CO/3748/2008

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

Royal Courts of Justice
Strand
London WC2

Date: Tuesday, 29th April 2008

B E F O R E:

MR JUSTICE FOSKETT

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THE QUEEN ON THE APPLICATION OF SELINA WARREN

Claimant

-v-

HER MAJESTY'S ASSISTANT CORONER FOR NORTHAMPTONSHIRE

Defendant

and

(1) GSL UK LIMITED
(2) NESTOR PRIMECARE SERVICES LIMITED
(3) DR SYED AHMED
(4) DR COLIN WEST

Interested Parties

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Mr Sadat Sayeed (instructed by Messrs Hickman Rose, London N1 1LA) appeared on behalf of the **Claimant**
Mr George Thomas (instructed by MDU Services Limited, 230 Blackfriars Road, London SE1 8PJ) appeared on behalf of the **Third and Fourth Interested Parties**

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J U D G M E N T

1. MR JUSTICE FOSKETT: On 24th March 2005 Michael Bailey, who was then aged 23, committed suicide in the segregation unit of Her Majesty's Prison at Rye Hill, near Rugby in Warwickshire. He had hanged himself with a shoelace attached to a small hole in the metal plate on the back of the door of his cell.

2. He was serving a 4-year prison sentence for two offences of possessing class A drugs with intent to supply. He would have been eligible for parole in September 2005, though his earliest expected release date was in July 2006. He had a number of convictions prior to those that led to his sentence for offences of robbery and drugs matters. He had been to prison prior to the sentence he was serving. He was, by his own admission, a cocaine user. Prior to the period shortly before his death there was no history of any mental illness and no psychotic episodes.

3. Rye Hill Prison is a purpose-built training prison for adult male offenders. It has an operational capacity of 660. Most prisoners transferred there are serving sentences of 4 years or more, with at least 18 months left to serve. It is privately-operated prison, run by GSL UK Ltd. Its medical and health care services are provided under contract by Nestor Primecare Services Ltd. As I understand it, at the material time a full-time employee of Nestor was employed as the health care manager at the prison. The medical practitioners who attended the prison, or at least the two whose names have figured in the application before me, were independent contractors engaged by Nestor. I will say more about their interest in the present application shortly, but they are Dr Colin West, a local GP, and Dr Syed Ahmed, a police surgeon and the 'on call' duty doctor at Rye Hill at the material time.

4. Sadly, as Lord Bingham observed in R (Middleton) v West Somerset Coroner [2004] 2 AC 182, at paragraph 5, suicide in prison is not a rare event. For reasons that require little, if any, elaboration, such an event will always be treated seriously. It will inevitably be followed by some form of inquiry and, of course, an inquest.

5. In the case of Mr Bailey, three prison officers were charged with manslaughter through gross neglect and another was charged with conspiracy to pervert the course of justice. They faced trial in the Crown Court, but the trial judge accepted submissions that they each had no case to answer and each was thus acquitted. That occurred in March 2007.

6. Given that there was, as might be anticipated, a substantial police investigation before such a prosecution was launched, it was inevitable that any inquest would have to be delayed until the prosecution had run its course. That inquest is scheduled to start on 6th May and is due to last four weeks or so. I have been told that 40 witnesses are due to be called.

7. Before I turn to the matter the subject of this application for judicial review, I should say a little about the other investigations that there have been. As part of the police investigation, Ms Yvonne Frances was asked by the Northamptonshire Police as early as 6th April 2005 to prepare a report on the management, medical and mental health

issues leading up to Mr Bailey's death. She was asked to be prepared to give expert evidence in any proceedings that Northamptonshire Police brought. I have not been told, but I imagine that she gave some evidence in the criminal proceedings. At all events, she did prepare a report dated 20th June 2005 which was very critical of the suicide and self-harm policy at Rye Hill at the time and of certain individuals in the way that they carried out their duties.

