Case No: CO/2690/2016

Neutral Citation Number: [2017] EWHC 2499 (Admin)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 20/10/2017

Before :

MR JUSTICE CHARLES
HHJ JUDGE LUCRAFT QC

- -

Between :

The Queen
(on the application of Muhammad Silvera) **Claimant**

and

Her Majesty's Senior Coroner for Oxfordshire **Defendant**
and
The Chief Constable of the Thames Valley Police
Interested Party 1
and
Oxford Health Hospital NHS Foundation Trust
Interested Party 2

- -

Jude Bunting (instructed by **Leigh Day**) for the **Claimant**

Hearing date: 26 July 2017

- -

Judgment

HHJ Mark Lucraft QC (Chief Coroner for England and Wales):

1. In this claim for judicial review Muhammad Silvera challenges the decision of the Senior Coroner for Oxfordshire not to resume the inquest into the death of his mother, Ms Vittoria Baker. It is submitted that the decision of the Senior Coroner not to resume the inquest and thereby to hold a full inquest into this death was unlawful. It is submitted that the Senior Coroner breached the investigative duty under Article 2 of the European Convention on Human Rights ("the Convention") and was irrational and in breach of the duty at common law to fully investigate this death.

2. Although the Senior Coroner for Oxfordshire takes a neutral stance in relation to this claim, and was not present nor represented at the hearing before this court, summary grounds were submitted on behalf of the Senior Coroner to identify the approach taken by the Senior Coroner and the factors he took into account in coming to a decision not to resume the inquest.

3. There are interested parties: the Chief Constable of Thames Valley Police and Oxford Health NHS Foundation Trust. Neither has played any role in these proceedings.

<u>The facts.</u>

4. Ms. Vittoria Baker died on or around 16th August 2012 in violent or unnatural circumstances. Her death was reported to the coroner. On a date unknown, but likely to have been in August or September 2012, the Senior Coroner for Oxfordshire opened an inquest into the death. At that stage a police investigation had commenced and so the inquest was adjourned pending the conclusion of that criminal investigation.

5. On 22nd July 2013 at a plea and case management hearing in the Crown Court Ms Baker's daughter (referred to in these proceedings as 'K') pleaded guilty to the manslaughter of her mother on the basis of diminished responsibility and was made the subject of a hospital order under the provisions of the Mental Health Act 1983. K was detained in a secure mental health hospital. K died on 8th June 2014 having suffered from deep vein thrombosis.

6. As well as the criminal proceedings, there were two other investigations into the role played by public authorities. On 31st December 2012, the Oxford Health NHS Foundation Trust completed what is termed a 'route cause analysis investigation report'. In March 2014, the Oxford Safer Communities Partnership completed a 'domestic homicide review' pursuant to section 9 of the Domestic Violence, Crime and Victims Act 2004.

7. On 1st July 2014, the Senior Coroner certified that the inquest would not be resumed. He wrote to Ms Baker's mother notifying her of that decision by a letter of the same date. On 10th August 2015, in the light of the content of the reports of the NHS Foundation Trust and the Oxford Safer Communities Partnership, the claimant's solicitors wrote to the Senior Coroner requesting that the inquest be re-opened. The Senior Coroner responded to indicate that he was seeking further information from the police and the NHS trust so as to inform his decision as to whether the inquest should be re-opened.

8. On 10th February 2016, the Senior Coroner stated that he had decided not to re-open the inquest. I cite the reasons he gives later in this judgment.

9. The Claimant's solicitors sent a letter before claim to the Senior Coroner on 11th April 2016 but the Senior Coroner upheld his decision.

Background to Ms Baker and events in 2012.

10. Ms. Baker was a person who had struggled with mental illness and alcohol problems over a lengthy period. She had two children: Muhammed Silvera (the claimant) and 'K'. Both were removed from her care when they were children.

11. In the course of her lifetime Ms Baker was detained on occasions under the Mental Health Act 1983 and diagnosed with paranoid schizophrenia. It appeared that 'K' suffered with similar problems but was reluctant to seek professional help.

12. Events in the months before the death of Ms Baker are of some significance. In early 2012 the Claimant and Ms Baker told Ms Baker's community psychiatric nurse about an incident in which 'K' had kicked Ms Baker whilst she was standing on the stairs. In May 2012, Ms Baker's community psychiatric nurse raised an adult safeguarding alert about Ms Baker due to concerns about the relationship between Ms Baker and 'K'. The alert identified that Ms Baker needed assistance with managing her finances and keeping her house in a fit state.

