Neutral Citation Number: [2025] EWHC 605 (Admin)

Case No: AC-2024-LON-001226

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT
DIVISIONAL COURT

Royal Courts of Justice
Strand, London, WC2A 2LL
Date: 14th March 2025

Before:

LADY JUSTICE MACUR

MRS JUSTICE HILL

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Between:

DOUGLAS AND CAROLE SHIPSEY	**Claimant**
- and -	
	Defendant
HM SENIOR CORONER FOR WORCESTERSHIRE	
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	**First Interested Party**
HEREFORDSHIRE AND WORCESTERSHIRE HEALTH AND CARE NHS TRUST	**Second Interested Party**

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Christopher Williams (instructed by **Irwin Mitchell Solicitors LLP**) for the **Claimant**
Briony Ballard (instructed by **Worcestershire County Council**) for the **Defendant**
Bridget Dolan KC (instructed by **Herefordshire and Worcestershire NHS combined Legal Services**) for the **Interested Parties**

Hearing date: 5 March 2025
Further written submissions: 6, 7 and 13 March 2025
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FINAL JUDGMENT

Approved Judgment

This judgment was handed down remotely at 12:00pm on 14th March 2025 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MRS JUSTICE HILL

Mrs Justice Hill:

Introduction

1. Bethany Shipsey died in Worcestershire Royal Hospital on 15 February 2017. She was 21 years old, having been born on 22 September 1995. Her family called her Beth. I refer to her throughout this judgment in that way in accordance with her parents' wishes.

2. Beth died from the toxic effects of Dinitrophenol ("DNP") in a quantity of unlicensed slimming tablets she had purchased over the internet. At the time of her death, she was on home leave from the in-patient mental health unit at Holt Ward, Newtown Hospital, Worcester.

3. This is her parents' application under the Coroners Act 1988, section 13. I reiterate my condolences to the Claimants for the tragic loss of their daughter. It has inevitably been necessary to make difficult decisions against a complex factual, legal and procedural background, but it is important to remember that at the centre of the case is the death of a vulnerable young person and a grieving family.

4. The Claimants' application arises from the narrative conclusion returned on 18 February 2018 at the end of the inquest into Beth's death by the then Senior Coroner for Worcestershire. The conclusion was to this effect:

> "Bethany Shipsey was a young woman with significant mental health difficulties who, on 15 February 2017, died as the result of suicide having deliberately ingested a quantity of tablets containing the drug Dinitrophenol which she had purchased over the Internet.
>
> She did so intending to take her own life and was admitted into the Worcestershire Royal Hospital at approximately 5:30 PM on that day.

> The clinicians having care of her recognised the extreme toxicity of the drug, the lack of antidote, the risk of rapid deterioration and the need for close monitoring of her condition with a view to providing supportive treatment.
>
> Notwithstanding this the clinicians failed to take sufficient or adequate steps to monitor her leaving them unprepared to deal with the rapid deterioration which ensued.
>
> There were significant failings in the care given to her which amounted to a lost opportunity to provide supportive treatment which although probably would not have saved or prolonged her life may nevertheless have done so".

5. Where an inquest has been held, the High Court's powers arise under section 13(1) where:

> "(b)….whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise…it is necessary or desirable in the interests of justice that an investigation (or as the case may be, another investigation) should be held".

6. The Defendant to the claim is the current Senior Coroner for Worcestershire. The Interested Parties, the Herefordshire and Worcestershire Health and Care NHS Trust and Worcestershire Acute Hospitals NHS Trust ("the NHS Trusts") are so recognised because they were Interested Persons in the Coroner's investigation and inquest, given their role in providing mental health services and emergency care to Beth before she died.

7. In their Part 8 claim form filed on 5 April 2024, the Claimants advanced their section 13 application on two grounds: Ground 1 relating to fresh evidence and Ground 2 relating to insufficiency of inquiry. Both grounds focussed on the aspects of the Record of Inquest relating to suicide and suicidal intent. By way of application notices dated 11 and 25 February 2025, the Claimants sought to amend their claim form and rely on further evidence, to advance arguments in relation to a potential unlawful killing conclusion.

8. At the end of the hearing on 5 March 2025 the court indicated that the Claimants were entitled to the relief they sought on the basis of Ground 1 as it was originally presented in 2024. These are the reasons for that decision.

The factual background

The events leading to Beth's death

9. Beth was clearly a much-loved daughter and sister. She liked travelling and photography. In particular, she adored nature and animals. Shortly before she died her parents had bought her a house, and she had planned to house animals there. Her occupation was given on the Record of Inquest as an animal rescuer.

10. Beth had a long history of difficulties with her mental health caused by an Emotionally Unstable Personality Disorder ("EUPD") and an eating disorder. She had engaged in frequent acts of self-harm including having taken 14 overdoses. She was admitted as an in-inpatient to Holt Ward on several occasions in 2015 and 2016.

11. On 7 January 2017, Beth was admitted to Holt Ward again. She had reported increased suicidal ideation and low mood despite regular contact from the home treatment team over the previous week.

12. On 11 January 2017 a multi-disciplinary ward review took place. Beth reported feeling better. Following the review she had leave off the ward with her father. The process of reviews and home leave continued.

13. On 15 February 2017, Beth left the ward at around 1 pm accompanied by her father and brother.

14. During the afternoon, Beth took a quantity of DNP pills whilst at home. She messaged friends on social media informing them she had taken the pills. At around 5.02 pm one of these friends called the West Midlands Ambulance Service, who attended Beth's home.

15. At 5.30 pm she was transferred to the Emergency Department ("ED") of Worcestershire Royal Hospital.

16. At 9.10 pm Beth went into cardiac arrest. At 10 pm she was pronounced dead.

The coronial proceedings

(i): The investigation

17. Having opened the inquest into Beth's death on 23 February 2017, the Coroner conducted a wide-ranging investigation. The bundle of statements and reports collated for the inquest runs to over 300 pages.