8. Ms Frances is a registered nurse, midwife and health visitor by training, and has a Master of Studies Degree in Applied Criminology and Strategic Management from the University of Cambridge. She was trained as an investigator by the Prison Service in 2002 and in recent years has worked freelance in the investigation of deaths in custody in prisons, approved probation premises and immigration centres. She has personal experience of work in prisons. It is apparent from the report of the Prisons and Probation Ombudsman for England and Wales, to which I will refer later, that she is regularly engaged by the Ombudsman's office to investigate matters of this nature. Ms Frances plainly has considerable relevant experience and expertise in investigations of this nature, though it is clear that she has no specific medical qualification or expertise in psychiatric matters, other than that which she will have gleaned from her work and training as a nurse.

9. Ms Frances' report, as I have said, was prepared in the context of the police investigation, but it was made available to the Prisons and Probation Ombudsman in the enquiries carried out on his behalf. Those enquiries were conducted on the Ombudsman's behalf after the collapse of the criminal trial and culminated in a 66-page report promulgated in July 2007.

10. Mr Stephen Shaw CBE, the Prisons and Probation Ombudsman, concluded that the circumstances surrounding Mr Bailey's death were among the most disturbing he had come across in about 300 cases of self-inflicted deaths that had been investigated. He said that there had been "individual and systemic failures of disturbing proportions." He took what he described as the "very unusual step" of recommending that his report should be sent both to the Minister and to the Chief Executive of the National Offender Management Service for their consideration.

11. It is impossible to distil the effect of that report in a few sentences, but it made a large number of recommendations, at least some of which impacted on the nature of the health care arrangements that subsisted at the time at Rye Hill. Ms Frances had been critical of certain medical assessments that were either made or not made in her appraisal of the matter.

12. That, therefore, represents a brief summary of the investigations carried out over the two years or so following Mr Bailey's death. An inquest will have been opened and adjourned pending these various matters, and it is the resumed inquest that gives rise to the present application.

13. The Coroner in this matter is Her Majesty's Assistant Deputy Coroner for

Northamptonshire. I well refer to him as "the Coroner" for convenience.

14. The application seeks to challenge the Coroner's decision not to call to give evidence a consultant psychiatrist, Dr Trevor Turner, who has provided a report to solicitors instructed by Mr Bailey's family. Dr Turner is currently based at the Homerton Hospital and is the Clinical Director at East London and the City Mental Health Trust. His expertise as a psychiatrist is not in issue, but the extent to which it is appropriate for him to participate in the inquest is.

15. I propose to keep my reference to the issues likely to arise at the inquest to the barest minimum. All I think I need to say for the purposes of dealing with the issue before me is this. Although Mr Bailey had showed no signs of mental illness previously, it seems clear that for about a week or so before his death he was behaving very bizarrely and out of character. Four days before his death he stripped naked and walked around the exercise yard at Rye Hill, reciting the Lord's Prayer and saying that he was ready to die. That is merely one example of his very unusual behaviour that seems to have started about a week before he committed suicide.

16. It appears that the Consultant Forensic Psychiatrist, Dr Russell, to whom the Health Care Manager of the prison spoke for advice, formed the view that Mr Bailey may well have been suffering from a psychotic episode and he suggested some antipsychotic medication. Whether the psychotic episode was, as some thought, the result of Mr Bailey taking illicit drugs or was caused in some other way, the fact is — and there really is no dispute about it — that Mr Bailey became significantly mentally disturbed at this time.

17. That such an event can occur in prison must, one would think, be something that the medical and other support systems in place should generally pick up and identify and, more importantly perhaps, deal with it so that, so far as practicable, the person undergoing or suffering the event is protected. If he is not protected and suffers harm (or, as here, he commits suicide) the failure to prevent that harm or death is a legitimate area of enquiry. Indeed, since death eventuated in this case and Article 2 of the European Convention on Human Rights is engaged, the State's investigative obligation under that Article will be discharged through the medium of the inquest.

18. The case of Middleton, to which I have referred, sets out the parameters within which such an inquiry is to be conducted through that medium. I will not extend this judgment by prolonged citation of the relevant parts of the opinion of the House of Lords, but paragraphs 33 to 37 in particular demonstrate how the need to answer the question "by what means and in what circumstances" did Mr Bailey die is to be achieved. The need to avoid any finding of criminal liability is of course emphasised, as is the need to avoid any determination of the question of civil liability.

