred to the *Jamieson* case, and drawn attention to the fact that it was not the function of an inquest to determine criminal or civil liability or to apportion guilt or attribute blame, added this:

> "This is not to detract from the importance of the role of the inquest in particular where someone dies in custody, as here, an inquest can provide the family with the only opportunity they will have of ascertaining what happened. In addition, as (Counsel) contends, an inquest verdict can have a significant part to play in avoiding repetition of inappropriate conduct and in encouraging beneficial change."

60. The case of *Regina (Middleton) v West Somerset Coroner and Another [2004] UKHL 10* also involved an inquest relating to a death in custody. The House of Lords was concerned with the compatibility of the Coroners Act 1988 with the state's procedural investigative duty under Article 2 of The Convention for the Protection of Human Rights and Fundamental Freedoms. Lord Bingham of Cornhill stated at paragraph 35:

> "Only one change is in our opinion needed: to interpret "how" in Section 11 (5) (b) (ii) of the Act and Rule 36 (1) (b) of the rules in the broader sense previously rejected, namely as meaning not simply "by what means" but "by what means and in what circumstances"."

61. In *Plymouth City Council v Her Majesty's Coroner for the County of Devon (Plymouth and South West District) and the Secretary of State for Education and Skills [2005] EWHC 1014 (Admin)*, Wilson J. reviewed the principles and evidence which would be required in order to trigger an Article 2 type of inquiry in relation to the role played by the child protection agencies relating to the death of a child. In the course of submissions to him it had been contended that the Part 8 SCR procedure would be sufficient to satisfy the state's obligation under Article 2, such that an Article 2 type inquest would not be required. Wilson J. made this observation at paragraph 94 of his judgment:

> "There are in my view aspects of a part 8 review which admirably qualify it to be the vehicle for an Article 2 investigation. It is likely to be rigorous, it is born of

> contributions by those with expertise in a variety of relevant fields; and indeed its midwife, the overview reporter, brings analogous expertise. Contrary to how it may appear at first sight, the review may also qualify as sufficiently independent. Furthermore part 8 requires at least an executive summary of the report to be made public. Nevertheless, Mr Storey's argument faces difficulties. A part 8 review is not a judicial inquiry. There is no hearing at which oral evidence is given and thus no facility for assertions to be directly tested by or on behalf of next of kin, although, by invitation, they can make written representations. But the main problem, with which another court may have to wrestle, is that the focus of a part 8 review is upon inter-agency failure rather than upon breach by agencies, sometimes in combination but surely more often when acting alone, of their duty under Article 2 to take all reasonable steps to protect the child's life".

62. In *The Queen (on the application of Butler) v HM Coroner for the Black Country District [2010] EWHC 43 (Admin)* the court was dealing with a *Jamieson* type inquest rather than one which engaged Article 2. Nevertheless Beatson J. stated at paragraph 62:

> "It is clear that the scope of a Jamieson inquest is not limited to the last link in the chain of causation…In *Dallaglio*'s case Sir Thomas Bingham stated that it was for the coroner to decide on the particular facts of the case at what point "the chain of causation becomes too remote to form part of his investigation"."

63. Indeed at paragraph 64 he stated that a *Jamieson* type inquest may require the investigation of systematic failures.

64. In *Regina (Smith) v Oxfordshire Assistant Deputy Coroner (Equality and Human Rights Commission Intervening) [2010] UKSC* p. 29 the Supreme Court were concerned with the engagement or otherwise of Article 2 in relation to an inquest concerning the death of a soldier. Lord Brown stated at paragraph 152:

> "I further agree with Lord Phillips PSC that in practice the only real difference between a Jamieson inquest… and a Middleton inquest is likely to be with regard to its verdict and findings, rather than its inquisitorial scope. As I pointed out in *Hurst [2007] 2AC189*, paras 27, 51, the scope of the inquiry is essentially a matter for the coroner. Such indeed had been eloquently recognised in *Jamieson [1995] QB 1* itself in the court's judgment given there by Sir Thomas Bingham MR (at paragraph 14 of the Court of Appeal's general conclusions, page 26)…"

At paragraph 154 he went on to state:

> " Although as I recognised in *Hurst [2007] 2AC189*, para 51, the coroner may sometimes choose to widen the scope of the inquiry if he recognises that Article 2 conclusions of fact (and thus a Middleton verdict and findings) are required, more probably (as Lord Hope envisages at para 95 of his judgment) the coroner is likely to decide the scope of enquiry with a view rather to the exercise of his rule 43 power to make a written report to a responsible authority aimed at avoiding similar fatalities in the future".

