CHIEF CORONER

LAW SHEET No.3

THE *WORCESTERSHIRE* CASE:

DISCLOSURE TO THE CORONER, NOT TO THE PUBLIC

Introduction

1. The decision in *Worcestershire County Council and Worcestershire Safeguarding Children Board v HM Coroner for the County of Worcestershire* [2013] EWHC 1711 (QB)[1], illustrates an important point. The public interest in the pursuit of a full and appropriately detailed inquest may outweigh a public interest claim for non-disclosure of a report into a death, particularly when the disclosure is to the coroner rather than to the public. Coroners should therefore expect greater disclosure to them so that they may properly assess the scope of an inquest and the witnesses to be called.

The issue in the case

2. A 16 year old girl was found hanging from a tree. Complying with their statutory duty, the Local Safeguarding Children Board (LSCB) undertook a Serious Case Review (SCR).[2] In the course of this review the LSCB obtained ten Individual Management Reviews (IMRs) and six Information Reports (IRs), in total some 600 pages of documentation. The LSCB produced an SCR Overview Report in draft form pending the outcome of the inquest.

3. The coroner requested the overview report and the IMRs and IRs. With reluctance the LSCB provided the overview report but not the other underlying reports.

4. The coroner therefore applied to the High Court for permission to issue witness summonses requiring the LSCB to produce the underlying reports. The LSCB applied to set the summonses aside on the basis that disclosure of the underlying reports was either protected by public interest immunity or unnecessary.

The submissions of the LSCB and the coroner

5. The LSCB submitted that it was in the public interest that there should be no public disclosure, so as to facilitate and promote candour from those who

[1] With thanks to the Senior Coroner for Worcestershire, Geraint Williams.
[2] See section 16(2), The Children Act 2004, and the Secretary of State's guidance, *Working Together to Safeguard Children (2010)*, Chapter 8.

contributed to the underlying reports, assuring them that what they said would be confined to those reports and go no further.

6. The coroner submitted that he sought disclosure of the underlying reports so that he could fulfil his statutory function of making proper inquiries into the death. He believed that the reports would assist him in determining the scope of the inquest by identifying the factors underlying the 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 pointed out that for the purposes of this case the disclosure sought was to the coroner in his inquisitorial role, and not to the public. He also needed to see the material to decide whether an Article 2 inquest was necessary. He submitted that the overview report was inadequate for all these purposes.

The decision

7. In the High Court, Baker J agreed with the coroner's submissions. He refused to set aside the summonses and held that the coroner was entitled to have disclosure of the underlying reports as well as the overview report.

8. The coroner was entitled to full disclosure so that he could decide what witnesses to call and what issues should be considered at the inquest.

9. With any claim for non-disclosure on the basis of public interest immunity, it was necessary to balance the perceived public benefit it afforded against the public benefit of disclosure. In this case the public interest in pursuit of a full and appropriately detailed inquest firmly outweighed the claim for non-disclosure, bearing in mind that disclosure was to the coroner, rather than the public.

10. The judgment also makes reference to Ministry of Justice guidance that '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'.[3]

Onward disclosure

11. Onward disclosure by the coroner to interested persons, and therefore to the public, would be a matter for determination by the coroner (subject to the supervision of the High Court). In this case, said Baker J, the coroner had willingly undertaken not to make any such disclosure without first giving the LSCB and other relevant agencies the opportunity to make submissions.

Disclosure to the coroner, not to the public

12. The distinction between disclosure to the coroner and disclosure to the public has always been significant. Coroners are frequently provided with reports which are not disclosed further. Police reports are a common example.[4] They are intended to assist the coroner in understanding the issues and deciding which witnesses are to be called at the inquest. Police reports are not adduced in evidence because they are not primary evidence.[5] The coroner will read a police report and

[3] *Guidance for coroners and Local Safeguarding Children Boards on the supply of information concerning the death of children*, at paragraph 3.5.
[4] See *R (Lagos) v HM Coroner for the City of London* [2013] EWHC 423 (Admin), [4] - [11]. See also *Re Wright's Application for Judicial Review* [2003] NI QB 17, applying the same approach in Northern Ireland in an Article 2 case; and *Re McCaughey (Judicial Review Application)* [2004] NI QB 2 at [11].
[5] *Lagos*, above, at [5].

use it to prepare for an inquest, but will not rely upon it as part of the evidence upon which he or she reaches a conclusion at the inquest.The same principles should apply to company reports where non-disclosure is claimed on the grounds of confidentiality or commercial sensitivity.

13. Therefore unless reports are provided on a voluntary basis for interested persons as well as the coroner, such as reports into the deaths of prisoners which are routinely disclosed to families by the Prisons and Probation Ombudsman, they will be received by the coroner on a confidential basis, for his/her eyes only. Whether there is any onward disclosure to interested persons will be a matter for the coroner considering submissions and following the provisions on disclosure of documents in the 2013 Rules[6] and in the caselaw.[7]

14. The *Worcestershire* case therefore illustrates in clear terms the two-stage process.[8] In the first stage the coroner should request all reports or other material which he/she believes to be relevant for the purpose of assessing the scope and content of his/her inquiry, pointing out that this is disclosure to the coroner only. The coroner should point out how the two-stage process works, referring to the *Worcestershire* case and this Law Sheet, both of which are publicly accessible on the judiciary website.

15. If there is objection to disclosure, the coroner should consider relying on the decision in the *Worcestershire* case to show that the public interest in disclosure should in the circumstances of the particular case outweigh the public interest in non-disclosure and that any disclosure needs to be sufficiently full for the coroner's statutory purposes.

16. In the second stage the disclosure of that material to the public, through interested persons, will be made in the usual way, giving those who may wish to argue against disclosure sufficient opportunity to do so.

In summary

17. In summary the lessons to be learned from the *Worcestershire* case (and the *Channel Four* case) are as follows:

    (1) An application by a coroner for disclosure need no longer be made by summons to the High Court or County Court. It may be made under the notice provisions in Schedule 5 of the 2009 Act. In particular a coroner who is conducting an investigation may require a person 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: paragraph 1(2)(b), Schedule 5.[9]

    (2) The process of disclosure is a two-stage process. In the first stage disclosure is to the coroner alone, for the purpose of deciding the scope of the inquest and the witnesses to be called. In the second stage the coroner decides whether there can and should be onward disclosure to interested persons.

---

[6] Rules 12-16, Coroners (Inquests) Rules 2013.
[7] See, for example, the *Worcestershire* case at paragraphs [69] – [73]. See also *Inner West London Assistant Deputy Coroner v Channel Four Television Corporation* [2007] EWHC 2513 (QB) (Eady J).
[8] *Ibid.* at [28].
[9] See *Worcestershire* case at [53].

(3) In the context of disclosure it should be remembered that a coroner's court is different from a civil court. Courts should be wary of 'trying slavishly to fit a coroner's inquest into the template of civil litigation'.[10]

18. The benefit of the decision in the *Worcestershire* case for coroners is the extent to which they may justifiably ask for material which they reasonably believe may assist them in their investigation. The decision reflects the trend in the courts towards greater disclosure, at least, as in this case, for the eyes of the coroner.

HH JUDGE PETER THORNTON QC
CHIEF CORONER

31 January 2014

[10] *Channel Four* case at [9].