19. It is not, as I think, disputed that the nature and efficacy of the medical support systems in Rye Hill Prison at the material time are relevant areas for consideration at the inquest provided that the parameters set out Middleton are respected. The Coroner

has effectively acknowledged this in his letter to the solicitors acting for Mr Bailey's mother, who brings this application, to which I will refer shortly.

20. Whilst those representing Dr West and Dr Ahmed, and indeed Nestor, challenge the appropriateness of Dr Turner as a witness, there is little dispute, as I perceive it, that the medical set-up in the prison is a relevant area for investigation at the inquest. Given the circumstances leading up to Mr Bailey's death, as I have recounted them briefly, it is difficult to see how they could not be.

21. So why has the Coroner rejected the family's request for Dr Turner to be called? The issue was raised at the pre-inquest review on 10th April, when he indicated he was not proposing to call Dr Turner, and the matter was ventilated again in subsequent correspondence. On 16th April the Coroner sent a detailed letter to the claimant's solicitors, which I think I should quote reasonably extensively. He acknowledged that Article 2 was engaged, and continued as follows:

> "During the course of my investigation and inquiry I have considered a vast amount of evidence that was provided to me following a detailed police investigation into the circumstances surrounding Mr Bailey's death and a detailed report from The Prison and Probation Service Ombudsman. I have made all such evidence available to Mr Bailey's family and to other interested persons.
>
> Dr Turner's report was submitted to me on behalf of the family as a proper interested person. At the pre inquest review, having considered his written report I indicated that I did not intend to call him as an expert witness. My reasons for doing so [were] that his brief biography submitted with his report confirmed that he was a consultant in general and community psychiatry based at Barts, Hackney and the Homerton Hospitals since 1987 and between 1994-1998 he was the Medical Director of The City and Hackney Community Services NHS Trust. He is currently Clinical Director in the East London & City Mental Health NHS Trust. His biography did not disclose that he had any experience of working within a prison environment. I am now informed by your letter [*this refers to a subsequent letter from the claimant's solicitors*] that Dr Turner had worked for five years as a reception medical officer at HM Prison Holloway in the 1980's and that he visits prisons once or twice [a] month as part of his consultancy practice. His report, however, deals in detail with what treatment Mr Bailey would have received if he had been a patient under the NHS outside of the prison setting. It fails to address the more important issue as to what care should have been afforded to Mr Bailey in prison. It is also apparent that Dr Turner has not visited HM Prison Rye Hill."

22. The letter then continued to refer to the report of Ms Frances to which I have also already referred. The Coroner then goes on at a later stage in the letter to say this,

having reviewed the background of Ms Frances and indeed her report:

> "It is quite clear from the report that she has produced, a copy of which I attach, that in compiling her report she has been able to consider all aspects of the healthcare needs that should have been provided to Mr Bailey by prison custody officers, the healthcare team and by the doctors employed in the prison. She is critical of the care given, by all those involved in Mr Bailey's care and sets out her findings in detail together with her conclusions.
>
> The view that I have is that the report of Ms Frances addresses all the relevant issues concerning the healthcare provided to Mr Bailey and on what should have been provided in a prison setting. It is therefore far more relevant than the report prepared by Dr Turner who confines himself to what would have happened if Mr Bailey had been seen in his unit as an NHS patient.
> I would remind all interested persons that the purpose of an inquest is to consider how, *and in what circumstances* Mr Bailey came by his death. It is not the purpose of an inquest to apportion blame or to determine matters of liability.
> The issues surrounding the provision of healthcare to Mr Bailey is adequately dealt with in the evidence of Ms Frances. Her report and the additional evidence that we will hear from the doctors involved will ensure that a full and sufficient inquiry takes place so as to comply with the provisions of the Coroner's Act and Article 2 of the Human Rights Act.
> In addition, I do not consider that it would be possible or appropriate for an inquest, particularly when sitting with a jury, to seek to determine issues of liability on the part of individuals. The jury will, however, be able to consider with the assistance of the report and evidence from Ms Frances whether the healthcare provided within Rye Hill Prison and the treatment afforded to Mr Bailey were appropriate. I do not consider the report from Dr Turner will in any way assist me or the jury in the inquiry."