18. In their joint statement dated 27 July 2017, the Claimants set out their extensive concerns about the standard of care Beth had received from the NHS Trusts before her death, both during her final ward admission and while in the ED. They described their interactions with the ED staff in some detail. They appended to their statement exhibit DCS4, comprising 7 pages of Facebook Messenger exchanges Beth had had with her friends after taking the pills.

19. The Coroner instructed several experts, namely Dr Stephen Morley (a Consultant Chemical Pathologist and Forensic Toxicologist) and Professor Simon Thomas (a Professor of Clinical Pharmacology and Therapeutics). He also adduced expert evidence obtained by the Claimants from Dr Iain McIntyre (a Forensic Toxicologist and Consultant) and Dr Roger Slater (a Consultant in Anaesthesia and Intensive Care).

20. There was general agreement between the experts that the cause of Beth's death was DNP toxicity. The focus of their evidence was the standard of the care she had received in the ED. They gave particularly detailed consideration to whether it was possible or indeed probable that Beth would have survived if the treatment had been different ("the survivability issue").

(ii): The inquest

21. The inquest hearing took place over 6 days between 9 January and 14 February 2018 before a coroner sitting alone without a jury. The Claimants were represented by counsel throughout as were the NHS Trusts (albeit that neither of those counsel were instructed on the section 13 application).

22. The Coroner heard oral evidence over several days from, among others, the Claimants, Dr Nirvana Chandrappa (Beth's Inpatient Consultant Psychiatrist at the Holt Ward), Dr Alireza Niroumand (a Senior House Officer who had treated Beth in the ED), Dr McIntyre and Dr Slater. The transcripts of their evidence make clear that the Coroner ensured that all these witnesses gave detailed evidence and were questioned by counsel.

23. The Coroner adduced some evidence on the question of Beth's state of mind at the time she ingested the pills and specifically whether she intended to die ("the intention issue"). However, the overall impression generated by the contemporaneous documentation is that the primary focus of the inquest was the survivability issue. All counsel instructed on the section 13 application agreed with this analysis.

24. At the end of the evidence, the Coroner heard submissions from counsel on the conclusions that were available on the evidence. The Claimants' counsel contended that a "short form" conclusion of neglect in relation to the care Beth received in the ED should be considered. He also argued that it would be unsafe for the Coroner to consider suicide as a possible conclusion, by reference to the criminal standard of proof that then applied.

(iii): The Coroner's ruling

25. On 14 February 2018 the Coroner summed up of the evidence and gave his ruling. The process took almost 2½ hours and the transcript of the Coroner's ruling runs to over 40 pages. This was a very thorough approach.

26. The Coroner set out the legal principles relevant to a Coroner's conclusion of suicide at paragraphs [4]-[5] and his findings of fact on that issue at [11]-[20]. He described the events in the ED at [21]-[50] and gave the Claimants' perspective on those events at [60]-[65]. He summarised the expert evidence in relation to DNP generally at [51]-[59] and on the survivability issue at [66]-[110]. The Coroner set out his overall determinations, findings and conclusions at [111]-[123].

27. As to the survivability issue, the Coroner accepted that certain failings in the medical care Beth had received in the ED amounted to failures in basic medical care; and that had they not occurred it was possible that she would have survived. However, as it was not probable that she would have done so, the failings did not have a direct causal connection to her death, rendering a neglect conclusion inappropriate in light of the case-law.

28. As to the intention issue, the Coroner recorded the Claimants' shared view that Beth had not intended to take her life: rather, they believed that, as with all her previous overdoses, her actions in taking the pills were a cry for help. She was otherwise feeling positive about life in her new home. However he noted that there was evidence pointing the other way, namely statements Beth had made to medical professionals to the effect

that she did intend to end her life, some aspects of her Facebook messages to similar effect, particular stressors in the days leading up to her death, her awareness of the risk of taking the pills and her statements as to the number of pills she had taken.

29. Having considered all the evidence the Coroner concluded that the necessary standard of proof was met for a short form conclusion of suicide, which he included within the overall narrative conclusion set out at [4] above.

30. Overall, I commend the Coroner for the comprehensive and sensitive way in which this investigation and inquest were carried out. The reasons for granting the section 13 application are not intended to amount to any direct, or even indirect, criticism of his conduct.

The judicial review proceedings

31. On 10 May 2018 the Claimants brought a claim for judicial review. The Claimants did not seek to challenge any of the findings made by the Coroner in respect of the medical care Beth received in the ED. However, they argued that the Coroner had acted irrationally and erred in law in reaching a conclusion of suicide. By way of relief, they sought amendments to the Record of Inquest to remove the phrases that referred to suicide and suicidal intent.

32. The judicial review claim was stayed pending the judgment of the Supreme court in *R (Maughan) v Oxfordshire Senior Coroner*, addressing the standard of proof for a conclusion of suicide in inquest proceedings. The Supreme Court handed down its judgment in *Maughan* on 13 November 2020: [2020] UKSC 46; [2021] AC 454, holding that the civil standard of proof was now applicable.

33. The stay on the Claimants' judicial review claim was lifted. They relied on fresh evidence in the form of (i) a further report dated 27 October 2020 from Dr McIntyre; (ii) a further report dated 26 January 2021 from Dr Morley; and (iii) reports dated October 2017 and 8 December 2020 from Dr Cosmo Hallström, Consultant Psychiatrist.

34. On 24 April 2021 David Lock QC, sitting as a Deputy Judge of the High Court, refused the Claimants' application for permission. The Deputy Judge did not accept that it was arguable that the Coroner had misdirected himself in law or reached conclusions that were not reasonably open to him on the facts he found proven. He did not accept that there was insufficient evidence which, if accepted, demonstrated that Beth intended to kill herself when she took the DNP pills.

35. As to the fresh evidence, the Deputy Judge noted that the Claimants had not made a section 13 application and that the circumstances in which the evidence could be admitted in the judicial review proceedings were very limited: see *R v HM Coroner for East Berkshire, ex parte Buckley* (1993) 157 JP 425, per Laws LJ at 428G. The Deputy Judge did not consider that any of the limited exceptions applied but observed that "in any event the reports do not undermine the evidence base relied upon by the coroner for reaching his decision about Beth's mental state".

