was pertinent. The judge in that case awarded £80,000 in basic damages. In *Belfken*, Karen Steyn QC, sitting as a deputy High Court judge, awarded £40,000 for 295 days' unlawful detention (following a prison term; see above).

Aggravated damages were appropriate. Although the judge was not persuaded that the Home Office had kept Mr Mohammed in detention, when it was obvious he should have been released, for reasons of political expediency, as Mr Mohammed had argued, he was uneasy about the position it had adopted. However, the failure to consider the *Hardial Singh* principles, breach of the r35 procedure, breach of the policy regarding the detention of torture victims, and the pursuit of an unmeritorious defence in the civil claim up to the eve of the hearing were aggravating features.

As to value, the judge recognised the following factors as relevant: there was no 'initial shock' owing to the preceding lawful custody; even so, the award is tapered downwards; the length of the preceding lawful custody was relevant; the prison regime was more restrictive than the IRC; immigration detention being open-ended is particularly difficult; the exacerbation of Mr Mohammed's illness; and the aggravating features identified. The judge awarded a total of £78,500 for the three periods (the basic and aggravated elements combined) as follows:

- £8,500 for period 1 (41 days);
- £25,000 for period 2 (139 days); and
- £45,000 for period 3 (265 days).

In a heartening postscript to the judgment, addressed to the 'sceptic' who would question his award of damages to this foreign citizen who had 'abused the hospitality of this country' (para 66), the judge reminded readers of the fundamental importance of the liberty of the individual, of holding the executive to account and that justice is done to all people.

In a subsequent judgment ([2017] EWHC 3051 (QB), 24 November 2017), the implications of the defendant's refusal to take up the claimant's Part 36 offer of £70,000 were considered. As the sum awarded was more advantageous than the offer, the penalties under Civil Procedure Rules 1998 r36.17(4) should have been applied unless it was unjust to do so. The defendant sought to argue that the claimant's poor character should reduce the rate of enhanced interest that fell to be awarded under the rule, and that the additional amount of damages to be awarded to the claimant should be net of any interest. The court held that it was the conduct of the litigation, not the personal history of the claimant, that was relevant to the consideration of the Part 36 penalties. Enhanced interest, indemnity costs plus interest and the additional 10 per cent of damages were awarded. The court held that the additional 10 per cent should be calculated by reference to the award plus any basic interest that had accrued, but excluding any enhanced interest applied pursuant to r36.17(4)(a).

- **R (Sapkota) v Secretary of State for the Home Department**
  [2017] EWHC 2857 (Admin), 13 November 2017

In an earlier judgment, the court had determined that the claimant's detention over a 36-day period was unlawful because the decision to curtail his leave on the basis that his marriage to a Portuguese national would be a sham and bigamous and the consequent decision to detain him were procedurally unfair as he had not been given a fair opportunity to rebut the allegations made against him.

Dinah Rose QC, sitting as a deputy High Court judge, rejected the home secretary's contention that the claimant had suffered no loss entitling him to only nominal damages, emphasising the burden on her, which she had not discharged in this case, to establish not only that a *Wednesbury*-reasonable decision could have been made but that she would, on the balance of probabilities, have acted fairly and lawfully. She had not provided evidence demonstrating this and so the claimant was entitled to compensatory damages.

In relation to the quantum of damages, the judge awarded £11,000 for the first 24 hours that the claimant was detained, due to the appalling way in which he was treated and the fact that he had no previous experience of custody and had no reason to believe he would be detained, which meant that it was particularly shocking to him; the judge explained that this sum may be regarded as either general damages or a basic award of £6,000 with aggravated damages of £5,000.

In respect of the remaining 35 days of the claimant's detention, the judge took into account the lack of proper provision for his religious needs and evidence of the physical and mental effects of detention on him, awarding the sum of £12,000.

Jed Pennington, Janet Farrell and Jane Ryan are solicitors at Bhatt Murphy, London.

Inquests: recent developments

Leslie Thomas QC, Daniel Machover and Adam Straw consider recent important cases on scope, witnesses, article 2 inquests and previous investigations, inquests based on written evidence, police investigation of serious crime, and deaths following medical negligence.

Leslie Thomas QC

Daniel Machover

Adam Straw

The scope of the inquest

- **R (Hambleton and others) v Coroner for the Birmingham Inquests (1974)**
  [2018] EWHC 56 (Admin), 26 January 2018

The Divisional Court quashed the decision of the chief coroner as to the scope of the inquests. The bombing of two pubs in Birmingham city centre in 1974 was, at the time, the worst peacetime loss of life in British history. Twenty-one people were killed and some 220 injured. The subsequent police investigation by West Midlands Police that led to the conviction of the Birmingham Six has become a byword for miscarriage of justice. There has been no full investigation of who was responsible by anyone other than West Midlands Police.