He concludes his letter with this paragraph:

> "I trust you will accept that I have reconsidered this matter again in some detail following receipt of your letter and I trust you will exhibit my letter and the report of Ms Frances to any subsequent application for judicial review."

23. In a short statement on 23rd April 2008 the Coroner added these two observations:

> "4. The reason that I decided not to call Dr Turner in order to give evidence is due to the fact that I have the benefit of independent evidence from a highly experienced expert namely Ms Yvonne Frances who has

> worked extensively in the prison service. I also felt that Dr Turner's report deals with a hypothetical situation of how Mr Bailey may have been treated had he been in the community. The report does not state which hospital Dr Turner is referring to and in my view his report would not have assisted me or indeed the jury in considering the circumstances of Mr Bailey's death.
>
> 5. Since my original decision I understand that the Claimant's solicitors are proposing that Dr Turner should also give expert evidence concerning the role of a GP in the prison service. I would respectfully submit that it would be inappropriate for Dr Turner to give such evidence before the inquest."

24. In summary, the position taken by the Coroner is this: (1) that all relevant medical and health care issues are dealt with adequately by Ms Frances' evidence and the evidence that will be called from the doctors; (2) that the "hypothetical situation of how Mr Bailey may have been treated had he been in the community" is irrelevant; (3) that it would be inappropriate for Dr Turner "to give expert evidence concerning the role of a GP in the prison service."

25. Since in his letter the Coroner indicated that an important issue was the care that Mr Bailey should have received in prison, I infer that the Coroner considered that Dr Turner's experience did not afford him the basis for offering evidence on that issue.

26. Mr Sadat Sayeed, on behalf of the family, challenges those conclusions. First, he says that the inquest will have no suitably qualified independent expert witness to assist on the medical or psychiatric condition affecting Mr Bailey in his last days and what kind of regime ought properly to have been in place to try to safeguard his welfare. He says that whilst the evidence of Ms Frances is to be welcomed, and of course highly relevant, she cannot step into the shoes of a medical expert. He acknowledges that a consultant forensic psychiatrist, Dr Ian Russell, will give evidence, but, as the Coroner has made clear, because he was a visiting psychiatrist at Rye Hill and had some indirect dealings with Mr Bailey, he is to be a witness of fact. Dr West and Dr Ahmed, whilst of course medically qualified, are in the same position and may also be the subject of some criticism.

27. Second, Mr Sayeed says that Dr Turner is an eminently qualified expert to help.

28. Third, Mr Sayeed says that what might have been expected by way of medical care in the community is relevant, because the standard of health service provision expected for prisoners is the same as the general public receives under the National Health Service. He draws attention to Prison Service Standard 22, which indeed so provides.

29. I have, of course, heard submissions from Mr George Thomas, who before me represented the interests of Dr West and Dr Ahmed. Those submissions have of course been of considerable assistance, but inevitably structured towards protecting his clients

from direct or indirect criticism at the inquest.

30. I have not had the advantage of submissions made on behalf of the Coroner, though I have, of course, knowledge of the reasoning had led to his conclusion.

31. The test I have to apply in determining the outcome of this application is a little uncertain. Because of the need to give a relatively speedy decision, given that the inquest is due to start in a week's time, I have not had much opportunity for mature consideration. As I have observed, I have not had submissions on behalf of the Coroner and neither counsel has been able to refer me to another decision that gives me direct guidance on how to decide whether the threshold for intervention by this court has been crossed. I was referred to R (Bloggs 61) v Home Secretary [2003] EWCA Civ 686, which involved a rather different factual scenario but contains some helpful observations in the judgments of Auld LJ at paragraph 65 and Keene LJ at paragraph 81 that I have borne in mind.