36. The Claimants did not renew the decision on permission at an oral hearing.

The 'fiat' process

37. On 5 October 2023, the Claimants initiated this section 13 application by seeking a *fiat* from the Attorney General, as required.

38. Again, the Claimants took no issue with the Coroner's findings on the survivability issue, but focussed on the intention issue. Their memorial to the Attorney General advanced two grounds. Ground 1 relied on the fresh expert evidence that had been advanced in the judicial review proceedings, as well as various statements from members of Beth's family. Ground 2 contended that there had been insufficiency of inquiry by the Coroner into the issue of suicide. The memorial anticipated at [131] that "the narrow scope of a new inquest would be limited to whether to record suicide, misadventure, or open conclusion in the Record of Inquest".

39. On 4 March 2024, the Attorney General's *fiat* was granted.

The procedural history of the section 13 application

The section 13 application as advanced in 2024

40. On 5 April 2024, the Claimants issued a Part 8 claim to bring their section 13 application before this court, as required. The section 13 application reflected the content of the Claimants' memorial.

41. PD49E, paragraph 20.3(3) provides that a Part 8 claim form bringing an application under section 13 must be "served upon all persons directly affected by the application within six weeks of the grant of the Attorney General's fiat". This is a very short time limit and it is understood that claimants regularly fail to comply with this requirement. However, the Claimants did so in this case.

42. Their Part 8 claim was served on the Defendant. In his Acknowledgment of Service the Senior Coroner indicated a position of neutrality on the claim. The Defendant's summary grounds from the judicial review proceedings were provided, together with a statement from the Coroner who had conducted the original inquest, explaining the rationale for the suicide conclusion in a little more detail.

43. The claim was also served on the NHS Trusts. They indicated in their Acknowledgment of Service that they did not intend to contest the claim.

The Claimants' two February 2025 applications

44. On 3 February 2025, and so around a month before the Divisional Court hearing that had been listed for 5 March 2025, the Claimants' solicitors informed the Interested Parties that the basis of the section 13 application was likely to change. On 11 February 2025 the Claimants issued an application notice seeking permission to rely on further evidence, extend time under CPR 3.1(2)(a) for the service of those documents and grant relief from sanctions under CPR 3.8 in relation to late service and filing, and non-service, of the documents.

45. By their 11 February 2025 application, the Claimants sought to challenge the Coroner's suicide conclusion on an additional factual, legal and evidential basis. They applied to rely on various items of further evidence, but in particular, a third report from Dr Hallström dated 24 January 2025. This was to the effect that Beth lacked the mental

capacity to form the intent to take her own life. The Claimants argued that, relying on the judgment of the Court of Appeal in *R v Rebelo* [2021] Cr App R 3, [2021] 4 WLR 52, a fresh inquest could find that Beth was unlawfully killed due to gross negligence manslaughter perpetrated by the person who sold her the DNP pills.

46. The Claimants' legal team had not become aware of *Rebelo* until late September 2024. *Rebelo* concerned the conviction of a supplier of DNP for gross negligence manslaughter for the death of Eloise Parry, a 21-year-old woman. Eloise, like Beth, suffered from an EUPD, which was a driving factor in her decision making when taking the substance and ultimately established the chain of causation between the gross negligence of the DNP supplier and the death.

47. Douglas Shipsey, Beth's father, explained in his witness statement dated 30 January 2025, that the Claimants had identified the supplier of the DNP pills to Beth as a man named Andrei Shepelev. Assisted by the Daily Mail, the Claimants had located Mr Shepelev in Volochysk in the Ukraine. A reporter had confronted Mr Shepelev and he admitted to selling the drugs to Beth, as was explained in a Daily Mail article dated 14 February 2018. Mr Shipsey himself had then travelled to the Ukraine with a wider team of reporters and it was arranged for him to confront Mr Shepelev, which he did. Again, Mr Shepelev admitted supplying the drugs, as described in a further Daily Mail article dated 6 September 2019.

48. By submissions filed on 13 February 2025, the NHS Trusts highlighted a series of procedural issues with the position the Claimants were now adopting, described further below. On the following day the Defendant adopted the NHS Trusts' position on the procedural issues. However, the Defendant indicated that his position on the section 13 application had changed in that rather than being neutral, the Defendant now positively supported the section 13 application.

49. On 18 February 2025 the Claimants' skeleton argument was served for the hearing. It did not address the procedural issues but stated that a further application notice was likely.

50. There was further correspondence between the parties. On 21 February 2025 the NHS Trusts' solicitor suggested that the section 13 application could be dealt with on the basis of its 2024 presentation, with any fresh investigation and/or inquest potentially dealing with the new matters that had been raised in the 11 February 2025 application. This, it was suggested, would avoid the procedural difficulties posed by the Claimants' change of position.

51. On 25 February 2025 the Claimants issued a further application repeating certain parts of their 11 February 2025 application and making further applications. The arguments in support of these various orders were drafted by Mr Williams of counsel and were lengthy, running to some 9½ pages of single-spaced text. Three potential draft orders were provided for the court to consider.

52. On the same day, the Defendant filed a revised skeleton argument confirming neutrality as to the resolution of the procedural issues but support for the section 13 application.

Our assessment of the procedural issues

53. The net result of the 11 and 25 February 2025 applications was that the Claimants sought **(1)** permission to rely on further evidence under CPR 8.6(1); **(2)** permission to amend their claim form under CPR 17.1(2)(b); **(3)** an order declaring that Mr Shepelev was not "directly affected" by the amended application for the purposes of PD49E, paragraph 20.3(3); **(4)** alternatively, permission to dispense with the requirement to serve the amended Part 8 claim form on Mr Shepelev on the grounds of exceptional circumstances, pursuant to CPR 6.16; **(5)** alternatively, permission to serve the amended Part 8 claim on him out of the jurisdiction under CPR 6.36, with time extended to do so under CPR 17.3(1)(b); and **(6)** an order providing the Claimants with liberty to apply to the court for further directions as needed.