13. In June 2012, police attended Ms Baker's property after reports that 'K' had smashed a glass table as a result of being angry with how much Ms Baker was drinking and the state of the house. The police recorded the incident but did not investigate whether Ms Baker was at risk from 'K'.

14. Also in June 2012, Ms Baker reported to her community psychiatric nurse that she was worried about 'K's' mental health. The community psychiatric nurse simply advised that K should move out.

15. In July 2012, Ms Baker's community psychiatric nurse observed 'K' laughing at unseen stimuli. 'K' refused to see her GP.

16. On 17th July 2012, a police officer was hit by a plant pot thrown by 'K'. 'K' was restrained and detained under s.136 Mental Health Act 1983. The s.136 assessment concluded that 'K' was thought-disordered, highly vulnerable, and that there were high risks associated with her unpredictable behaviour and social isolation. 'K' was admitted under s.2 Mental Health Act 1983 to the Allen Ward at The Warneford Hospital, Oxford. 'K' escaped from the hospital on 19th July 2012, causing staff to report to police that 'K' was "*very unwell*" and "*at risk of committing violence*" towards Ms Baker.

17. The police told staff at Allen Ward that it was their responsibility to secure the return of 'K', but that the police would provide support if required. The staff attended Ms Baker's house but did not feel comfortable approaching 'K' without the police. Due to their fears, the staff left and asked the police for assistance in executing the warrant. Eventually, 'K' was returned to hospital on 29th July 2012. On 30th July 2012, she was transferred to a Psychiatric Intensive Care Unit ("PICU"). On 4th and 5th August 2012, 'K' was removed to the de-escalation room in restraints following violent outbursts.

18. On 10th August 2012, a consultant doctor with no prior knowledge of 'K' decided that 'K' did not meet the criteria for sectioning under s.3 Mental Health Act 1983. 'K' agreed with him to be discharged from the PICU into an open ward as an informal

patient. That night 'K' refused to take her medication because part of her agreement to be an informal patient was that she would cease taking medication.

19. On 11th August 2012, 'K' absconded from the hospital by climbing out of her bedroom window. The police were informed. Ward staff told police that 'K' was unwell and psychotic, that she had assaulted a member of staff, and that being out in public meant that she "*might do something*". The staff member said at the end of the call, "*maybe she is holding mum [Ms Baker] hostage".* The police said it was the ward's responsibility to locate K but they will attend Ms Baker's address to undertake a welfare check.

20. The police attended at Ms Baker's address. 'K' told the police that she would return to the ward and she was assessed as posing a low risk. The police informed staff at the ward, who raised further concerns about the potential wellbeing of Ms Baker when 'K' had not returned and they were unable to reach Ms Baker. They further raised concerns about the welfare of their staff if they tried to retrieve 'K'. The police responded by saying that they would attend if 'K' threatened staff. It is not clear if staff from the ward attended to retrieve 'K' or what steps were taken after 11th August. The missing person's report remained open.

21. On 16th August 2012, the Claimant's grandmother contacted the police raising her concern that she had not heard from Ms Baker for some days. Police forced entry into the property and found Ms Baker, deceased, in the property. K was also in the property and was arrested.

<u>Investigations.</u>

22. In addition to the criminal investigation and subsequent proceedings, there were two other investigations into the circumstances that led to the death of Ms Baker.

23. On 31st December 2012, the Oxford Health NHS Foundation Trust completed a "Root Cause Analysis Investigation Report". The authors of the 43 page report are three people working in senior positions for the Trust. They are said not to be directly involved in the clinical care or the line management of any of the staff delivering care. [Para 2.2 on page 8]. From a reading of the report it is clear that the report is an internal review of NHS care provided to 'K'. The investigation is not one that is conducted in public and did not include any independent expert input. The report was reviewed and approved by a separate panel. That panel too was drawn from within the NHS. On page 7 of the report it is stated that the review *"is focused on the care and treatment of Miss K and her mother Ms B, both under the care of Oxford Health NHS FT."*

24. Although there was contact with the Claimant and his cousin, there does not appear to have been any formal communication with the family. All of the clinical records were considered as well as electronic documentation held by the wards, photographic evidence on the wards, email communications and interviews with staff. It appears that the claimant had a meeting with the investigators and notes were taken of that meeting and he was asked to approve the notes, but played no formal role in the investigation. [See section 8 of the Report at 24-25].

