Neutral Citation Number: [2015] EWHC 3522 (Admin)

Case No: CO/5270/2015

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
DIVISIONAL COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: Thursday 3rd December 2015

Before:

LORD JUSTICE McCOMBE
And
HHJ PETER THORNTON QC, CHIEF CORONER

Between:

THE QUEEN (on the application of DEANA FULLICK)	**Claimant**
and	
HM SENIOR CORONER FOR INNER NORTH LONDON	**Defendant**
and	
THE COMMISSIONER OF POLICE FOR THE METROPOLIS LONDON AMBULANCE SERVICE	**Interested parties**

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Ms. Phillippa Kaufmann QC and Mr. Sam Jacobs (instructed by **Bhatt Murphy Solicitors**) for the **Claimant**
The Defendant was not represented.

Hearing dates: 24 November 2015

Judgment
As Approved by the Court

HH Judge Peter Thornton QC :

Introduction

1. This is the judgment of the court.

2. We heard this case on 24 November 2015. At the conclusion of the hearing we announced that the claim for judicial review succeeded and that the court ordered that the inquest be held with a jury. We said that our written reasons for so deciding would follow in due course. This judgment gives our reasons.

3. On 7 February 2015 Susan Sian Jones, then aged 47 years, was taken ill at Hornsey police station in London which she had voluntarily attended as a witness. She did not recover and sadly died at the Whittington Hospital on 15 February.

4. This is an application for judicial review of the decision of the senior coroner for the area of Inner North London (the coroner) to hold the inquest without a jury.

5. In view of the fact that the inquest has not yet been held, the relevant events will be summarised only briefly.

The events of 7 February 2015

6. Ms Jones was a vulnerable woman. Although she had been staying temporarily in the flat of a male friend she was homeless. On 7 February she made an allegation of a serious offence allegedly committed two months earlier by the same friend and the police arrived at his flat in Finsbury Park, north London, to speak to both Ms Jones and the friend. There is evidence from police officers that Ms Jones was drunk and very agitated. She described herself as an alcoholic and indicated that she suffered from high blood pressure and was on various medications including methadone.

7. At the flat Ms Jones gave an account to the police of her allegation, but was reluctant to stay. In fact she left through a rear window. She was stopped in the street by further police officers, then allowed to go on her way in the company of her sister. Soon afterwards she went to the park (Finsbury Park) and was seen with a beer can in her hand.

8. The police took her complaint seriously. They wanted a full statement from her. They traced her to the park gates and invited her to make a statement. She agreed. She consented for that purpose to travel in a police vehicle to Hornsey police station.

9. In an interview room she gave a full account of her allegation. She was talkative. Once the interview was completed, she remained in the interview room for a specialist team to attend. The time by now was about 17.00 hours. There was expected to be a delay in their attendance. Ms Jones was not in custody or detention. She had attended the police station voluntarily as a potential witness.

10. In the interview room Ms Jones was sitting on a chair. She was seen to place her head on the table and appeared to go to sleep. The door was left open and police officers waited outside for the specialist team. Ms Jones was heard to be ‘snoring’. She remained in this position for quite some time. She was checked once, but not roused.

Eventually, the ‘snoring’ ceased and she was checked again. This time there was no sign of breathing.

11. The ambulance service was called immediately, at 18.56 hours and a police officer commenced CPR. A paramedic arrived soon after 19.00 hours. Although Ms Jones began to breathe again on her own, she never fully recovered. She died at the hospital on 15 February 2015.

The proceedings

12. The coroner was informed of her death and requested a post-mortem examination. Following the examination, the pathologist, Dr Simon Poole, concluded that Ms Jones had died from a combination of drug and alcohol toxicity, significant myocardial fibrosis and atherosclerosis of two major coronary arteries.

13. The coroner opened and adjourned the inquest. She listed the inquest hearing for 30 November 2015.

14. In the course of correspondence solicitors for the claimant, the daughter of Ms Jones, asked the coroner to conduct the inquest with a jury. The coroner refused.

15. This claim is therefore made for judicial review of that decision. The claimant has been represented by Ms Phillippa Kaufmann QC with Mr Sam Jacobs of counsel, instructed by Bhatt Murphy, solicitors. We are grateful for their helpful oral and written submissions.

16. The other Interested Persons in the inquest proceedings have chosen not to make representations to us or to be present at the oral hearing.