Public interest immunity

65. The origin of the modern approach to cases involving a claim for public interest immunity is to be found in the case of *Conway v Rimmer and another [1968] AC910* where the court's duty to perform a balancing exercise was recognised, between the competing public interests that harm should not be done to a public service by the disclosure of documentation and the public interest that the administration of justice should not be frustrated by withholding those documents.

66. *In D v NSPCC [1978] AC171* the House of Lords recognised the public interest in withholding disclosure of material which could disclose the identity of The Society's informants, on the basis that to do so would be likely to frustrate the aims of the society in protecting vulnerable children by dissuading prospective informants in making disclosures to the society.

67. In *Regina v Chief Constable of West Midlands Police ex parte Wiley [1995] 1AC274* The House of Lords was concerned with a claim that public interest immunity attached as a class to documentation generated by a police complaints procedure. This was rejected and caution was expressed as to the extension of public interest immunity to new classes of documentation. Lord Woolf at page 305e stating:

> "The recognition of a new class based public interest immunity requires clear and compelling evidence that it is necessary".

68. In *Taylor v Anderton (Police Complaints Authority Intervening) [1995] 1 WLR 447* the Court of Appeal was dealing with a claim that public interest immunity attached to the reports generated by an independent investigation under the Police and Criminal Evidence Act 1984. The court recognised that the case of *Regina v Chief Constable of West Midlands Police, ex parte Wiley (Supra)* had decided that public interest immunity did not attach as a class to statements obtained in the course of such an inquiry. However the Court of Appeal decided that public interest immunity would attach to the reports themselves. Sir Thomas Bingham MR stated that:

> "I am fully alive to the existence of a current of opinion strongly flowing in favour of openness and disclosure. I am also, however, mindful of the fundamental public interesting in ensuring that those responsible for maintaining law and order are themselves un-corrupt, law abiding, honest and responsible. I do not myself find the points made by Mr Cartwright in his affidavit to be unconvincing, unrealistic or suggestive of self-interested special pleading. In very many cases where an

> investigating officer is appointed, there must be real prospect of civil, criminal or disciplinary proceedings. I have no difficulty in accepting the need for investigating officers to feel free to report on professional colleagues or members of the public without the apprehension that their opinions may become known to such persons. I can readily accept that the prospect of disclosure in other than unusual circumstances would have an undesirably inhibiting effect on investigating officers reports. I would therefore hold that the reports of investigating officers made in circumstances such as these form a class which is entitled to public interest immunity. That does not, of course, shut out the plaintiff if he is able to satisfy the judge, applying the familiar tests, that, on the backs of this case, the public interest in disclosure of the contents of these reports or any part of them, outweighs the public interest in preserving the confidentiality of these reports. That is a matter for the trial judge and it is a judgment which he will be very well fitted to make".

Disclosure

69. In *Re A Subpoena (Adoption Commissioner for Local Administration) [1996] 2FLR 629* the court was dealing with a claim by a local authority that the Commissioner for Local Administration who was involved in an investigation into alleged mal-administration in relation to adoption proceedings, should not have disclosed to him the records held by the local authority concerning the adoption application. At page 637 Carnwath J. stated,

> "…I would conclude that in the normal case the balance which Parliament thought appropriate in relation to the disclosure of material to, or by, the Local Commissioner is to be found in the Act and the relevant regulations. Provided the Commissioner can show that the material is bona fide required for the purpose of his investigation, and that he is able and willing to comply with the necessary restrictions on disclosure by himself and his staff (which are in any event secured by the provisions of the Act), then in my view the balance should normally come down in favour of disclosure. That is the conclusion reached by the Master and I would, in principle, agree with him. It may be that in the result the role of the court is not dissimilar to that of a court exercising judicial review powers. However that is wholly appropriate where the court is seeking to exercise supervisory control over another body which has a vital investigatory role and on which Parliament has conferred powers which are in many respects as extensive as those of the High Court".