25. The review identified shortcomings in the organisation of care for 'K'. It noted that 'K' was repeatedly reluctant to engage with staff. The conclusions and recommendations made by the review are set out in sections 13 and 14 at pages 36 to 39.

26. In March 2014, the Oxford Safer Communities Partnership carried out a 'Domestic Homicide Review' (DHR). DHRs were established on a statutory basis by section 9 of the Domestic Violence, Crime and Victims Act 2004. The review was chaired by Steve Appleton – an independent chairman. The DHR panel comprised nine other individuals as well as the chairman. Mr Appleton trained as a social worker and specialised in mental health, working as an approved Social Worker. The panel members [set out on pages 6-7 of the report] included representatives the City and County councils as well as from the various agencies involved, notably Thames Valley Police and the Oxford Health NHS Foundation Trust.

27. The report runs to some 90 pages. At paragraph 1.11 it is made clear that the DHR was conducted in private. [Page 13] It is stated that all documents and information used to inform the review are confidential. [Page 13]. The extent of the family involvement is set out as [Pages 13-14]:

> *The family of Adult A and Adult B have been kept advised of the work of the DHR panel throughout the process. This contact was via letters, emails, phone calls and third party support to advise them of progress. In early contact the review panel were mindful of the participation of family members in the legal process pertaining to Adult B. Initial contact was facilitated by Family Liaison Officers at Thames Valley Police.*
> *Early attempts to engage members of the family with the DHR process were responded to by the family, who at that stage did not wish to meet with or speak with panel members or the DHR chair.*
> *Following the conclusion of the trial, the panel Chair, along with another member of the panel met separately with Adult A's mother and sister, Adult C and with Adult B herself.*
> *Meeting have been held with Adult D who has been proactive in engaging with the process. The panel Chair met with him as an individual and met with him and Adult B together. We have taken account of his wish to advise the panel of the family history and its relevance to the case. We have had further communication with him and his advocate via telephone and email.*
> *Adults B, C, D and the sister of Adult A have had the opportunity to read and comment on the full draft of the Overview Report and their views have been taken into account.*
> *During our conversations with both Adult B and Adult D they told us about a number of their concerns relating to their engagement with statutory services.*

28. The report then identifies those concerns. Although there was greater involvement in the analysis by the Claimant and other family members, it is noted that there was no opportunity to be present while any of the review work was carried out.

29. Section three of the report [pages 55-64] sets out the conclusions of the DHR panel and section four sets out the recommendations [pages 65-71]. Part of the conclusions state: "The behavioural and management challenges that Adult B presented, coupled with her recent history of violence, probably in the context of her mental health difficulties, specifically assault and criminal damage and her difficult relationship with Adult A were not given the due weight in the risk assessment process." The report also concludes that the homicide was not predictable, but was preventable. [Pages 63-64].

<u>The decision of the Senior Coroner.</u>

30. On 10th February 2016, the Senior Coroner for Oxfordshire in a letter to the solicitors for the claimant gave his decision not to resume the inquest into the death of Ms Baker. In his letter after referring to the DHR Report and the Route Cause Analysis Investigation Report by Oxford Health NHS Foundation Trust, he stated:

> *It is also to be noted that [K] was an informal patient at the time when Ms Baker was killed. I see from your letter dated 10 august 2015 that you believe that there should be an Article 2 inquest. There is perhaps an arguable case that Article 2 is applicable but, I do not think it is as [K] was not detained.*
>
> *As to resuming the Inquest, be it a Jamieson or Article 2 Inquest, the relevant provisions are in paragraphs 7 and 8 of Schedule 1 to the Coroners and Justice Act 2009. It states that a suspended investigation may only be resumed if the Coroner thinks that there is sufficient reason to do so. The decision is of a highly discretionary character as stated in the case of R. v. Inner West London Coroner Ex p Dallaglio (1994). It is in fact unusual for an Inquest to be resumed if there has been a substantive hearing about the death in the Crown Court. The test is whether the facts of the death have been adequately aired in public. The matters to be determined by a Coroner at Inquest are: the identity of the Deceased and How, When and Where the Death occurred. These matters have been adequately aired at the Crown Court Trial. Even if Article 2 was applicable, which I do not believe it is, I believe that the combination of the Crown Court Trial and the investigations that I have referred to (which are specifically in relation to the mental health aspects) are, when taken together, sufficient to satisfy Article 2.*

31. There are two primary points made on behalf of the Claimant. Firstly, it is submitted that when the Senior Coroner considered whether to resume and to hold a full inquest, he applied the incorrect test. Secondly, it is submitted that the investigations the Senior Coroner relied upon to make his determination were not ones capable of discharging the obligation under Article 2 of the Convention.