32. Both counsel who have appeared before me have agreed that since the obligation on the Coroner is to hold an inquest that is Article 2 - compliant, I need to go further than merely asking whether his decision is Wednesbury reasonable or unreasonable. I must form my own view of whether what is proposed is likely to be Article 2 - compliant, giving, however, appropriate weight and observing appropriate deference to the decision taken by someone who, unlike most judges, will have considerable experience of conducting inquests. The difficulty, of course, is knowing where within the two ends of that spectrum to pitch the threshold for intervention at this stage in the overall process.

33. At the end of the day, it has to be a matter of impression, albeit informed by the particular circumstances of the individual case, and by the principles and parameters set out authoritatively by the House of Lords in Middleton in particular. The judgment to be formed by the court must also be informed by the practice adopted generally in Coroners' Courts. My attention has helpfully been drawn to the twelveth edition of Jervis on the Office and Duties of Coroners, the principal editor of which is Professor Paul Matthews, Her Majesty's Coroner for the City of London. The text I am about to quote was composed before Middleton and so must be read subject to it, but it affords me helpful guidance on current practice. The quotation is from the section in chapter 10 of that book dealing with witnesses. Paragraph 10-13, which has the heading "Power to call witnesses", reads as follows:

> "The coroner must also consider whether persons should be called as witnesses, and how best to secure their attendance at the inquest. Unlike ordinary civil proceedings, where witnesses are called by the parties, and cannot be called by the judge except with their consent, and criminal proceedings, where the judge *has* power (to be sparingly exercised) to call witnesses but the parties themselves usually do so, at an inquest it is the coroner alone who has the power to call witnesses.

This is a consequence of the inquisitorial nature of the proceedings before the coroner. It is his duty to conduct an investigation, rather than to hear and determine issues raised by parties to litigation. Hence the coroner, and no-one else, decides which witnesses can give relevant evidence, and hence shall be called. This applies to the production of documents as to the giving of oral evidence. And notwithstanding that there may be an obligation at common law for all persons able to give evidence to attend at the inquest, it is still for the coroner, on the basis of 'expedience', to decide who should be examined. He will do this by reference to the proper scope of the inquiry. Privilege to refuse to answer questions put is not a conclusive reason for not calling a person as a witness."

34. The next paragraph is paragraph 10-14, which is headed "Medical evidence" and reads as follows:

"Formerly it was held that the coroner should call a 'surgeon' to give medical evidence in all cases of sudden or violent death, and particularly when a criminal charge was likely to be made. Statute now provides that the coroner may summon as a witness any fully registered medical practitioner who appears to have attended the deceased during his last illness or at his death, and who may be asked for his opinion as to how the deceased came by his death. If it appears that no such practitioner attended the deceased, the coroner may summon instead (for the same purpose) any such practitioner in practice near the place of death. Failure to obey the summons is a (summary) criminal offence. These powers are little used today: the deceased's doctor will be summoned for his factual rather than his opinion evidence. In practice medical evidence is called at every inquest: in some cases more than one medical witness may be desirable or necessary, particularly where the medical issues are complex and involve more than one medical speciality, or where complaint is made of medical treatment received or some allegation of negligence is made. Even if the coroner is himself medically qualified, he cannot give expert evidence, and will need to call a suitably qualified medical expert in appropriate cases. That does not of course, mean that the coroner must call all the available experts: it is a matter for him."

35. The final paragraph by way of quotation is paragraph 10-15, and the heading for that is "Challenge to coroner's decision on witnesses":

"But a coroner's decision not to call a particular witness, or to ignore the possibility of evidence from a particular quarter, is not unassailable. It is clear that where, at an inquest, the coroner refuses to seek to obtain relevant documents, or to hear potential witnesses having relevant evidence to give and being available to give that evidence at the hearing, or even where he declines to call such witnesses and as a result makes an insufficient inquiry, the whole inquest is liable to be quashed. Thus,

> although it is in the discretion of the coroner as to who should be called and examined as witnesses, there will be cases where any decision by the coroner *not* to call particular witnesses will be quashed by the court and the coroner will be ordered to call such witnesses. As long as the coroner has made a definitive decision, it is unnecessary to wait for the inquest to be held before challenging that decision."