70. In *McCaughey (Judicial Review Application) [2004] NI QB 2* the court was dealing with an application concerning the non-disclosure to the coroner of a police report prepared for the DPP and certain unredacted copies of intelligence reports concerning

the decision that no prosecution should arise out of the death of the deceased. Weatherup J. at paragraph 9 onwards stated,

> "The first police objection to the disclosure of the police report is the confidentiality of the police report. The application concerns disclosure of the police report to the coroner so that he may determine what if any relevance it has to these particular inquests. I am satisfied that there can be no confidentiality in such police reports prepared by the police as part of their public duty that would prevent them being received by a coroner for the purposes of his public duty to conduct an inquest, where the police report is potentially relevant to those proceedings.
>
> 10. The second objection concerns relevance…….an effective investigation would include the coroner considering any potentially relevant document generated by police. The police report is potentially relevant on the grounds that it may indicate to the coroner lines of enquiry that have been undertaken by the police or that may not have been undertaken by the police that would be relevant to the task of the coroner. Counsel for the coroner did accept that potential relevance on this basis could not be excluded. I find that the police report is potentially relevant.
>
> 11. The third objection concerns the impact of disclosure on the future candour of police reports. The fourth objection concerns a "chill" on public participation in criminal investigations if witnesses were subject to criticisms that became public. These matters are important to general public interest but might impact on the efficacy of criminal investigations but I find that they do not apply to disclosure to a coroner for the purpose of an inquest. I do not find confidentially, candour or "chill" to be grounds on which a potentially relevant police report should be withheld from the coroner…….
>
> 16. It is for the coroner to decide on receipt of the report whether it is in fact relevant to the inquest and if so, what directions he will give for the conduct of the inquest or what steps he requires to be taken in his investigation.
>
> 17. This application is not concerned with the disclosure by the coroner of relevant material in the police report. If the police disclose a police report to a coroner and there are issues of confidentiality or other sensitive issues or public interest issues arising the police should of course give notice to the coroner to that effect and the issues can be addressed as the nature of the situation requires".

71. In *Inner West London Assistant Deputy Coroner v Channel Four Television Corporation [2008] 1WLR 945* the court was dealing with an application by the

Assistant Deputy Coroner for a witness summons to compel the production of documents concerning a journalist investigation into the subject matter of the inquest. Eady J. recognised that in civil proceedings there was authority to the effect that a witness summons should only be issued where the court was satisfied that the documentation sought was necessary for the fair disposal of the matter, that relevance was not decisive and that the summons should not be issued where a "fishing" exercise was taking place (see *South Tyneside Borough Council v Wickes Building Supplies Limited [2004] NPC 164*). However, at paragraph 6 Eady J. stated:

> "…However, I need to focus upon the distinctive nature of a coroner's inquest, which differs in fundamental respects from that of civil litigation of the kind which has been considered in the recent judicial observations to which I have referred. As with disclosure of documents, so with the witness summons directed to third parties, it is possible in the context of civil litigation to define both relevance and (to an extent) "necessity" by reference to the statements of case, where the issues are identified. There is nothing closely comparable in relation to a coroner's inquest, which is inquisitorial in nature…"

72. He went on to observe that the scope of the inquest was essentially a matter for the Assistant Deputy Coroner which was likely to include lessons which will be learnt for the greater protection of the public in the future. At paragraph 9 onwards he said,

> "Factors of this kind, illustrate very clearly, why it is that the court should be wary of trying slavishly to fit a coroner's inquest into the template of civil litigation, merely because it is in that context that the provisions of CPR Rule 34.4 have so far been considered.
>
> 10. It may be that the overriding objective of the CPR requires economy and selectivity as to the deployment of even relevant issues and evidence, but that has little direct bearing on the coroner's declared objective of obtaining an exhaustive picture of what happened on 30th and 31st August 1997, and of the surrounding circumstances as well as the aftermath. An unduly selective or narrow approach to the evidence may hinder his task of allying suspicions and/or making any recommendation for the future."

73. In dealing with the submission that it was for the coroner to establish that the documentation was potentially relevant, Eady J. at paragraph 18 said,

> "……In reality, of course, that is impossible because the coroner does not know what is there. In my judgment, there is every reason to conclude from the subject matter of the programme that this new material will also be relevant, and that it is necessary for him to have it in order to present the jury with the fullest and fairest account of what took place. No doubt he and the jury could manage with a partial account but,

> in the particular circumstances of this case, the fullest analysis possible is required".