32. In relation to the first point, in the letter written by the Senior Coroner he refers to *"whether the facts of the death have been adequately aired in public"*. With respect to the Senior Coroner that is not the test to be applied in these circumstances. Paragraph 8 of Schedule 1 to the Coroner and Justice Act 2009 states that: "*(1) An investigation that is suspended under paragraph 2 may not be resumed unless, but must be resumed if, the senior coroner thinks that there is sufficient reason for resuming it."* The test requires a coroner to consider whether there is sufficient reason for resuming the inquest.

33. The Senior Coroner referred in his letter to the decision of the Court of Appeal in *R. v. Inner West London Coroner, ex parte Dallaglio and another* [1994] 4 All ER 139 where the nature of the discretion to resume an inquest was considered. Our attention was drawn to a couple of passages in the judgment of Simon Brown LJ (as he then was) and specifically at page 155 e:

> *The decision to be made under s 16(3)* [a reference to the Coroners Act 1988 which is in identical terms to the provision in the Coroners and Justice Act 2009] *is of a highly discretionary nature and in no way circumscribed by a need to find exceptional circumstances, only 'sufficient cause'. The coroner*

states that 'only rarely' are inquests resumed after criminal proceedings but, of course, the section itself expressly envisages, rather than discourages, such a course.

34. In relation to the question as to whether Article 2 of the Convention is applicable here, in my judgment when one looks at the facts of this case, the investigative duty required by that article is clearly triggered. The question for this court is whether the Senior Coroner was in error to find that the investigations that have taken place to date in relation to this death were such as to discharge that investigative obligation?

35. The Senior Coroner refers in his letter of February 2016 to the 'Crown Court Trial' together with the two reports as being sufficient to satisfy Article 2 of the Convention. There was, in fact, no Crown Court trial. At an early hearing an acceptable plea was tendered and 'K' was made the subject of a hospital order. The two other investigations comprised an internal NHS Trust investigation that was carried out in private and the DHR was expressed to be private and confidential.

36. In the course of his submissions Mr Bunting took us to a number of authorities in support of his submission that the investigations here are insufficient to satisfy the obligation in Article 2 of the Convention. It is not necessary for me to rehearse here all of the passages referred to in oral argument or as set out in the skeleton argument. Of particular assistance is the decision of the House of Lords in *R. (Amin) v. Secretary of State for the Home Department* [2004] 1 AC 653. The case concerned the death in March 2000 of Zahid Mubarek, a 19 year-old prisoner who was then serving a sentence in Feltham Young Offender Institution. He was murdered by Robert Stewart, with whom he shared a cell. The issue in the appeal was whether this country had complied with its duty under Article 2 of the Convention to investigate the circumstances in which this crime came to be committed. The Secretary of State refused a request from the family for a public inquiry into the death on the grounds that such an inquiry would not be in the public interest. That decision was challenged by way of judicial review. The judge granted a declaration that an independent public investigation with the deceased's family legally represented, provided with the relevant material and able to cross-examine the principal witnesses should be held in order to satisfy the state's procedural duty under Article 2 of the Convention to investigate the deceased's death. The Secretary of State appealed that finding. The Court of Appeal concluded that the series of inquiries that had been held did satisfy the state's duty and set aside the judge's order. The family then appealed to the House of Lords.

37. At paragraphs 9 to 13 of the speech of Lord Bingham he set out the four sets of investigations and the adjourned inquest that had taken place:

> *9. Stewart was charged with murder, and his trial started on 24 October 2000. He admitted the killing. The issue was whether he was guilty of murder or of manslaughter by reason of diminished responsibility. He was convicted of murder. Although the court heard evidence of the circumstances immediately surrounding the killing, including the actions of prison officers at that time, there was no exploration at the trial of cell allocation procedures or other events before the murder.*
>
> *10. An inquest into the death of the deceased was formally opened on 31 March 2000 and then adjourned pending trial of the murder charge against*

Stewart. Following the conviction HM Coroner for West London declined to resume the inquest, a decision to which she adhered despite representations inviting her to reconsider it. In an affidavit she has given detailed reasons why the constraints to which coroners and inquests are subject make an inquest an unsuitable vehicle for investigating publicly the issues raised by this case.