The inquests were resumed in 2016 and the chief coroner appointed to preside over them. He decided that they would be article 2 (European Convention on Human Rights (ECHR)) inquests, which meant he would be required to investigate by what means and in what circumstances the deceased came by their deaths. However, he also decided that he would not investigate who was responsible for the bombings. The 10 claimants, who are relatives of those killed in the bombings, challenged that decision by judicial review. Their claim was upheld by the Divisional Court.

The Divisional Court decided that the coroner had misdirected himself. He did not ask himself the right question. In determining the scope of an article 2 inquest, coroners must ask themselves whether the particular factual issue at stake (here, the identity of the bombers and those who assisted them) is sufficiently closely connected to the deaths to form part of the circumstances of the death.

To put it another way, the coroner should decide whether the factual issue is too remote from the circumstances of the death. This is not a matter of causation as it is understood in contract or tort, but is a more flexible test. Once the coroner decides that the factual issue does form part of the circumstances of the death, they are

required, by Coroners and Justice Act (CJA) 2009 s5(1) and (2), to investigate it.

The court decided that the chief coroner failed to ask himself that question. He approached the scope of the inquests as a matter for his broad discretion, having regard to a wide range of factors. He proceeded on the basis that, even if an issue did fall within the circumstances of the death, he could decide not to investigate it. The fact that he asked himself the wrong question led the court to quash his decision.

The Divisional Court also held that the coroner's decision about the scope of the inquest is an exercise of judgement, rather than an exercise of discretion. This means that a successful challenge to the decision can be made on the basis that it is wrong, rather than on the more demanding basis that it is irrational or disproportionate.

At para 23 of his reasoning (3 July 2017), the chief coroner referred to his *Law Sheet No 5: the discretion of the coroner* (16 February 2015; revised 18 January 2016), particularly paras 3–8, which say that a coroner has a broad discretion as to the scope of an inquest. That law sheet will need to be reconsidered in light of this judgment.

The court went on to give some general guidance. It noted that the fact that the jury is precluded by CJA 2009 s10(2)(a) from making a determination which is framed in a way that determines any question of criminal liability of a named person, and the fact that the primary responsibility for detecting and prosecuting individuals for crimes vests with the police and prosecuting authority, are not (at least without more) reasons for excluding the identification of perpetrators from the scope of the inquests. The prohibition in s10(2)(a) is confined to determinations of the questions in s5(1) and (2). There may be inquests in which the identity of those involved in violent deaths may properly be within the scope of the inquest.

The Divisional Court also said that issues of fairness and proportionality may be relevant to the scope of the inquest. Fairness in the process may involve fairness to those who have a profound and abiding interest as relatives of the deceased as well as to those who may be implicated in a homicide. The size and complexity of an investigation into criminal responsibility of individuals 43 years after the events, following very detailed police investigations, may be a relevant factor, but it is not an overwhelming factor.

By its findings a jury may be able to identify an individual involved in the planning, planting, procuring or authorising of the bombing without breaching the statutory prohibitions, despite the prohibition in CJA 2009 s10(2). A jury may explore facts bearing on criminal and civil liability.

The court decided, however, that ECHR article 2 did not require the inquests to investigate the perpetrator issue. In respect of the investigation of the responsibility of members of the public (as opposed to public authorities) for a homicide, a police investigation may satisfy article 2 if it seeks to enforce the criminal law so far as is reasonably possible. That standard was met in this case.

Witnesses

- **R (Maguire and others) v Assistant Coroner for West Yorkshire (Eastern Area)**
  [2018] EWCA Civ 6,
  17 January 2018

The claimants were the children and husband of Ann Maguire, who was stabbed and killed at school by a 15-year-old pupil. Several pupils had been aware that the attacker had brought a knife into school that day and that he wished to kill her. Those pupils were interviewed by the police. The coroner conducting the inquest into Mrs Maguire's death decided that the rules and policies that the school had in place in relation to pupils bringing weapons into school, and the reporting of such incidents by other pupils, fell within the inquest's scope. The coroner decided that the pupils should not be called to give oral evidence because the risk of harm to them from revisiting the events outweighed the value of any further evidence they could give. The High Court dismissed an application for judicial review challenging the coroner's decision not to take oral evidence from the pupils, and the claimants appealed that decision.

The Court of Appeal dismissed the appeal. It concluded that the decision about which witnesses to call to give evidence at an inquest may be challenged in judicial review proceedings on traditional public law grounds. The context of any challenge will be that the coroner has a duty to conduct a thorough inquiry within the scope they have determined to enable the statutory purposes to be satisfied. There may be cases in which it can be shown that, absent an identified line of inquiry or examination of a particular available witness, the procedural obligation under article 2 cannot be satisfied. But in the generality of cases, the issue will be whether the failure to investigate something or obtain evidence, including by calling a witness, was *Wednesbury* unreasonable.