*Applications **(1)** and **(2)***

54. Under **(1)**, the Claimants sought permission to rely on (i) Beth's notes from the Worcestershire Acute Hospitals NHS Records (incorporating West Midlands Ambulance Service NHS Foundation Trust Records) from 15 February 2017; and her psychiatric mental health care notes from 22 September 2016 to 10 March 2017; (ii) a further copy of the October 2017 report from Dr Hallström which had been served previously but the fresh version of which contained the signed expert declaration; (iii) exhibit CS1 to Carole Shipsey's witness statement dated 28 January 2021, which was erroneously excluded from the application bundle; (iv) a joint witness statement from Douglas and Carole Shipsey dated 17 January 2025 and its exhibits; (v) a third report from Dr Hallström dated 24 January 2025; and (vi) the witness statement from Mr Shipsey dated 30 January 2025 referred to at [47] above.

55. Under **(2)**, the Claimants sought permission to amend their Part 8 claim form under CPR 17.1(2)(b) (albeit that the application erroneously cited CPR 17.3(1)). They sought permission to amend the claim form by adding to it an Appendix 1 entitled "Unlawful Killing – Based On Further New Evidence From Dr Hallstrom". This was a particularised account of the possibility of an unlawful killing conclusion being available at any fresh inquest based on *Rebelo* and the third report from Dr Hallström dated 24 January 2025.

56. Applications **(1)** and **(2)** may well have been relatively straightforward had the claim continued to involve only the Defendant and the NHS Trusts. However the fundamental difficulty for the Claimants, as the NHS Trusts and Defendant identified, was that the content of the new material and proposed amendment brought Mr Shepelev's role into sharp relief. This was the theme underpinning the other four applications made by the Claimants.

*Applications **(3)** and **(4)***

57. Application **(3)** involved consideration of (i) the novel legal question of the proper interpretation of the phrase "directly affected" in PD49E, paragraph 20.3(3); and (ii) whether, however the phrase was to be interpreted, Mr Shepelev fell within it.

58. As to (i), the court's provisional view was that the phrase should be interpreted in the same way as CPR 54.1(f), which defines an Interested Party for the purposes of judicial review proceedings as any person (other than the claimant and defendant) who is "directly affected" by the claim. The meaning of CPR 54.1(f) was recently considered

in *R (Watson) v Chief Constable Greater Manchester Police* [2025] EWHC 332 (Admin).

59. As to (ii), the remedy sought by the Claimants on their amended claim was an investigation and inquest in which Mr Shepelev's role in having allegedly committed a homicide offence would be a central issue. This could, in theory at least, lead to him being prosecuted. This potential effect on Mr Shepelev of the remedy sought is slightly more "remote" than the scenario that was present in *Watson*; and Mr Shepelev would have certain procedural protections in any fresh coronial investigation. However, the court's provisional view was that these differences were not necessarily ones that justified an order declaring that he was not directly affected by the application, as sought by the Claimants.

60. The alternative application under **(4)** above relied on the court's power under CPR 6.16(1) to dispense with service of a claim form entirely. The wording of the rule makes clear that the power applies only in "exceptional circumstances". This was a highly problematic application in light of Court of Appeal authority indicating that the discretion under CPR 6.16(1) is confined to cases where there have been unsuccessful attempts at service: see, for example, *Anderton v Clwyd CC (No.2)* [2002] EWCA Civ 933 at [57] and *Kuenyehia v International Hospitals Group Ltd* [2006] EWCA Civ 21 at [26]. There had been no such attempts here: indeed the 25 February 2025 statement from the Claimant's solicitor, Yogi Amin, explained the various steps that could now be taken by tracing agents to attempt to locate Mr Shepelev and serve the amended claim form on him.

*Applications **(5)** and **(6)***

61. Application **(5)**, seeking permission to serve the amended Part 8 claim on Mr Shepelev out of the jurisdiction under CPR 6.36, appeared legally sound. However, if granted, it would render significant further delay inevitable. The Claimants sought an extension of time by a combination of CPR 17.3(1)(b) and CPR 7.5(2) to 6 months from the date on which any amendment to the claim was permitted (as is standard for service out cases). There was a very real possibility that Mr Shepelev would not be capable of being located, not least given the war in the Ukraine. If he could be located, he may refuse to engage. If he did engage, his views would need to be taken into account at a further hearing of the section 13 application, directions for which application **(6)** was focussed on.

62. The court's best estimate was that this approach would delay determination of the Claimants' section 13 application by around another 12 months with any fresh coronial investigation or inquest taking place another 12 months after that. In support of application **(4)** the Claimants relied on the fact that the time it has taken for them to get to this point has had a serious emotional and psychological toll on them. They argued that likely further delays would only compound the impact on their psychological wellbeing. The court entirely accepted that proposition and was concerned to avoid the route laid out by applications **(5)** and **(6)** unless absolutely necessary: it would, realistically, mean the Claimants would be involved in litigation for over a decade since Beth's death. This would inevitably be a barrier to their healing. The prospect of extensive further delay made this route inherently unattractive.

Conclusion on the procedural issues

63. All counsel agreed that these procedural difficulties only arose if the Claimants' section 13 application was determined on the basis advanced in 2025 (indeed, success on applications **(1)** and **(2)** was required to enable them to advance the application in this way).

64. Accordingly, counsel for the Claimants, Mr Williams, was invited to advance his application in the first instance, on the basis of the section 13 application as it was advanced in 2024 only. He was invited to focus his submissions on Ground 1, which he did.

65. Having heard those submissions the court concluded that it was possible to determine the section 13 application in the Claimants' favour based solely on the material served in 2024, for the reasons detailed in the following section.

66. Accordingly, it did not become necessary to decide the various procedural issues discussed above. The court is nevertheless grateful for all counsel's assistance with this aspect of the case, especially given the relative lateness of the Claimants' applications. These submissions crystallised the issues and without them the approach set out in the preceding paragraphs would not have been possible.