36. Mr Sayeed said that it is often easier to judge after an inquest has been held whether it would have been better for a particular witness to have been called to make it Article 2 - compliant. That may be so, but I cannot use that expedient to avoid a difficult decision at this stage. In any event, it is far better, for obvious reasons, to endeavour to ensure that an inquest is Article 2 - compliant before it takes place than to become engaged in the argument after a lengthy and expensive public exercise has taken place.

37. Mr Thomas has emphasised that the criticisms of what occurred at Rye Hill are likely to focus mostly on what can be termed systemic failures, rather than on individual failures. I suspect that there is some force in that, but as the House of Lords explained in Middleton, the borderline between the two is "indistinct and there will often be some overlap between the two".

38. Doing the best I can on the material before me, my conclusion is that independent expert evidence, both at consultant and general practitioner level, may be evidence that will help the jury answer the questions said to be relevant in Middleton.

39. Given that what is to be expected of the systems of health care within a prison and of the individuals who provide it is the NHS standard available to the general public, then evidence of what that standard is is, in my view, relevant. It would help to inform the issue of the adequacy or otherwise of the systems in place and of the way those operating those systems have acted. The need to avoid issues going to civil liability, which may of course also depend on evidence of a similar nature, would need to be addressed, but the fact that the evidence may be similar is not a reason for excluding it from the purview of the inquest.

40. I sense that this issue may have exercised the Coroner in making his decision. If I may say so, with respect, I can well understand that. But it seems to me to be more an issue of controlling the way in which the evidence is given and in the way it is, if received, put before the jury than ruling it out as a matter of principle. Indeed, I am not entirely sure that the Coroner has ruled evidence of this nature out in principle, but unfortunately the debate has focused almost exclusively on whether Dr Turner should provide that evidence.

41. What I am about to say is no reflection at all upon Dr Turner, whose expertise in the field of psychiatry is unquestioned. However, the Coroner has taken the view that Dr Turner's proposed evidence goes further than it legitimately can for the reasons given in the letter and statement to which I have referred. Whilst others may well have taken a different view, I think it would be wrong for me to characterise that decision as so

obviously wrong that I should interfere with it. As Jervis and general experience shows, a coroner has a wide discretion about how the proceedings are conducted and who it is "expedient" to call as a witness. The coroner is not obliged to accept a proposed witness and, as I have said, I for my part would be very slow to interfere with that kind of decision.

42. It follows from this, therefore, that I am not prepared to grant the specific relief sought in the claim form, namely a declaration that the decision was unlawful, that it be quashed and that a mandatory order requiring the Coroner to call Dr Turner be made. I am, however, of the view that an inquest in this particular case that does not have available to it evidence from an independent consultant psychiatrist and, I would add, an independent general practitioner, would not comply with Article 2. This is not a decision I have reached lightly, because I recognise it may have implications for the commencement of the inquest. However, I cannot avoid the decision simply because it may be inconvenient.

43. The Coroner has said, as of course is to be expected, that he will abide by any order of the court. Subject to anything that counsel may wish to say, I would not propose to make any specific order. My view is, I trust, clear. How it is translated into practical effect for the purposes of the inquest is very much a matter for the discretion of the Coroner, assisted by the parties who will be taking part. My position is simply that the effect of the Coroner's decision concerning Dr Turner potentially deprives the inquest of evidence that may help the jury in its task. I am merely saying that this is a gap that should be filled. I have indicated my view that it should be filled by both a consultant and a general practitioner, the latter because the systems in place will inevitably have been served on a daily basis by general practitioners.

44. I should emphasise that this decision is confined solely to the facts of this particular case. It does not necessarily follow that evidence of this kind will be required in every case of a suicide in prison.

45. Gentlemen, that is all I propose to say by way of decision. I am happy to hear you on what order, if any, I should make. As you will understand from what I have said it seems to me, I am not granting you the relief you seek but I am indicating what requires to a be done to make the inquest Article 2 compliant.

46. MR SAYEED: My Lord, I am grateful for your Lordship's considered and careful judgment. My Lord, having heard what your Lordship said at the very end, I certainly would want a little time to consider your Lordship's judgment before making a suggestion as to what order to be made. I think that probably also goes to matters of leave to appeal and also the issue of costs as well.