11. The police investigated whether the Prison Service or any of its employees should be prosecuted for manslaughter by gross negligence or under section 3 of the Health and Safety at Work etc Act 1974. The advice of counsel was that there was insufficient evidence to provide a realistic prospect of securing any conviction relating to the death of the deceased. His family were so informed in August 2001.

12. The terms of reference of the Butt inquiry were to investigate the circumstances surrounding the murder and in particular to consider the issue of shared accommodation both generally and with particular reference to Stewart, in the light of what was known about his criminal history and institutional behaviour. The family of the deceased were consulted about these terms of reference but were not present at any stage of the investigation and although invited to meet Mr Butt did not avail themselves of this opportunity. Mr Butt's report was in two parts, completed at the end of October and November 2000 respectively. Copies of both parts were made available to the family, save for certain confidential annexes relating to individual prisoners, and no restriction was placed on their use of the report, save for the transcripts of interviews with members of the Prison Service annexed to the first part of the report. The report was made available to the police and the Commission for Racial Equality ("the CRE") but was not published. It identified a number of shortcomings at Feltham and made 26 recommendations for change.

13. On 17 November 2000, the CRE announced that it would be conducting a formal investigation into racial discrimination in the Prison Service. Its terms of reference were wide-ranging and general across the Prison Service but made specific reference to the circumstances leading to the murder of the deceased and any contributing act or omission on the part of the Prison Service. The family were involved in the preparation of the terms of reference and expressed views on the procedures proposed. The family wrote to the CRE asking that they be allowed to participate in its inquiry and for its hearings to be in public, but the CRE refused this request. It stated that the inquiry had to be seen to be impartial and that, although there was to be a "public component" in its proceedings, it could not conduct the whole inquiry in public. In the event, a public hearing was held on 18 September 2001 when certain high-level policy witnesses made statements and were questioned by counsel for the CRE. Before this hearing the family were offered a meeting with counsel at which they could raise topics which they would like to be covered in the cross-examination. They did not take up this offer and did not attend the public hearing. They had no opportunity to question witnesses. The CRE published its report relating to the deceased in July 2003, very shortly

before the hearing in the House. It made a finding of race discrimination against the Prison Service and identified 20 respects in which the administration of Feltham had failed.

38. Having then set out the domestic law and the convention and the decision of the judge as well as the decision of the Court of Appeal, at paragraph 30 Lord Bingham concludes as follows:

> *30. A profound respect for the sanctity of human life underpins the common law as it underpins the jurisprudence under articles 1 and 2 of the Convention. This means that a state must not unlawfully take life and must take appropriate legislative and administrative steps to protect it. But the duty does not stop there. The state owes a particular duty to those involuntarily in its custody. As Anand J succinctly put it in Nilabati Behera v State of Orissa (1993) 2 SCC 746 at 767 "There is a great responsibility on the police or prison authorities to ensure that the citizen in its custody is not deprived of his right to life". Such persons must be protected against violence or abuse at the hands of state agents. They must be protected against self-harm: Reeves v Commissioner of Police of the Metropolis* [2000] 1 AC 360. *Reasonable care must be taken to safeguard their lives and persons against the risk of avoidable harm.*
>
> *31. The state's duty to investigate is secondary to the duties not to take life unlawfully and to protect life, in the sense that it only arises where a death has occurred or life-threatening injuries have occurred: Menson v United Kingdom (Application No 47916/99) (unreported) 6 May 2003, page 13. It can fairly be described as procedural. But in any case where a death has occurred in custody it is not a minor or unimportant duty. In this country, as noted in paragraph 16 above, effect has been given to that duty for centuries by requiring such deaths to be publicly investigated before an independent judicial tribunal with an opportunity for relatives of the deceased to participate. The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others.*
>
> *32. Mr Crow was right to insist that the European Court has not prescribed a single model of investigation to be applied in all cases. There must, as he submitted, be a measure of flexibility in selecting the means of conducting the investigation. But Mr O'Connor was right to insist that the Court, particularly in Jordan v. United Kingdom 37 EHRR 52 and Edwards v. United Kingdom 35 EHRR 487, has laid down minimum standards which must be met, whatever form the investigation takes. Hooper J loyally applied those standards. The Court of Appeal, in my respectful opinion, did not. It diluted them so as to sanction a process of inquiry inconsistent with domestic and Convention standards.*