The merits of the Claimants' section 13 application, as advanced in 2024

The legal framework

67. As noted at [5] above, where an inquest has been held, the section 13(1)(b) test is whether "…by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise…it is necessary or desirable in the interests of justice that…another investigation…should be held".

68. The correct approach to this test was set out in *HM Attorney General v HM Coroner of South Yorkshire (West) and another* [2012] EWHC 3783 (Admin); [2012] Inquest LR 143, the section 13 application that led to the fresh inquests into the deaths of those who died as a result of the Hillsborough football stadium disaster. At [10], Lord Judge LCJ, held as follows:

> "The single question is whether the interests of justice make a further inquest either necessary or desirable. The interests of justice, as they arise in the coronial process, are undefined, but, dealing with it broadly, it seems to us elementary that the emergence of fresh evidence which may reasonably lead to the conclusion that the substantial truth about how an individual met his death was not revealed at the first inquest, will normally make it both desirable and necessary in the interests of justice for a fresh inquest to be ordered. The decision is not based on problems with process, unless the process adopted at the original inquest has caused justice to be diverted or for the inquiry to be insufficient. What is more, it is not a pre-condition to an order for a further inquest that this court should anticipate that a different verdict to the one already reached will be returned. If a different verdict is likely, then the interests of justice will make it necessary for a fresh inquest to be ordered, but even when significant fresh evidence may serve to confirm the correctness of the earlier verdict, it may

> sometimes nevertheless be desirable for the full extent of the evidence which tends to confirm the correctness of the verdict to be publicly revealed" [emphasis added].

Application of the legal framework to this case

69. Having reviewed all the evidence filed by the Claimants in support of their section 13 application in 2024, I am satisfied that the section 13(1)(b) test is met. This is because, in summary, the "new facts" and "new evidence" now relied on, when read cumulatively, provides a much fuller evidential platform for consideration of the intention issue. It is possible that, in light of all that evidence, a fresh investigation would conclude that it is more likely than not that Beth did not, in fact, intend to take her own life.

70. This position is reached by considering three categories of new facts and evidence.

(i): New evidence from Beth's family including evidence of her social media use

71. As noted at [18] above the Coroner who conducted the inquest did have available some evidence of Beth's social media use. However, the fresh evidence in the form of further statements from the family, further social media use (around 39 pages' worth) and a detailed analysis of that social media use, paints a more comprehensive and potentially different picture.

72. The new statement from Douglas Shipsey, Beth's father, dated 20 April 2023 exhibits social media activity between Beth and her boyfriend and Beth and himself on the afternoon of 15 February 2017. They include her saying to her boyfriend that she had done something "really stupid" and asking her father for advice on what would happen if she had taken all of the DNP pills.

73. One interpretation of this evidence is that it contradicts the other statements made by Beth to medical staff suggesting that she had an intention to die. Mr Williams posited, and I accept, that it is possible that her statements to that effect should in fact properly be interpreted as a desire to get urgent treatment to alleviate the acute symptoms of DNP toxicity, a desire to get urgent treatment through a fear of death, the product of irrational thoughts driven by emotion and/or a further example of her recognised attention-seeking behaviour.

74. The new statement from Carole Shipsey, Beth's mother, dated 11 August 2023 provides further social media evidence indicating Beth being in a light mood, evidencing optimism and forward planning on 15 February 2017. She described her new boyfriend who she had met on New Year's Eve and some activities she had planned with her animals. There are messages suggesting that she was petrified of telling anyone she had taken the drugs because it was "like my 15th overdose"; her saying "not again" in relation to being in hospital; and her saying "I'm sure my body can handle it" referencing the DNP pills. Again, this evidence is arguably inconsistent with suicidal intention.

75. The new statement from Thomas Shipsey, Beth's brother, dated 18 January 2023 describes Beth watching TV and scrolling on her phone just before the ambulance arrived on 15 February 2017; describing the pills to him as "herbal diet pills" and saying

"I'll see you later" to him as she left. Again, this could counter the suggestion of suicidal intent.

(ii): New evidence from Dr Cosmo Hallström, Consultant Psychiatrist

76. At the inquest the Coroner sought to explore the intention issue from a clinical perspective with Dr Chandrappa. However, he was Beth's treating psychiatrist; and he only felt able to offer the Coroner limited assistance on this issue. As the Coroner explained in his statement dated 10 May 2024 at [59]-[60], at the conclusion of his evidence Dr Chandrappa was given the opportunity to read through the totality of the social media messages with his legal representative and indicate whether having done so he felt in a position to offer a view on Beth's intent. He felt that it was would be too speculative for him to offer a view.

77. In contrast, Dr Hallström is an independent expert instructed by the family. He has reviewed the totality of the social media material now available and has provided expert evidence specifically on the intention issue.

78. The Claimants obtained the first report from Dr Hallström in October 2017, but did not provide it to the Coroner because the focus of that report was the extent to which the care Beth received for her mental health care was appropriate. He concluded that it had been; and this issue did not feature in the inquest. However in this report at [87] Dr Hallström had concluded that the indications were that Beth "did not take the tablets with suicidal intent".

79. In his second report dated 8 December 2020 Dr Hallström gave a more detailed analysis of the intention issue. He reviewed Beth's Facebook messages from 15 February 2017 about taking the pills. He concluded at [26] that they did not "display obvious suicidal intent" but "more an impulsive act to relive [sic] tension, something that was poorly thought out and was recognised as risky behaviour at the time but not with suicidal intent". He opined that the messages displayed "the sort of confused thinking that people with Emotionally Unstable Personality Disorders exhibit".