The statutory provisions

17. Since July 2013 the decision of a coroner whether to conduct an inquest with a jury has been governed by section 7 of the Coroners and Justice Act 2009 (the 2009 Act). There are mandatory and discretionary provisions.

18. The relevant provisions, mandatory and discretionary, of section 7 are as follows.

> “**7 Whether jury required**
>
> (1) An inquest into a death must be held without a jury unless subsection (2) or (3) applies.
>
> (2) An inquest into a death must be held with a jury if the senior coroner has reason to suspect—
>
> (a) that the deceased died while in custody or otherwise in state detention, and that either—
>
> (i) the death was a violent or unnatural one, or
>
> (ii) the cause of death is unknown,

(b) that the death resulted from an act or omission of—

(i) a police officer, or

(ii) a member of a service police force,

in the purported execution of the officer's or member's duty as such, or

(c) that the death was caused by a notifiable accident, poisoning or disease.

(3) An inquest into a death may be held with a jury if the senior coroner thinks that there is sufficient reason for doing so.

(4) …"

The request for a jury

19. The coroner had ruled at a pre-inquest review hearing on 11 June 2015 that 'this case does not necessitate a jury inquest'. This was a provisional decision which she stated would be revisited later.

20. The claimant's solicitors first raised the issue of holding the inquest with a jury with the coroner in correspondence in their letter of 28 September 2015. The solicitors submitted to the coroner that the mandatory provisions of section 7(2)(b) applied. The events at the police station amounted to an omission of a police officer in the execution of that officer's duty, and on two potential bases:

> "Firstly, if the death has been caused or contributed to by a failure to put in place appropriate policies, there may be an omission in the execution of duty by whoever is responsible within the force for putting in place policies to safeguard life. Secondly, there may be an omission by individual officers dealing with Ms Jones in the execution of their duty in that reasonable steps were not taken to protect Ms Jones' life …"

21. In the alternative, the claimant's solicitors submitted that, given the issues raised in the case, there was sufficient reason for holding an inquest under section 7(3) of the 2009 Act and accordingly the coroner should exercise her discretion to do so.

22. By email of 7 October the coroner repeated her earlier refusal to order a jury to be summoned. She stated that she had no reason to suspect that the death had resulted from the act or omission of a police officer (section 7(2)(b)) and no sufficient reason for exercising her discretion (section 7(3)).

23. On the same date, 7 October, the claimant's solicitors reiterated the family's request for a jury and observed that the family would agree to an adjournment so that the inquest could be held with a jury.

24. On 19 October, the coroner in a six page letter set out the reasons for her decision on the jury point (and on other points) in some detail. It is the decision in this letter to refuse to hold the inquest with a jury which is now challenged by way of application for judicial review.

25. In the letter the coroner restated her earlier conclusions. She referred to Ms Jones being in a police station but not in custody, to her putting her head on the table in an interview room and sleeping while waiting for the specialist team, to her snoring, and to police officers entering the room when the snoring stopped. Referring to both the mandatory and discretionary provisions of section 7, she concluded:

> "On the face of this, it does not appear to me that Ms Jones died as a consequence of the act or omission of a police officer … The execution of an officer's duty is not synonymous with any possible duty of care that may be owed. And of course it is not synonymous with any question of Article 2 engagement …Thus I remain of the view that I do not have reason to suspect that Ms Jones's death resulted from the act or omission of a police officer in the purported execution of his or her duty, and so it is not mandatory for me to sit with a jury… I am not persuaded that it would be in the interests of justice for me to exercise my discretion to sit with a jury."

26. The coroner also referred in this letter to the 'very earliest availability in the court diary for a jury inquest' being October 2016, almost 12 months later than the scheduled date for the inquest (30 November 2015).

The claimant's submissions

27. The claimant submits that the mandatory provisions of section 7(2)(b) apply because there was sufficient evidence or information before the coroner for her to have 'reason to suspect – (b) that the death resulted from an act or omission of – (i) a police officer … in the purported execution of the officer's … duty'. In the alternative, the claimant submits that if the mandatory provisions do not apply the coroner should have exercised her discretion under section 7(3) to summon a jury because there was 'sufficient reason' for doing so.

