CHIEF CORONER

Law Sheet 6

R (on the application of Maughan) v. HM Senior Coroner for Oxfordshire

[2020] UKSC 46

1. On 13 November 2020 the Supreme Court gave judgment in the case of ***Maughan***. By a majority of three to two the Supreme Court ruled that all conclusions in coronial inquests, whether short form or narrative, are to be determined on what is known as the civil standard of proof: the balance of probabilities [para. 97]. This is a test that coroners are used to dealing with as they (and juries directed by them) apply it in the overwhelming majority of inquests.

2. In giving the leading judgment Lady Arden stressed that a "coroner's inquest is not a criminal proceeding" [para 2]. Pointing out that the role of inquests has changed [paras 8 to 10], and that inquests are not concerned with criminal justice but with the investigation of deaths [para 81], she stated that "the public are likely to understand that there is a difference between a finding at an inquest and one at a criminal trial where the accused has well-established rights to participate actively in the process" [para 93]. There are many judicial statements to the effect that inquests are inquisitorial proceedings and so are fundamentally distinct from criminal or civil trials.[1]

3. The decision in ***Maughan*** serves to emphasise that an inquest is a fact-finding exercise and not a method of apportioning guilt. At any inquest where unlawful killing may be in issue, it will now be particularly important for the coroner to explain the distinction between criminal proceedings and inquests. The explanation should set out the nature of the inquest process as a fact-finding inquiry with the objective of

[1] See R v South London Coroner, Ex Parte Thompson (1982) 126 SJ 625 (cited with approval by Lord Kerr in Maughan (dissenting) at para. 141).

answering the four statutory questions (who the deceased was; and when, where and how the deceased came by his or her death). Where a coroner or coroner's jury comes to a conclusion of unlawful killing, that finding has no bearing on criminal proceedings, which are subject to a materially higher standard of proof (as well as entirely different procedural rules).

4. There are nine short form conclusions which appear in the notes to the Record of Inquest form that is scheduled to The Coroners (Inquests) Rules 2013[2]: (i) accident or misadventure, (ii) alcohol/drug related, (iii) industrial disease, (iv) lawful/unlawful killing, (v) natural causes, (vi) open, (vii) road traffic collision, (viii) stillbirth, (ix) suicide. For seven of those conclusions, the decision in *Maughan* makes no change to the approach of coroners or any interested persons.

5. For another of the short form conclusions, suicide, the decision of the Supreme Court confirms the position as determined by the Divisional Court in *Maughan* on 26 July 2018 ([2018] EWHC 1955 (Admin)) and reaffirmed by the Court of Appeal Civil Division on 10 May 2019 ([2019] EWCA Civ 809). Coroners, and (where they have been engaged) juries, have applied the law and the civil standard of proof to the two elements in inquests where suicide has been in issue: (a) that the deceased took his or her own life and (b) that he or she intended to do so.

6. The decision of the Supreme Court in *Maughan* clearly makes a material change to the approach to be taken to one of the short form conclusions, unlawful killing. The legal rule had previously been that a conclusion of unlawful killing could only be returned if the coroner or jury were satisfied to the criminal standard (beyond reasonable doubt) that a crime of murder, manslaughter or infanticide had been committed, resulting in the death. The coroner or jury had to be satisfied that all the elements of the offence were established to the criminal standard. As a result of the decision in *Maughan*, the civil standard (balance of probabilities) applies. The conclusion should be returned if (and only if) the coroner or jury is satisfied as a matter of probability that the crime of murder, manslaughter or infanticide has been committed, resulting in the death. Each of the elements of the relevant offence needs to be established to the civil standard.

[2] There are a further four conclusions which appeared in the notes to the 1984 form but do not form the basis for the Office of National Statistics statistics.

7. This change must be viewed in its wider context. In 2019 there were fewer than 166 conclusions of unlawful killing[3] made by coroners or juries in inquests[4] out of a total number of 31,284 inquest conclusions, or approximately 0.5%.

8. Although the decision in *Maughan* will probably have some continuing impact on the figures, the issue of unlawful killing is likely to feature in relatively few cases. In those cases where it does arise, the Chief Coroner would expect coroners to take a well-reasoned and fact-specific approach when faced with submissions and / or decisions as to the conclusions that are open to consideration.