47. MR JUSTICE FOSKETT: That may be so. Leaving aside any consequential matters for present purposes, it seemed to me.... I have had to give that judgment extempore for obvious reasons, so I have not been able to produce something to be handed down and equally therefore communicated immediately to the Coroner because, as a matter

of if only common courtesy, I feel that I should be doing that fairly soon.

48. I am hoping that a transcript will be available by the end of the day, so that I can approve it and it can then be transmitted in full form to the Coroner. I may, subject to your agreement, invite my clerk simply to email him to tell him the outcome of today, because there is such a limited period of time between now and when the inquest is due to start. But that is a matter we can discuss.

49. What I suggest you do is perhaps you and Mr Thomas have a word outside and see what you think ought to be done in the light of my judgment, and you can make any other applications you wish. I have a couple of other matters to deal with. If you want a bit more time after that, then of course I will give it to you.

50. MR SAYEED: I am grateful, my Lord.

51. MR THOMAS: Could I say, the Coroner will be informed as soon as possible. It is my instructions that his office in fact contacted my instructing solicitor this morning to find out what had happened. My view, just very briefly, is this. There are of course different ways of getting to a satisfactory conclusion in this particular inquest.

52. MR JUSTICE FOSKETT: Yes.

53. MR THOMAS: I do not want to disturb it starting on Tuesday.

54. MR JUSTICE FOSKETT: No. I would very much like to avoid that, but I cannot obviously do much about that.

55. MR THOMAS: If it is the case that, given the indication you have given, that the matter can be reconsidered by the Coroner, it may avoid the need to continue, as my learned friend says, to issues such as leave to appeal. I do not know.

56. MR JUSTICE FOSKETT: Let me deal with the other two matters that I have to, which will take me a little while. If you are ready then to help me after that we will revisit it. But certainly my intention would have been just to send a short email indicating the nature of the decision that has been made, and hopefully the full judgment can be communicated to the Coroner as soon as I have received it.

57. MR THOMAS: Yes.

58. MR JUSTICE FOSKETT: Anyway, I will hear from you a little later on during the course of the morning.

(The case of Kaanijo was interposed)

59. MR SAYEED: My Lord, I have had an opportunity to consider our written notes of your extempore judgment. The position of the claimant is as follows. Unfortunately, I am not sure that my learned friend will agree with our position in terms of the course that we suggest should be taken. Certainly we would ask that the transcript of your

judgment be communicated to the Coroner as soon as possible, given that the inquest is now merely seven days away.

60. My Lord, as far as an order is concerned, we would seek an order from your Lordship. Essentially it would be a declaratory order, a declaration which we submit follows from your Lordship's judgment, and the declaration will have two main points. The first point is this. It be declared that the inquest due to start on 6th May will not be Article 2 compliant without the evidence of a consultant psychiatrist and a GP expert. The second point of declaration we seek is that in the assessment of the standard of care which Michael Bailey received, the standards in the NHS are relevant. That again is a point of principle, one which was objected to by essentially the Coroner and the representatives for Dr West.

61. So we would ask for a declaration of those two points because they naturally flow from your judgment. What the order does not do is to force the Coroner to take any particular step, merely to bring it to his attention that these two points emerge from your judgment. The case management issues which arise from that are a matter for the Coroner, and no doubt interested parties will have representations to make to the Coroner on that.

62. MR JUSTICE FOSKETT: My only point about that, Mr Sayeed, is that the Coroner is a responsible public official, who will doubtless give appropriate weight to the judgment that I have given. I do not think there is any need to grant a declaration because of course he will, I am sure, respond appropriately anyway to the judgment. Secondly, he has already indicated in his statement that he will abide by any decision — I said "order of the court", but I am sure he will understand that the decision is effectively that. So I would, for my part, not wish to go to the formality of granting a declaration unless there was some dispute about the effect of what I have said. But I hope that my judgment is clear.

63. MR SAYEED: My Lord, I wonder whether, your Lordship suggested earlier there will be a brief email to the Coroner, whether those points could be flagged up for the Coroner. The Coroner needs to act straightaway. When I say "straightaway", I mean the Coroner needs to get moving on this point today.