80. Dr Hallström concluded as follows:

> "41. It is entirely consistent with her diagnoses...that Beth was relatively happy around lunchtime on the 15th of February 2017, but then quite suddenly was overwhelmed by emotions as she herself suggests and acted impulsively in some way in response to this.
>
> 42. I am not in a position to give a definitive answer as to her intention at the time of taking the tablets, but at the time of my original report, I quite clearly thought that it was not her intention to kill herself when she took the tablets but the sort of impulsive act that people with her sort of EUPD engage in…
>
> 43. On the balance of probabilities I do not think that it was her intention to kill herself, but more an impulsive act of deliberate self-harm possibly to reduce tension or at worst an episode of "Russian Roulette". She certainly did not know that she would inevitably die as a consequence of taking the overdose, as she would for example have known if she had

> placed a ligature around her neck and suspended herself in a place where she would avoid detection.
>
> 44. There was a lot of ambivalence expressed in her contemporary Facebook messages, and very little to suggest [that] she wanted to die. That was in contrast to what she told the A&E doctor and the Ambulance staff".

81. Mr Williams rightly contended that the totality of Dr Hallström's new evidence is consistent with the suggestion that Beth's underlying EUPD condition drove her to take the DNP pills to relieve tension, as opposed to her actions being motivated by an intention to end her life.

(iii): New toxicology evidence

82. The new toxicological evidence from both Dr McIntyre and Dr Morley also sheds a slightly different light on the intention issue.

83. Noting that the level of DNP observed in Beth's post-mortem blood was lower than in any other reported case, in his new report Dr McIntyre concluded that it was more likely than not, indeed beyond reasonable doubt, that she had ingested "significantly fewer" than the 30 DNP pills she had referred to. Dr Morley also expressed the view that it is likely that she had consumed less than 30 DNP pills on the afternoon of her death and concluded that she may have taken as few as 10 or indeed as little as half of a tablet.

84. The Coroner concluded that Beth had taken a "significant quantity" of DNP: [19] of his ruling. The new evidence casts doubt on this conclusion. It can credibly be said that taking a smaller number of tablets is less consistent with suicidal intent than taking a larger number.

85. Further, the Coroner accepted that Beth had a propensity to exaggerate. Although he relied on what she said about the number of pills she had taken as one of the evidential features that justified a suicide conclusion, a firmer conclusion about how many pills she had in fact taken is relevant to the reliability of her comments, and thus her intention.

Conclusion on the section 13(1)(b) test

86. Accordingly, the combined effect of all the fresh evidence reasonably leads to the conclusion that "the substantial truth" about how Beth died was not revealed at the original inquest making it both desirable and necessary in the interests of justice for a fresh investigation to be ordered. Moreover, a different outcome is possible.

87. This is a section 13 application brought by the family of the person who died. Their views are a material consideration to which considerable weight should always be attached, particularly where, as in this case, there has been a lengthy delay: *HM Senior Coroner for Gwent re the Inquest into the Death of Vaughan* [2020] EWHC 3670 (Admin) at [10].

88. The fact that some, indeed perhaps all, of the new facts or evidence could have been obtained by the Claimants ahead of the first inquest is not decisive on a section 13

application: see *Bloom v North London Assistant Deputy Coroner* [2004] EWHC 3071 (Admin) at [28] and the other cases cited in *Jervis on Coroners* (15th Edition) at 19-14.

89. For these reasons, I grant the section 13 application on the basis on which it was originally advanced in 2024, in respect of Ground 1.

90. As the Claimants have succeeded on Ground 1, there is no need to consider their arguments under Ground 2 in any detail. However, had it been necessary to determine this ground, I would have found that there was no insufficiency of inquiry by the Coroner: far from it, for the reasons articulated at [17]-[30] above this was a comprehensive and sensitive investigation.

Relief

The legal framework

91. Where the criteria in section 13(1)(b) are satisfied, section 13(2) provides that the High Court may:

> "(a) order an investigation under Part 1 of the Coroners and Justice Act 2009 to be held into the death either—
>
> (i) by the coroner concerned; or
>
> (ii) by a senior coroner, area coroner or assistant coroner in the same coroner area;
>
> (b) order the coroner concerned to pay such costs of and incidental to the application as to the court may appear just; and
>
> (c) where an inquest has been held, quash any inquisition on, or determination or finding made at that inquest".

92. As Ms Ballard, counsel for the Defendant, highlighted, the term "inquisition" was used in the now repealed Coroners Act 1988. With the coming into force of the Criminal Justice Act 2009 ("the CJA") in July 2013, the inquisition form was replaced with "Form 2" or the Record of Inquest; see also *Re HM Senior Coroner for Northamptonshire* [2024] EWHC 2331 (Admin) at [19].

93. The word "determination" refers to the questions required to be answered under the CJA, sections 5(1) and (2), namely who the deceased was and how, when and where and (where appropriate) in what circumstances the deceased came by his or her death: see the CJA, section 10(1)(a). These matters are recorded at Box 3 of the Record of Inquest form. Box 4 is for the "Conclusion of the Coroner as to the death". In Beth's case the Coroner used a single narrative conclusion to meet the requirements of both Box 3 and Box 4. Such a course is permissible and indeed common.

94. The word "finding" refers to the particulars required by the Births and Deaths Registration Act 1953 to be registered concerning the death: the CJA, section 10(1)(b). There was no concern about these findings in Beth's case.

The issues relating to relief in this case

95. The issue of the appropriate relief in this case generated two novel and difficult issues. These were the subject of comprehensive written submissions from counsel for which I am very grateful. They have, between them, many years of coronial law experience. They ultimately agreed the legal position on the two issues. However, given the novelty of the issues, and because I have accepted their analysis, it is important to set the position out in a little detail.

(i): Whether it is permissible to amend the Record of Inquest by quashing parts of it

96. The court's powers under section 13(2)(c) (as opposed to on a claim for judicial review) do not extend to amending a Record of Inquest by quashing specific wording and substituting the court's own wording. The statutory language makes no mention of the addition of words to a Record of Inquest. In *HM Senior Coroner for South London v HM Assistant Coroner for South London* [2022] EWHC 1388 (Admin), it was confirmed that the court cannot make this kind of amendment on a section 13 application. There, it was held that the application could not result in the Record of Inquest being amended by the court quashing a conclusion that the death had been "alcohol related" and replacing it with one of "natural causes to which alcohol contributed": [8], [15] and [20].