28. Ms Kaufmann submits that the mandatory provisions of section 7 apply because there is sufficient evidence or information before the coroner of the matters required. First, Ms Kaufmann drew attention to the low threshold for the test of 'reason to suspect': *R v Inner North LondonCoroner ex parte Linnane* [1989] 1 WLR 395 at 398; *R (on the application of Davey) v HM Coroner for Leicester City and South Leicestershire* [2014] EWHC 3982 (Admin) at [7].

29. Secondly, she submitted that there was evidence or information that the death had resulted from an omission by police officers. Police officers had recognised that she was vulnerable and needed help to be able to give a good account of herself. Arguably, therefore, the police assumed responsibility for Ms Jones when they brought her to the police station as a witness. One police officer had written in her

witness statement of her duty of care towards Ms Jones and her wish to ensure her safety. Another referred to taking her to a place of safety.

30. Just as there are protocols and procedures in place for the care of vulnerable detainees, particularly those who have consumed alcohol, so should there be procedures to protect those who are voluntarily on police premises. At the very least, submitted Ms Kaufmann, training in relation to detainees should have put police officers at the police station on notice of the possible risks involved with Ms Jones and taken steps to avoid them.

31. The physical risks for a vulnerable witness were considered by Dr Nat Cary, a pathologist instructed by the family. He described how Ms Jones had been at risk while intoxicated from her position 'namely upright and slumped forwards with her head on the table'. This could have contributed to airway obstruction and led to a state of unconsciousness some considerable time before she was found to be unresponsive. He posed the question: If the state of unconsciousness had been discovered earlier, is it possible that her cardiac arrest could have been prevented?

32. Ms Kaufmann therefore submits that on a low threshold test there was sufficient material before the coroner that the omissions of the police, both institutional and individual (as the claimant solicitors had expressed in their letter of 28 September), may have resulted in the death of Ms Jones. Further, there is no reason to believe, she submits, on the face of the witness statements before the coroner that the police were not in the execution of their duty, purported or otherwise.

Discussion and conclusion

33. We consider that there is some force in these submissions.

Mandatory provisions: section 7(2)(a)

34. In the first place it is well known that the 'reason to suspect' test has a low threshold and is objective in its nature. Coroners are familiar with the phrase 'reason to suspect'. It is to be found not only in section 7 of the Coroners and Justice Act 2009, but also in section 1 of the Act. Under section 1 the 'reason to suspect' test is the well-understood starting point for the coroner's duty to investigate a death. A coroner who is made aware that the body of a deceased person is within that coroner's area must as soon as practicable conduct an investigation into the death when the coroner has *reason to suspect* that the death is violent or unnatural, or the cause of death is unknown or the deceased died while in custody or otherwise in state detention.

35. The phrase 'reason to suspect' is not defined in the 2009 Act, but it is well known to the common law, particularly in the context of arrest. In *Dumbell v Roberts* [1944] 1 All ER 326, 329 the requirement that a constable should before arrest satisfy himself that there do in fact exist reasonable grounds for suspicion of guilt was described as a 'very limited' requirement.

36. 'Reasonable suspicion' has never been equated with prima facie proof. The latter consists of admissible evidence; the former can take into account matters that could

not be put in evidence at all: *Hussien v Chong Fook Kam* [1970] AC 942, 949; see also *Al Fayed v Commissioner of Metropolitan Police* [2004] EWCA Civ 1679, [50]. 'Reason to suspect' does not require positive proof or even formulated evidence; any information giving 'reason to suspect' will suffice: *R v Inner London Coroner, ex parte Linnane* [1989] 1 WLR 395, 398.

37. For our purposes we adopt the approach of Hickinbottom J in the coroner case of *R (Davey) v HM Coroner for Leicester City and South Leicestershire* [2014] EWHC 3982 (Admin) at [7]:

> "'Reason to suspect' is a low threshold for the triggering of the obligation to empanel a jury, 'suspicion' for these purposes being a state of conjecture or surmise arising at the start of an investigation in which obtaining a prima facie proof is the end (*Hussien v Chong Fook Kam*) [above]."

38. Applying the test objectively, we are satisfied that there was sufficient material before the coroner such that the mandatory provisions of section 7(2)(b) applied. There is reason to suspect that the death resulted from the omission of a police officer in the purported execution of the officer's duty. Ms Jones may not have been a detainee in custody at the police station, but she was a vulnerable visitor, as the police knew from the afternoon's earlier events. At the very least she needed looking after.