64. MR JUSTICE FOSKETT: I do understand that. All right. I hear what you say.

65. Is there anything you want to add to this, Mr Thomas?

66. MR THOMAS: My Lord, you have indicated you are not minded to make --

67. MR JUSTICE FOSKETT: I just think it is unnecessary.

68. MR THOMAS: It would potentially also add complication as well.

69. MR JUSTICE FOSKETT: A complication?

70. MR THOMAS: For example, there were various points as to what if the Coroner alighted on a course of action that he thought met with the substance of your concerns but would not be following the exact route that you propose. I do not think we need to trouble ourselves about hypothetical situations.

71. MR JUSTICE FOSKETT: I may or may not be correct, but I hope that my views are clear from the judgment I have written, which I shall obviously have the opportunity of correcting later on today and making sure it is absolutely crystal clear. I will, because I have been invited to, make some informal communication to the Coroner so that he knows the broad outcome of today.

72. MR SAYEED: There is a further application, my Lord.

73. MR JUSTICE FOSKETT: Yes.

74. MR SAYEED: My Lord, we would seek our costs in this matter and we request costs for the following reason. My Lord, what we say is notwithstanding your judgment, which essentially does not either grant or dismiss the claim for judicial review, but essentially gives pointers, as it were, to the Coroner, we say that it does amount to essentially a partial victory on our behalf. The position of both the Coroner and of the MDU was that the current evidential set-up as proposed by the Coroner met the requirements of Article 2. Your Lordship has found in the judgment that that is not the case. It was clearly the position of both the Coroner and of the MDU that this inquest did not need the evidence of a consultant psychiatrist. Your Lordship --

75. MR JUSTICE FOSKETT: Who are you seeking the costs against?

76. MR SAYEED: My Lord, we are seeking the costs against the Medical Defence Union. We are aware of the difficulties in seeking costs against the Coroner, who remains neutral. But the point is that it is also the fact that it was clearly the position of the MDU that the standard of care in the NHS was irrelevant. Your Lordship has again put an end to that position. It was never our position that a GP expert was not needed in this inquest. Therefore, in my submission, my Lord, the only relief which we sought, which was a mandatory order requiring the Coroner to call Dr Turner himself, we 'haven't achieved that and we accept that, that is why I call it a partial victory. But the fact is that the Coroner remained neutral and the case of Davies in the Court of Appeal makes it quite clear that where a judicial body, and particularly a Coroner, remains neutral, there is no basis to seek costs against a judicial body who remains neutral. However, that cannot be said and the same protection does not apply to the MDU. Not only did they pick up the Coroner's baton, but they ran with it. Many of the points which they made have, in essence, been denied by your judgment.

77. On that basis, my Lord, I suggest that we are essentially partial victors and much of what the MDU has submitted to the court has been rejected. My Lord, had I been making submissions to your Lordship on my own, the hearing would have been significantly shorter. In the end, for the purposes of the judicial review the MDU

became the defendant. My submissions were directed at meeting their points. That is the basis, my Lord, on which I say we are entitled to partial costs, on the basis we have partial victory.

78. MR JUSTICE FOSKETT: I am afraid I am against you and I do not need to trouble Mr Thomas on this. I have been much assisted by the representations that I have heard because I was not going to hear any representations from anybody else. I do not mean that offensively to Mr Thomas, but you were going to have to come here whatever the position. So I am afraid it is a no order as to costs situation as far as I am concerned.

79. MR SAYEED: Just one final matter, our client is publicly funded. We would ask for a detailed assessment.

80. MR JUSTICE FOSKETT: Yes, of course you should have that.

81. MR SAYEED: I am grateful, my Lord.

82. MR JUSTICE FOSKETT: Unless there are any other applications, I will proceed as I indicated. I will, when I get back to my room when I have dealt with the next matter, formulate a short email to the Coroner, indicating my decision and tell him, I hope, that I will be able to let him have a full transcript no later than tomorrow morning and we will see where you go from there.

83. Anyway, I am very grateful to you both for your assistance.