97. Whether the court has the power under section 13(2)(c) to amend a Record of Inquest by merely quashing, removing or "red-lining" offending words was the specific issue to which counsel's submissions were addressed. Their agreed position was that such a course is permissible. Having considered the issue with care, I conclude that they are right, for the following reasons.

98. *First*, the pre-2013 version of section 13(2)(c) only permitted the High Court to quash an inquisition. This was the subject of a statutory amendment in July 2013, to expand the scope of section 13(2)(c) into its current form and include the power to quash a "determination or finding made at an inquest": see the Coroners and Justice Act 2009 (Consequential Provisions) Order 2013 (SI 2013/1874), Article 2(5)(e).

99. This statutory amendment had the effect of giving the court greater flexibility. The plain meaning of the revised section 13(2)(c) is that it is open to the court to quash the wording in a determination or finding that is no longer considered correct, even if the court does not consider that quashing the entire Record of Inquest is appropriate. Quashing the wording of a particular determination or finding rather than an entire Record of Inquest amounts, in substance, to removing or red-lining the offending determination or finding.

100. *Second*, it being accepted that there is a power to quash a determination or finding, there is no reason of principle why the power cannot be exercised in relation to part of a determination or finding.

101. *Third*, while the editors of Jervis on Coroners have stated in successive editions that it is not permissible on a section 13 application "to remove offending words" from a Record of Inquest, this has generally been said alongside the correct proposition that the court cannot substitute its own conclusion. The authorities relied on to support any intended free-standing proposition that the court cannot "merely" remove the offending words are problematic. The cases cited, namely *R v Walthamstow Coroner Ex p. Rubenstein* [1982] Crim LR 509 and *Re Sheppard* (Unreported April 28, 1992, DC),

were decided on the basis of the more limited pre-2013 statutory regime. The extracts from several Chief Coroners' Annual Reports footnoted in Jervis appear, with all due respect, to have been premised on a partial statement of the law as it was in July 2013, namely the assertion that the court's powers were "limited to quashing an inquest". As noted at [98] above the court's powers were, by July 2013, wider than this. As Ms Dolan KC's helpful research indicated, the passage was used once in the 2014/2015 report and then repeated in several later reports, without amendment. This was probably because the Chief Coroners were focussed on what they were hoping to achieve: namely a statutory amendment to achieve the "substitution" route that is available in judicial review claims for section 13 applications: see [96] above. It is likely that in the course of this endeavour the existence or otherwise of the "mere amendment" route was not a priority.

102. *Fourth*, while in the *South London Senior Coroner* case at [19], the Divisional Court held that the court does not on a section 13 application "have the power to amend the finding or to substitute its own finding for that of the Coroner", the underlined phrase needs to be understood in its full context. These were that the facts of that case went beyond mere amendment and amounted to substitution: see [96] above. The point was therefore *obiter*. It also relied, in part, on the passage in Jervis discussed in the preceding paragraph. The point was repeated in *HM Assistant Coroner for Inner North London* [2024] EWHC 1085 (Admin) at [11](f), but with no further authority for the proposition cited. In neither of these cases does the mere amendment point appear to have been the subject of full argument, as it has been here.

103. *Fifth*, to the extent that the relevant passage in Jervis was endorsed by me in *Re HM Senior Coroner for Northamptonshire* [2024] EWHC 2331 (Admin) at [26], this was a passing observation that had again not been the subject of full argument. It was only one of several reasons for dismissing the Coroner's section 13 application.

104. For all these reasons I accept the position of counsel that it is open to this court to amend the Record of Inquest by quashing certain parts of the Coroner's determinations.

105. It is appropriate to take that course in this case. I therefore quash the parts of the Coroner's determinations to the effect that Beth died "as the result of suicide"; and that when she ingested the tablets she "did so intending to take her own life" in the first and second paragraphs of the Record of Inquest set out at [4] above. Such a course is appropriate and necessary because the combined effect of the new evidence is that these determinations are no longer evidentially sound. A new investigation may well lead to different determinations on the issue of Beth's intent being made.

(ii): Whether it was necessary to order a fresh coronial investigation

106. In every other section 13 application with which counsel and the court were familiar, the High Court has made the quashing order and then remitted the case to the Coroner to conduct a fresh investigation and/or inquest.

107. However, having considered the position, counsel agreed that this further step was not in fact necessary: rather, it was their shared view that the court could simply quash the offending determinations under section 13(2)(c) and do no more. I accept that counsel are correct for the following reasons.

108. *First*, although a decision not to order a fresh investigation might appear counter-intuitive because the entire focus of section 13(1)(b) is that such a course is necessary or desirable in the interests of justice, there is no reason of principle to suggest that such a decision is incorrect. The court can properly conclude on particular facts that the section 13(1)(b) test is met; but then conclude on the same or further facts that the relief ordered under section 13(2) does not need to include a fresh investigation.

109. *Second*, support for this analysis can be drawn from the structure of section 13(2) which is disjunctive. It lists the powers the court has in a permissive fashion. It does not require that in every case where the quashing power under section 13(2)(c) is exercised, the court must order a fresh investigation under section 13(2)(a) or indeed make a costs order under section 13(2)(b).

110. *Third*, support for the suggestion that a full further investigation is not necessary can be drawn from the *South London Senior Coroner* case at [15] where the Divisional Court held that when a section 13 application succeeds, "it does not necessarily follow that there must be a fresh inquest". At [20] and [21] the court remitted the case to the Coroner on the basis that although the conclusion as to the cause of the death had to be re-determined, there was only one conclusion reasonably open to the Coroner. Similarly, in *Mays v HM Senior Coroner for Kingston Upon Hull and East Riding of Yorkshire* [2021] EWHC 3604 (Admin) at [39] it was accepted that the fresh inquest would involve admitting the entirety of the transcript of the first inquest as documentary evidence under the Coroners (Inquests) Rules 2013, rule 23 and limiting the evidence adduced to the new material.