33. There was in this case no inquest. The coroner's decision not to resume the inquest is not the subject of review, and may well have been justified for the reasons she has given. But it is very unfortunate that there was no inquest, since a properly conducted inquest can discharge the state's investigative obligation, as established by McCann v. United Kingdom 21 EHRR 97. It would overcome the problems exposed by this appeal if effect were given to the recommendations made in "Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review 2003" (Cm 5831) (June 2003), and no doubt that report is receiving urgent official attention.

34. The police investigations into the criminal culpability of Stewart and the Prison Service were, very properly, conducted in private and without participation by the family. The Advice Report on which counsel based his advice not to prosecute the Prison Service or any of its members was produced in evidence during these proceedings but not before. It is written in an objective and independent spirit, but it raises many unanswered questions and cannot discharge the state's investigative duty.

35. The trial of Stewart for murder was directed solely to establishing his mental responsibility for the killing which he had admittedly carried out. It involved little exploration, such as would occur in some murder trials, of wider issues concerning the death.

36. There is no reason to doubt that Mr Butt set about his task in a conscientious and professional way. He explored the facts, exposed weaknesses in the Feltham regime and recommended changes which, it is understood, have been and are being implemented. It is however plain that as a serving official in the Prison Service he did not enjoy institutional or hierarchical independence. His investigation was conducted in private. His report was not published. The family were not able to play any effective part in his investigation and would not have been able to do so even if they had accepted the limited offer made to them.

37. The CRE report, which was not before the judge or the Court of Appeal, brings additional facts to light (although some of these, such as the discovery of a handmade wooden dagger under Stewart's pillow after the murder, raise many further questions). The report has been published. But the CRE inquiry, conducted under the Race Relations Act 1976, was necessarily confined to race-related issues and this case raises other issues also (as did Edwards, where there was no race issue). Save for a single day devoted to policy issues, the inquiry was conducted in private. The family were not able to play any effective part in it and would not have been able to do so even if they had taken advantage of the limited opportunity they were offered. Whether assessed singly or together, the investigations conducted in this case are much less satisfactory than the long and thorough investigation conducted by independent Queen's Counsel in Edwards' case, but even that was held inadequate to satisfy article 2(1) because it was held in private, with no opportunity for the family to attend save when giving evidence themselves and without the power to obtain all relevant evidence.

> *38. I consider that the judge was right to reach the conclusion and make the order which he did. For the foregoing reasons, and those given by my noble and learned friends Lord Slynn of Hadley, Lord Steyn and Lord Hope of Craighead, I would accordingly allow the appeal and restore his order.*
>
> *39. I cannot accept the submission of Mr Crow that any further inquiry is unlikely to unearth new and significant facts. The papers before the House raise questions which any legal representative of the family would properly wish to pursue and the discovery of further new facts of significance may well be probable. But it is true that there are factual areas - for example, the killing itself, and the cause of death - which have already been fully explored and of which little or no further examination is required. Many of the factual findings made by Mr Butt and the CRE can no doubt be taken as read. It will be very important for the investigator to take a firm grip on the inquiry so as to concentrate the evidence and focus the cross-examination on issues justifying further exploration. Reliance should be placed on written statements and submissions so far as may properly be done at a hearing required to be held in public. All those professionally engaged, for any party, should bear in mind their professional duty to ensure that the investigation of this tragic and unnecessary death is conducted in a focused and disciplined way.*

39. In my judgment, the Senior Coroner should have taken a decision to resume the inquest. His decision not to do so, was unlawful and in breach of both the obligations under Article 2 of the Convention and the common law obligations to do so. Taken together the Crown Court proceedings and the two internal investigations did not satisfy the requirements in this case. In all the circumstances, this claim for judicial review should be allowed.

Charles J:

40. I agree.

41. The Chief Coroner for England and Wales has sat as a member of the Court in a number of the cases to which we were referred relating to the decisions of Coroners. Where, as here, the challenge does not engage any of the duties of the Chief Coroner of England and Wales as such it seems to me that this is both appropriate and helpful.