9. Where a conclusion of unlawful killing is one that on the facts is open to the coroner or the jury, then the coroner will need to direct himself (or the jury) as to what elements need to be established for the offence(s) that may be in play[5] and then to apply the civil standard to the facts as they relate to each element of the offence.

10. It is the Chief Coroner's intention that the Guidance and Law Notes referred to below will be amended to take into account the decision in *Maughan*.

Finding a conclusion of unlawful killing

11. Law Sheet No.1 on 'Unlawful Killing' identifies the elements of murder, manslaughter (both as to unlawful act and gross negligence forms), corporate manslaughter, and infanticide. A conclusion of unlawful killing is restricted to the criminal offences of murder, manslaughter and infanticide[6], and reference should continue to be made to that Law Sheet for the elements of the offences set out. The judgment in *Maughan* has not altered this aspect of the relevant case law. For a conclusion of unlawful killing to be returned by a coroner or jury, each element of the relevant offence must be established to the civil standard.

12. For a coroner sitting with a jury, after all the evidence has been heard it is necessary for the coroner to decide what potential conclusions to leave to the jury, applying the '*Galbraith* plus' test[7]. Where unlawful killing is a potential conclusion on the facts, the

[3] i.e. There were 166 'all other' conclusions which includes killed unlawfully, killed lawfully, attempted or self-induced abortion, cause of death aggravated by lack of care, or self-neglect, want of attention at birth, stillborn and disasters.
[4] https://www.gov.uk/government/statistics/coroners-statistics-2019
[5] Note that these elements may involve principles of criminal law. For instance, where there is an issue of self-defence or defence of others, the principles applying are those of criminal law: see R (Duggan) v North London Assistant Deputy Coroner [2017] 1 WLR 2199.
[6] See R (Wilkinson) v HM Coroner for Manchester South [2012] EWHC 2755 (Admin).
[7] See Law Sheet No.2 – Galbraith Plus

coroner will need to consider whether a jury, properly directed, could find all the elements of the relevant offence proved on the balance of probabilities and whether such a conclusion could safely be reached.

13. Paragraph 26 of Law Sheet No. 1 refers specifically to Rule 25 of the Coroners (Inquests) Rules 2013 and the requirement that if, during the course of an inquest, it appears to the coroner that the death of the deceased is likely to have been due to a homicide offence and that a person may be charged in relation to the offence, the coroner must adjourn the inquest and notify the DPP[8]. The decision in *Maughan* makes no difference to the application and interpretation of Rule 25.

14. In some cases of deaths following restraint, medical cases and other situations in which allegations of negligence arise, coroners will be faced with legal submissions to the effect that unlawful killing is a conclusion which is properly open to the coroner or jury. Subject only to the modification that a conclusion of unlawful killing is now to be determined on the balance of probabilities, coroners should continue to approach the question whether unlawful killing is an available conclusion as they presently do, following the necessary steps summarised in Law Sheet No. 1.

15. Where a coroner is sitting with a jury, if unlawful killing is a conclusion properly open on the facts, the coroner will need to give a reasoned judgment explaining why, and direct the jury accordingly. A reasoned decision will equally be expected of the coroner if unlawful killing is not, in the coroner's judgment, a conclusion properly open to the jury on the facts of the case.

Short-form and narrative conclusions

16. There is no requirement in law for a coroner or inquest jury to use any particular form of words when recording a conclusion on the Record of Inquest. The notes on the current prescribed form of the Record of Inquest (Form 2), which set out suggested short form conclusions that may be adopted, do not 'codify the law' as to standards of proof (see *Maughan* at paras. 15 to 57). A short form conclusion (of which unlawful killing is one) is not required to be returned as a matter of law, whether as part of a longer narrative or standing alone. Rather it is for the coroner (or for the coroner's jury subject to the coroner's directions) to choose the appropriate form of words to

[8] See also the agreement between the CPS, NPCC, Chief Coroner and Coroners' Society of England and Wales: https://www.cps.gov.uk/sites/default/files/documents/legal_guidance/coroners_agreement_2016.pdf

reflect the findings of fact on the critical issues relating to the death in the case in question.