At paragraph 27 Eady J. said,

> "It is important to remember also how restricted will be the disclosure in this case. The effect of my order will be to reveal the documents concerned to the coroner, only, in the first instance. He will examine and filter the material paying proper regard to the competing considerations which I have had to take into account. He is obviously fully aware of the policy underlying Article 10 of the Convention and the sensitivity of journalistic materials. He will only reveal such information as he attains if it is necessary and proportionate to do so. That will be a similar exercise to the one I am performing, but different, since he will be addressing those factors with a view to wider dissemination of material (e.g. to the interested parties and/or to the jury).
>
> 28. There is every reason to suppose that this staged process will afford appropriate safeguards to all concerned…"

Evidence

74. The Board's evidence comprised in the main that of the former and present independent chairs, Hilary Thompson and Diana Fulbrook.

75. Hilary Thompson in her affidavit sworn 14.3.13 stated at paragraph 25,

> "I am firmly of the view that both the SCR overview report and any IMRs should not, as a matter of principle, be disclosed."

76. At paragraph 19 she stated,

> "My concern over disclosure of the SCR overview report and the IMRs, which is a very substantial concern, related to the principle that this is intended to be a confidential process, culminating in a publicly published report. It is intended to allow all those involved to speak candidly about what happened so that lessons can be learned. That is, and has always been, a crucial aspect to the process as a whole. If that principle is not maintained the practical value of the process will be greatly reduced, if indeed any remains."

77. Diana Fulbrook echoed these sentiments in relation to IMRs and IRs, stating at paragraph 3 of her affidavit sworn on the 18.2.13 that,

> "Any disclosure of individual agency Reviews would seriously compromise their purpose in respect of identifying lessons to be learnt and would result in the production of documents designed to explain things publicly in ways that can be

> understood and to protect staff and vulnerable families, rather that analysing professional practice with a critical edge that results in better understanding and improved practices."

She also went on to question the need for HM Coroner to have disclosure of these documents, as he now had disclosure of the draft overview report.

78. On 2.4.12 Hilary Thompson wrote to the contributing agencies requesting "confirmation" of their views of her intention to provide a copy of the draft overview report to HM Coroner, and her resistance to the disclosure of the IMRs and IRs. She obtained something of a mixed response to this letter as can be gleaned from the contents of tabs 110 – 119 of the bundle. Whilst it is not easy to reconcile the names of the organisations provided in those responses with the names of the contributing agencies listed at paragraph 6.2 of the draft overview report, it is apparent that whilst the majority of the respondents supported her stance, those at tabs 111, 113 and 114 were content for disclosure of their IMRs or IRs to be made to HM Coroner and those at tabs 110 and 115 were unclear or undecided.

79. Hilary Thompson followed up her initial letter with a further one on 20.11.12 in somewhat trenchant terms, again asking for the views of the contributing agencies to The Board's proposed course of action. Such responses as were received were again in the main supportive of The Board's stance, including now two such agencies, at tabs 125 and 127, who had initially expressed a willingness to disclose their IMRs or IRs to HM Coroner. Interestingly the Independent fostering agency was one of the two agencies, tabs 121 and 124, which remained content for HM Coroner to receive a copy of their IMR.

80. HM Coroner swore an affidavit on 15.2.13 stating that

> "I should make clear that my principal objective as coroner, and the primary function of an inquest, is to investigate the facts of a death, rather than to find fault or establish liability."

He went on to say that

> "I have an obligation to inquire into the death and to call appropriate witnesses. I cannot abrogate that function to any other body, and certainly not to solicitors who act for an interested person in the inquest proceedings. In any event, I am concerned to see the SCR material in order to obtain a better understanding of relevant events in D Baker's life and her contact with statutory agencies. That will assist me both in deciding what witnesses to call and in considering what questions to ask them."

He concluded that,

> "I also wish to stress that, if I obtain the material which is sought and I later decide that any of it should be disclosed to the inquest proceedings, or used in evidence, I shall give adequate notice of my intention to the Claimants and I shall

> afford them the opportunity to make any objections (whether based on public interest immunity, relevance or other considerations.)"

81. There were also witness statements from 3 other HM Coroners concerning their experience with the disclosure to them of SCR material for use in their inquests.