111. *Fourth*, there are understandable reasons why this situation does not appear to have arisen before. This is that in most cases, quashing parts of a Record of Inquest would leave unacceptable gaps in it that render a fresh investigation necessary. That is not the case here. Rather, after parts of the Record of Inquest the court are quashed, there remains a full narrative conclusion that determines the statutory questions required by the CJA, section 5(1), namely who the deceased was; and how, when and where she came by her death.

112. In oral submissions Mr Williams made clear that the Claimants would be content with this more limited form of relief, together with the correction to the public record that will effectively be achieved through this judgment. This was the relief that they had sought in their initial judicial review claim in 2018. They no doubt did not focus on it in their section 13 application given the widely accepted position that this route was not open to them on such an application. Given the exceptionally long period of time in which they have been embroiled in court proceedings since Beth's death and the need for some form of closure, I can readily understand why the Claimants were content to take this course.

113. The current Senior Coroner and the retired Senior Coroner were both in court at the hearing. Ms Ballard's submissions confirmed their agreement to the proposition that if the relevant parts of the determinations were quashed, the Record of Inquest would not be left in a misleading or incomplete state such that a fresh investigation was required. They recognised that the quashing effected by this court is not a positive determination on the issue of suicide but rather a conclusion that the evidence now available is sufficient to quash parts of the earlier determinations.

114. Ms Dolan KC made clear that the NHS Trusts acceded to the course suggested, again accepting that the Record of Inquest would not be rendered incomplete if no further investigation was ordered. This course has the additional benefit of avoiding the need for Trust staff to give evidence again, in circumstances where there were concerns about potential difficulties with their recall many years after their contact with Beth and about their welfare.

115. Accordingly, I am satisfied that on the facts of this case it is not necessary to order a fresh coronial investigation.

Costs

116. Once it became apparent that the Coroner would consent to the section 13 application in its 2025 permutation, by email sent by their solicitors on 24 February 2025 the Claimants indicated that they would not seek their costs. This may have been because at that stage the Claimants' legal representatives were labouring under the misapprehension that a section 13 application can be disposed of by the consent of the parties without a hearing.

117. After the draft judgment was circulated, the Claimants changed their position and indicated that they sought their costs against the Coroner. I can well understand why they would prefer to have their costs paid: they are funding this litigation themselves, and the multiplicity of applications filed by their solicitors will have increased those costs.

118. However, authority at the highest level makes clear that a Coroner will not be ordered to pay costs on a section 13 application that has succeeded, unless the Coroner has acted flagrantly improperly, "entered the fray" or unreasonably refused to consent to a section 13 application: *R (Davies) (No. 2) v HM Deputy Coroner for Birmingham* [2004] 1 WLR 2739, per Brooke LJ at [22], [43] and 47] and Sir Martin Nourse at [58]; and the related authorities of *R (Gudanaviciene) v Immigration and Asylum First Tier Tribunal* [2017] 1 WLR 4095, per Longmore LJ at [36] and *R (Maguire) v HM Senior Coroner for Blackpool and Fylde* [2023] 3 WLR 103, per Lord Sales at [117].

119. The draft judgment made clear there was simply no basis for considering that the Coroner's conduct of the original inquest or of these proceedings fell into any of these categories.

120. As Ms Dolan KC's submissions highlighted, supported by Ms Ballard, the possibility of costs orders against Coroners only arises because unlike other judicial office holders there is no process by which Coroners' decisions can be appealed: the Coroners and Justice Act 2009, section 40 provided for a new system of appeal to the Chief Coroner against some decisions and determinations made by coroners in connection with investigations and inquests into deaths. However, this section was never brought into effect and has now been repealed (albeit that in 2021, the House of Commons Justice Committee recommended the introduction of a system of appeal similar to that in section 40).

121. The Claimants gave no indication of the basis on which they contended that a costs order should be made against the Coroner in this case. On receipt of the detailed submissions from Ms Dolan KC, agreed by Ms Ballard, Mr Williams quite rightly

withdrew the application. Accordingly, no order will be made for costs against the Coroner.

122. The Claimants did not seek their costs against the NHS Trusts, who had played a slightly more active part in the proceedings than the Coroner. For the avoidance of doubt there would have been no basis whatsoever for any such order: on the contrary, it was the comprehensive submissions from the NHS Trusts, in particular, that enabled the Claimants to find a way through the procedural issues created by their 2025 applications and to achieve the novel remedy that has now been granted.

Conclusion

123. For all these reasons, the Claimants' section 13 application succeeds.

124. By way of relief, the parts of the determinations in the Record of Inquest referred to at [105] above are quashed under section 13(2)(c). Accordingly, the Record of Inquest now reads:

> "Bethany Shipsey was a young woman with significant mental health difficulties who, on 15 February 2017, died having deliberately ingested a quantity of tablets containing the drug Dinitrophenol which she had purchased over the Internet.
>
> She was admitted into the Worcestershire Royal Hospital at approximately 5:30 PM on that day.
>
> The clinician having care of her recognised the extreme toxicity of the drug, the lack of antidote, the risk of rapid deterioration and the need for close monitoring of her condition with a view to providing supportive treatment.
>
> Notwithstanding this the clinicians failed to take sufficient or adequate steps to monitor her leaving them unprepared to deal with the rapid deterioration which ensued.
>
> There were significant failings in the care given to her which amounted to a lost opportunity to provide supportive treatment which although probably would not have saved or prolonged her life may nevertheless have done so".

125. No order for costs is made.

126. It is the court's hope that this judgment affords the Claimants and those concerned in the NHS Trusts at least some closure. I repeat my thanks to all counsel for their very helpful submissions in this tragic and complex case and for the sensitivity they have all shown.

Lady Justice Macur:

127. I too express my condolences to Beth's family.

128. I agree with this erudite judgment in all respects. Specifically, I adopt the reasoning as regards the ‘Amendment of the Record of Inquest’ in [96] to [105] and the ‘Necessity to order a Fresh Coronial Investigation’ in [106] to [111].