17. Chief Coroner's Guidance No.17 on 'Conclusions' urges coroners, wherever possible, to record a short-form conclusion, with or without a narrative. This has the advantage of being simple, accessible for bereaved families and the public, and is also clear for statistical purposes. The *Maughan* decision does not alter this Guidance.

Gross negligence manslaughter

18. The elements of the offence of gross negligence manslaughter are set out in the case of R v Adomako [1995] 1 AC 171 as summarised in Law Sheet No. 1. Each of the six elements of the offence must be established on the balance of probabilities before a coroner or jury may return a conclusion of unlawful killing based upon the offence of gross negligence manslaughter.

Resumptions

19. Guidance No. 33, 'Suspension, adjournment and resumption of Investigations and Inquests', was issued on 7 October 2019. It sets out the approach coroners should take to suspension of inquests, including in those cases where a person either has been, or may be, charged with a homicide offence involving the death of the deceased or an offence alleged to be a related offence. It also deals with situations where the question arises whether an inquest adjourned for criminal proceedings to take place should be resumed.

20. As before the decision in *Maughan*, an acquittal of a defendant following a criminal trial does not automatically mean that a coroner will need to resume the inquest. By the same token, a conviction by plea or trial does not automatically mean that there need be no resumption of the inquest. In either scenario, there may be issues requiring further public investigation that necessitate a resumption. A number of decisions of the High Court assist coroners with decisions in this kind of case. Three of them are relatively recent: *R (on the application of Silvera) v. HM Senior Coroner for Oxfordshire* [2017] EWHC 2499 Admin, which is referred to in Guidance No. 33; and the recent decisions in *R (on the application of Skelton v. HM Senior Coroner for West Sussex* [2020] EWHC 2813 Admin and *R (on the application of Grice) v. HM Senior Coroner of Brighton and Hove* [2020] EWHC 3581 Admin. Coroners will

need to consider requests for resumption with care and give, as with any other judicial decision, a reasoned judgment. Where a trial at the Crown Court has explored the key issues relating to death, any suggestion that an inquest hearing is necessary should be scrutinised with care.

21. If the inquest is resumed following a criminal trial of a homicide offence in relation to the death, the inquest determination may not be inconsistent with the outcome of the criminal proceedings: see para. 8(5) of Schedule 1 to the Coroners and Justice Act 2009. If in such an inquest the coroner or inquest jury find that the requisite elements of murder, manslaughter or infanticide are established on the balance of probabilities then a conclusion of unlawful killing will be permissible even though there has already been an acquittal of the offence following a homicide trial. Such an inquest conclusion would not be inconsistent with a criminal jury having already found that they were not satisfied of the very same matters beyond reasonable doubt. However, if there has been a criminal trial at which a person has been convicted of a homicide offence, then the coroner or jury at a subsequent inquest could not reach a conclusion to the effect that the offence had not been committed.

Scope of resumed inquests

22. As with any inquest, the role of the coroner is to determine the scope of the inquiry with care so as to ensure that it is looking at the key issues. If application is made to resume an inquest after criminal proceedings have concluded, reference should be made to Guidance No. 33 and in particular to paragraphs 32 to 38, as well as paragraphs 39 to 43, which address a point that arises in some cases of resuming historic inquests.

23. All decisions of coroners as judicial office holders are potentially susceptible to challenge by judicial review. This covers decisions out of court sent by letter or email, or communicated in any other way, as much as those in court, and so it is imperative that all coroners give clear reasons for any judicial decision they make. Depending on the decision, this may be done in a letter or short document. If a significant decision is communicated orally it is best practice to reduce the ruling or decision to written form and circulate it to all relevant interested persons.

24. It would be prudent for all senior coroners to alert their local authorities to the change in the law made in the *Maughan* case and any implications they identify for their areas. Where an inquest might justify it, senior coroners should also consider

Guidance No. 40 and the appointment of solicitor or counsel to the inquest to assist the coroner with any decisions arising from the change in the law.

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CHIEF CORONER

13 January 2021