39. In broad terms the question to be answered therefore is as follows: Could or should the police have done more? We do not presume to answer that question; we do not express a view one way or another about it. That will be a matter for the jury to consider in all the particular circumstances of this case, having heard the evidence and been properly directed by the coroner.

40. For our part we are satisfied that the coroner had, on the information before her, reason to suspect the matters set out in section 7(2)(b). Hence, the mandatory requirement for a jury inquest was satisfied. The coroner erred in law in concluding the contrary.

Discretionary provisions: section 7(3)

41. Had we decided that the mandatory provisions did not apply, we would have been minded to conclude that the coroner acted unreasonably in the exercise of her discretion under section 7(3) to hold the inquest without a jury.

42. The correct approach to the exercise of discretion under section 7(3), following the decisions of the Divisional Court in *R (Paul and others) v Deputy Coroner of the Queen's Household* [2007] EWHC 408 (Admin), [2008] QB 172, and *R (Shafi) v HM Senior Coroner for East London* [2015] EWHC 2106 (Admin) at [69], is for the coroner to consider all relevant matters. These include, amongst other matters:

    i) the observation in *Paul* at [44] that a factor relevant (but not determinative) to the exercise of the coroner's discretion which ought to be taken into consideration is the wishes of the family,

ii) submissions made on behalf of any other Interested Person,

iii) the further observation in the case of *Paul* at [45] that it is appropriate to 'consider whether the facts of the instant case bear any resemblance to the types of situation covered by the mandatory provisions',

iv) the circumstances of the death (in this case in a police station), and

v) any uncertainties in the medical evidence.

43. It should also be noted that the Divisional Court in *Paul* at [42] advised that no decision on whether to summon a jury should be made until after the coroner had determined the scope of the inquest.

44. The coroner does not appear to have considered the matters listed above, in particular, for the purposes of this case, (1), (3) and (4). Had she done so, we feel sure that she could only have decided to exercise her discretion to conduct the inquest with a jury. Instead she ruled in her letter of 19 October: 'I am not persuaded that it would be in the interests of justice for me to exercise my discretion to sit with a jury.' Not only did the coroner fail to consider all relevant matters; she also applied the wrong test. The test is a 'sufficient reason' test, not an 'interests of justice' test.

45. In view of our decision on the mandatory provisions it is not strictly necessary to deal with Ms Kaufmann's submissions on the discretionary provisions. But we hope that our observations will assist coroners in the future.

46. Good case management in more complex or difficult cases will usually require that matters of importance such as whether a jury is required should be aired and decided at a pre-inquest review hearing, particularly where the issue may be contentious. Rule 6 of the Coroners (Inquests) Rules 2013 provides that a coroner may at any time during the course of an investigation and before an inquest hearing hold a pre-inquest hearing. Such a hearing provides the coroner with the opportunity to list matters of importance for discussion in open court and, where necessary, for ruling with brief written reasons: for the appropriate procedure for pre-inquest review hearings see *Brown v HM Coroner for the County of Norfolk* [2014] EWHC 187 (Admin) at [38]-[44]. Sometimes, particularly where from the family's point of view there is much to discuss, a public hearing may be better than correspondence.

Evidential matters: Dr Simon Poole

47. The claimant raises a further submission upon which permission to apply for judicial review has been refused. She renews her application.

48. Taken briefly, the claimant, through her solicitors, has invited the coroner to put to the coroner's pathologist, Dr Poole, six questions in advance of the inquest. In addition to the six questions six further points were made in a later letter.

49. The coroner has refused to put the questions and the points to Dr Poole. In her letter of 19 October 2015 she responded that the inquest was the proper forum for any

questions of Dr Poole and not beforehand. It would be wrong to ask a busy pathologist to undertake additional work which she did not regard as necessary.

50. The claimant has instructed Dr Nat Cary, pathologist. The six questions and the further points were raised by the claimant on his advice. They relate to the events shortly before Ms Jones was found to be unconscious in the interview room at the police station. They concern the positioning of Ms Jones in the interview room, the timing of the discovery that she was unconscious, the length of time she may have been unconscious and whether earlier attention from the ambulance service could have prevented the cardiac arrest.