82. HM Coroner for South Shropshire said that in general he had experienced no problem with the information flow from LSCBs within his area. He is currently involved in an inquest where he has received certain material from the LSCB, together with one of the IMRs and is going to consider whether he requires a copy of the remaining IMRs once he has received a copy of the SCR overview report.

83. HM Deputy Coroner for Greater Manchester South is currently investigating the death where an SCR has taken place and has already received a copy of the 15 IMRs which have been submitted to the SCR. She has sought permission from those contributing agencies to disclose copies of their IMRs to the interested parties in the inquest and 12 of those agencies have agreed to this proposal. The remaining 3 IMRs will be the subject of a PII hearing in due course.

84. HM Coroner for Sunderland said that he has always had disclosure of SCR material including both the draft reports and the IMRs. This being on the basis that he would not disclose them further without a PII hearing. Indeed he said that,

> "Without this information, I do not see how it would be possible for a coroner to conduct a thorough investigation/sufficient inquiry and to be able to fulfil our function with regard to Rule 43."

85. Tabs 70 – 107 of the trial bundle contain the witness statements which HM Coroner has already obtained from a number of those individuals who had a role to play in the care of Dana Baker in the period between 2009 and the date of her death.

86. In the light of the Board's concession that the undisclosed IMRs and IRs contain potentially relevant material for the purposes of the inquest, and having already read both the draft SCR overview report and the above mentioned witness statements, I considered it necessary to read this undisclosed material for the purposes of this case.

Discussion

87. It is clear that LSCBs play a crucial role in the safeguarding of children within their areas. This being particularly so in regard to "looked after" children. One of the most important mechanisms by which the LSCBs are enabled to fulfil their role, in appropriate circumstances, is by carrying out SCRs. The ethos underlying SCRs is not one of individual retribution for past conduct rather it is one of individually and collectively learning lessons for the future, with a focus upon inter-agency cooperation.

88. In turn, the efficacy of SCRs requires the cooperation of the individual contributing agencies involved and in particular those working within them. In contrast to the SCR overview report, the current statutory guidance envisages that the IMRs and IRs will

remain confidential within the SCR and to a limited number of properly interested bodies. Although it does not say so in terms, it is likely that this is with a view to promoting an openness which it perceives might be lacking if wider dissemination to the public took place. Despite reflecting a somewhat pessimistic view of human nature, this rationale is one that has been recognised by the courts in a not dissimilar context as acknowledging reality and thus potentially justifying a claim for public interest immunity (*Taylor v Anderton (Police Complaints Authority intervening*), *supra*).

89. The promotion of the welfare of children and their protection from serious harm are of course principles of the utmost importance in a civilised society. Parliament has primarily entrusted the role of upholding those principles to the local authorities. It is they who are responsible for establishing LSCBs, which in turn seek to ensure compliance both by the local authorities and their contributing agencies with their respective duties. It is therefore important that the ability of the LSCBs to carry out that role is promoted, rather than hampered. It is the clear view of The Board in this case that the degree of openness which is required in order for them to properly carry out their SCR role would be unlikely to be forthcoming from those contributing to it if the contents of those contributions were open to full public scrutiny. This view gains support from the current statutory guidance and is balanced by the fact that the full SCR overview report is now published. In these circumstances I consider that there is sufficient merit in those views that a potential claim for public interest immunity can be sustained in relation to IMRs and IRs.

90. However as with any claim for non-disclosure on the basis of public interest immunity, it is necessary to balance the perceived public benefit it affords, against the public benefit of disclosure, both in relation the principle of open justice and the particular requirements of justice in the context in which it is being examined.

91. It is clear that if the relevant provisions of The Coroners and Justice Act 2009 are implemented, this balance will be required to be determined by a Senior Coroner; subject to the supervisory jurisdiction of this court. However, until such time, this balance is one which is required to be carried out by this court.

92. In doing so, it is necessary to bear in mind a number of factors which are likely to subsist in such cases:

    i) HM Coroner has an equally crucial role in investigating suspicious deaths within his area, including the death of a "looked after" child who has died a "violent or unnatural death."

    ii) Subject to the supervisory jurisdiction of this court, the scope of an inquest is essentially a matter for the coroner, (*Regina v HM Coroner for North Humberside and Scunthorpe ex-parte Jamieson*, supra). Indeed in cases involving the death of a "looked after" child, and where an Article 2 type of inquiry is required, it may be that the State's procedural investigative obligations would not be satisfied by the SCR process, and would require that inquiry to be carried out in the context of a *Middleton* type inquest. (*Plymouth City Council v Her Majesty's Coroner for the County of Devon (Plymouth and South West District) and the Secretary of State for Education and Skills*, supra). Even where such an inquest is not required, the coroner's Rule 43

powers may require a fuller investigation into the circumstances in which the death occurred. Moreover, a *Jamieson* type inquest may require the investigation of systematic failures (*The Queen (on the application of Butler) v HM Coroner for the Black Country District*, supra).

iii) Reflecting the pre-eminent role of HM Coroner in deciding the scope of an inquest, this court will only interfere with such a decision in exceptional circumstances, (*Regina v Inner West London Coroner ex-parte Dallaglio & Another, supra*).

iv) The role of HM Coroner is not an adversarial one, but an investigative one, such that questions of relevance and necessity are unlikely to be as decisive as they would be in the context of civil litigation, (*Inner West London Assistant Deputy Coroner v Channel Four Television Corporation*, supra).

v) Where in the context of a claim of public interest immunity a balance has to be struck between competing public interests, it may be that because of the nature of his inquiry the balance ought normally to be in favour of disclosure to HM Coroner, (*Re A subpoena (Adoption Commissioner for Local Administration*, supra).

vi) What is sought is not disclosure of the IMRs and IRs to the public in general or indeed anyone else, save and except HM Coroner. Thus the argument in favour of non-disclosure arising out of the need to encourage openness within the IMRs and IRs is likely to be significantly diluted, (*McCaughey (Judicial Review Application)*, supra). This being in contradistinction to the situation which may arise with the question of disclosure to members of the public (*ICO Decision Notice Plymouth City Council Reference FS50084360* and *ICO Decision Notice London Borough of Haringey Reference FS50234513*).

vii) The question of any further disclosure is a matter for HM Coroner, having taken into account any further arguments in favour of non-disclosure and subject to the supervisory jurisdiction of this court; thus maintaining sufficient safeguards to those properly seeking non-disclosure of these documents (*Inner West London Assistant Deputy Coroner v Channel Four Television Corporation*, supra).

93. Just as LSCBs and their contributing agencies play a vital role in child protection, so do coroners play a vital role in investigating suspicious deaths including "looked after" children such as Dana Baker. Coroners fulfil this role not as an adjudicator in an adversarial system, but as an investigator charged with a duty to make such inquiries. The courts having described that duty as one which involves the coroner ensuring that the relevant facts are "fully, fairly and fearlessly investigated." It is clear that this role may in appropriate cases involve detailed and extensive inquiries which go beyond the narrow question as to how the deceased came by his death, and include those matters relevant to Article 2. In any event systematic failures by state agencies and lessons to be learnt for the future protection of other vulnerable children may be required to be considered. Pre-eminently these will be matters for the coroner to decide, subject to this court's supervisory jurisdiction.

94. In the present case HM Coroner has made it clear that although it was a distinct possibility that an Article 2 type inquest will be required, he has not as yet made this decision. Indeed one of the reasons why he considers that he requires copies of the IMRs and IRs in this case is to assist him in reaching this decision. In any event he would have to consider whether he should invoke his Rule 43 powers. Beyond these considerations HM Coroner seeks disclosure of this documentation in order to carry out his inquisitorial role by identifying the factors underlying her death, the identity of the relevant witnesses, the identity of the relevant documents and the lines of inquiry which it would be necessary to pursue with those witnesses.

95. He cannot of course know precisely what is contained within these IMRs and IRs. However he submits that it is likely to be relevant material for these purposes and that they are likely to contain substantially more detail which is of potential relevance than that contained in the draft overview report. In such a specialised field, it would be of assistance to him to understand how each of the contributing agencies interpreted their own and others' fulfilment of their respective duties to Dana. Moreover, the draft overview report may have omitted matters of particular relevance to HM Coroner, as it has a different and distinct function to that of an inquest.

96. Having taken the opportunity of reading both the draft SCR overview report and the IMRs and IRs in this case, it is apparent that the former provides a reasonably thorough review of the contact which the various contributing agencies had with Dana prior to her death. It provides a good deal of critical analysis of the inter-agency failures, together with some of the failures of the individual agencies themselves and their staff.