51. Ms Kaufmann submits that Dr Poole should be required to answer these questions in advance of the inquest because he has not addressed any of these issues in his report. Dr Poole states how death occurred but without reference to the events leading up to it. If the questions are answered time and money might be saved. Without knowing the answers Dr Cary might have to attend the inquest unnecessarily. The coroner has acted irrationally in refusing to put the questions to Dr Poole.

52. In our judgment this point is unarguable. Matters of evidence of this kind are best managed by the coroner in an individual case and not by the High Court. Coroners have a broad discretion in the evidence which is called and how it is called. As Brooke LJ stated in *R v Coroner for Lincolnshire, ex parte Hay* (1999) 163 JP 66; [2000] Inquest LR 1: 'We are unwilling for our part to fetter the discretion of a coroner by being at all prescriptive about the procedures he should adopt in order to achieve a full, fair and thorough hearing.' This is very much a matter for the coroner to handle, sensibly and fairly, as she sees fit.

53. Nevertheless, now that the inquest will have to be adjourned for a jury to be summoned, the coroner may wish to reconsider asking Dr Poole to answer the questions in advance of the inquest. The coroner has said that she wishes to protect a busy pathologist from extra work. That is understandable. We have no doubt, however, that the experienced Dr Poole, if asked, would gladly assist the court, the family and the public by answering questions on an important and relevant issue, not just at the inquest but in advance of the inquest, so that the scope of the coroner's inquiry is clarified. If he were to do so, time, money, and perhaps anxiety, might well be saved in the long run. We consider this is a matter for the coroner.

Article 2

54. Finally, we do not wish to leave this case without reference to the issue of whether the inquest will be one in which Article 2 of the European Convention on Human Rights, the right to life, is engaged or not. The claimant has invited the coroner to rule that for the purposes of the investigation and inquest Article 2 is engaged. And this is a matter for the coroner.

55. Whether Article 2 is engaged or not may have consequences. In some cases (not this one) the coroner's decision that Article 2 is engaged may provide a springboard for a legal aid application for the family. In Article 2 cases the conclusions of the coroner (or jury) may be judgmental: see *R (Middleton) v HM Coroner for West Somerset*

[2004] 2 AC 182 at [37]. In non-Article 2 cases they may not: see *R v HM Coroner for North Humberside and Scunthorpe, ex parte Jamieson* [1955] QB 1, 24. It is therefore important that the coroner provides a clear answer to this question.

56. The coroner dealt with this point on several occasions in correspondence. In each she stated that the inquest would be 'Article 2 compliant'. In her letter of 19 October, for example, she wrote: 'My officer … has already explained to you that I do not conduct inquests where article 2 of the European Convention on Human Rights is engaged and those where it is not engaged in any way differently, and so for this reason the inquest will certainly be article 2 compliant.'

57. This statement, in our view, is not entirely clear. It does not say whether Article 2 is engaged. It could mean that the coroner conducts all inquests the same way, whether Article 2 is engaged or not. In which case this may be an inquest which is 'Article 2 compliant' (perhaps in the procedural sense) but not one in which Article 2 is engaged. The coroner seems to suggest in her letter of 19 October that Article 2 is not engaged when she refers to the four statutory questions, who died, and when, where and 'how' did she come by her death. 'How' suggests a non-Article 2 *(Jamieson*) inquest, as opposed to an Article 2 (*Middleton*) inquest in which the 'how' becomes the wider question of 'in what circumstances': section 5(2) of the 2009 Act. On the other hand the phrase 'article 2 compliant' tends to suggest in ordinary language that Article 2 may be engaged.

58. We do not know which of these meanings, or any other, is intended. In all cases where the issue of Article 2 is raised for consideration, the coroner should respond with clarity. If necessary the coroner should rule, with brief reasons. Interested Persons need to know whether the coroner considers that Article 2 is arguably engaged, either as a general duty or as an operational duty, so that they can know whether the State's procedural duty of investigation is triggered.

59. It would therefore be helpful if the coroner could clarify her statement. If Article 2 is engaged for the investigation (and inquest) she should say so. If, in her judgment, it is not engaged, she should invite the Interested Persons to make representations, should they wish to do so.

Conclusions

60. For the reasons given we grant the application for judicial review of the coroner's decision to hold the inquest without a jury and order that the inquest shall be held with a jury. It is to be hoped that the coroner will be able to arrange a listing of the hearing before October 2016.

61. We refuse the claimant's renewed application for permission to judicially review the decision of the coroner on the evidence point.