97. However it is equally apparent that the IMRs and IRs provide considerably more detail concerning both the nature and degree of contact which both individuals and contributing agencies had with Dana. Furthermore, although the reports are by no means universal in their thoroughness and rigour, many of them contain detailed critical analysis of their own and others failures in respect to their care of Dana, over and above that which is summarised in the overview report. This is not to be in any way critical of the overview report itself. It is a product of its terms of reference and is intended, as its name suggests, to be an overview of the situation disclosed in the IMRs and IRs upon which it subsists. Moreover its purpose is not aligned with that of an inquest, such that there may be matters of potential relevance to the inquest, which are not contained within the overview report.

98. Having carried out this exercise, I have reached the view that there is in this case every reason to conclude that the IMRs and IRs do contain significantly more detailed information of potential relevance to HM Coroner for the purposes of his inquiry, over and above that which is contained in the draft overview report and the witness statements and documentation he has already obtained in the course of his inquiry. This being in terms of allowing him to consider the scope of his inquiry in its proper context, including the necessity or otherwise of an Article 2 inquiry/Rule 43 report, and to provide him with appropriate guidance as to the identity of potential witness and documents, the pursuance of relevant lines of inquiry and the framing of questions for those witnesses in the course of the inquest.

99. In this regard, if HM Coroner is enabled to read the IMRs and IRs in this case, he may decide that there is no need to pursue the role which some of the contributing agencies

played as part of the inquiry. Or, he may decide that not only will it be necessary to pursue their role as part of the inquiry but that a particular individual or a particular role will require further investigation. Thus the inquiry may be expanded or contracted, in whole or in part. These will be essentially matters for HM Coroner. However he will at least have the advantage of making his decisions upon a full and informed basis, in contrast to his partial view at the present time.

100. I have considered whether I should carry out a line by line analysis of the IMRs and IRs, comparing and contrasting the evidence contained in each of them with that contained within the draft overview report. However the Board did not seek to take this approach and, recognising that the disclosure in this case is being sought not by a member of the public but by HM Coroner, it would in my judgment neither be a necessary nor proportionate use of the court's time, bearing in mind the view that I have reached as to the potential relevance of this documentation as a whole to HM Coroner. In this regard I also bear in mind that in the context of disclosure to HM Coroner, an unduly narrow approach to the criteria of relevance and necessity may not further the interests of justice. This also appears to be in line with the current guidance provided in relation to matters of potential relevance between the LSCBs and the police.

Conclusion

101. Therefore although I am prepared to accept that some of the material contained in the IMRs and IRs is potentially immune from disclosure on the basis of furthering the public interest of openness within the production of the IMRs and IRs, as the disclosure in this case is to HM Coroner, rather than the public, I consider that the public interest in the pursuit of a full and appropriately detailed inquest into the death of Dana, firmly outweighs the claim for non-disclosure. Such that I decline The Board's application to set aside the witness summons granted by Master Cook in relation to the IMRs and IRs which are in their possession in relation to the SCR concerning the death of Dana Baker.

102. In this regard it is of relevance that the IMRs and IRs themselves are authored reports by individuals who have a varying degrees of independence from those contributing agencies. As such the reports themselves, whilst being in part based upon interviews with individuals from those agencies, do not contain any transcripts or extensive summaries of those interviews. Moreover, I have considerable doubts whether the promotion of openness will in any event be hindered by knowledge of disclosure to HM Coroner, rather than to members of the public.

103. I should make it clear that nothing which I have said in relation to the balance of public interest in relation to the issue of disclosure of this material to HM Coroner indicates where the balance should fall vis a vis members of the public, including any interested parties at the inquest. This will be a matter for determination by HM Coroner in due course, subject to the supervisory jurisdiction of this court. In that context it may be that a far more detailed approach will need to be taken in relation to the contents of the various IMRs and IRs at that stage. Furthermore HM Coroner has undertaken not to make any such disclosure without first notifying the Board and relevant contributing agencies, allowing them sufficient time to make submissions to him and thereafter, if advised, to seek to invoke this court's supervisory jurisdiction. Thus there will be sufficient safeguards in place in order to protect the proper interests

of the Board, the contributing agencies and those individual professionals who have been involved in this matter.