In this case, the coroner's decision was rational. No rules or policy existed. Whether that was a matter for adverse comment was something the inquest could fully, fairly and fearlessly explore without the evidence of the pupils. It was open to the coroner to conclude that the pupils would be harmed by giving evidence; indeed, it was common ground that calling the pupils concerned would exacerbate their trauma. There was little, if anything, to place in the balance against the potential harm to the interviewed pupils of giving evidence.

Article 2 inquests and previous investigations

- **R (Silvera) v HM Senior Coroner for Oxfordshire**
  [2017] EWHC 2499 (Admin),
  20 October 2017

This was a challenge to a coroner's decision not to resume a suspended inquest into the death of a woman who had been killed by her daughter after the daughter absconded from a psychiatric hospital. Before the killing, a doctor had decided that the daughter did not meet the criteria to be sectioned and so she was moved to an open ward. She absconded and a few days later killed her mother. The coroner decided that the other investigations satisfied ECHR article 2, taken together. The claimant challenged that decision.

The court concluded that the coroner had applied the wrong test for resumption. The coroner had referred to the test as being 'whether the facts of the death [had] been adequately aired in public' (see para 30). In fact, the correct test was, under CJA 2009 Sch 1 Part 2 para 8, 'the senior coroner thinks that there is sufficient reason for resuming' a suspended investigation. That was highly discretionary and there was no need to find exceptional circumstances.

The court held that the enhanced article 2 procedural duty was engaged. The question for the court to decide was whether the coroner had erred in finding that the investigations that had taken place were sufficient to discharge that duty. In other words, it was for the court to decide that issue for itself, it was not a discretionary matter for a coroner. The daughter pleaded guilty to manslaughter on the basis of diminished responsibility and so there was no criminal trial. Two other investigations into the responsibility of the relevant public authorities took place: a 'root cause analysis investigation report' by the NHS trust and a 'domestic homicide review' by the Oxford Safer Communities Partnership under Domestic Violence, Crime and Victims Act 2004 s9. Both were conducted in private. Taken together, those proceedings had not satisfied article 2 and so the coroner's decision would be quashed.

Inquests based on written evidence

- **Mueller v HM Area Coroner for Manchester West**
  [2017] EWHC 3000 (Admin),
  22 November 2017

The deceased committed suicide in a hotel. Her husband brought this application under Coroners Act (CA) 1988 s13, seeking a fresh inquest.

The deceased had had a complex personal life and mental health issues. She left a suicide note, part of which was addressed to an unidentified 'you' and stated: 'he will leave you for ambition'. The officer summarised the note in her statement for the inquest and concluded that the second part was addressed to an unknown female who appeared to be having an affair with the claimant.

The coroner wrote to the claimant and the family, asking whether the inquest could be dealt with on written evidence and whether they accepted a verdict of suicide. The letter set out the relevant documentation, including the officer's statement. The claimant responded, to agree with the coroner's suggested approach. At the inquest, the coroner summarised the important evidence, referred to the note without reading from it, and read out the officer's statement. Press articles then alluded to the wife's belief that the claimant was having an affair.

The High Court noted that the suicide note did not bear the meaning that the officer had sought to give it. There was no basis for concluding that the claimant's wife was asserting that he was having or may have had an affair. One precondition for quashing an inquest under CA 1988 s13 is if there has been an irregularity in proceedings. That could arise if the coroner failed to comply with the Coroners (Inquests) Rules 2013 SI No 1616. Rule 23 sets out the procedure for written evidence. The coroner should have informed the claimant that an interested person could object to the admission of any written evidence. The coroner should also have read out all of the note at the inquest, whereas he only read parts of it. Those two errors constituted an 'irregularity of proceedings' for the

purpose of CA 1988 s13.

However, the inquest was not quashed because there was no real risk that justice had not been done. There was no suggestion that a different conclusion would be reached at a fresh inquest, and there was no challenge to any of the evidence adduced, save for the officer's interpretation of the note.

The High Court gave the following general guidance for this type of inquest (at para 31):

Where, as in this case, a coroner sets out with an intention of dealing with the inquest by reading the statements, it is equally important to explain to all concerned, in advance, exactly what that will mean. The coroner should indicate which statements and documents are likely to be read or summarised at the public hearing, and which parts (if any) of the statements or documents are not to be read. Statements of witnesses often include relevant and non-relevant matters and may refer to documents. In cases involving suicide it is particularly important to indicate to all concerned whether any note has been found, what it says and whether any other evidence is connected to the note that may shed light on the contents of the note. The family should be alerted to the contents of any statement or document that may cause them concern. Equally where a coroner does not intend to include part of a statement or document, and the family wish it to be included, then subject to relevance, the coroner should have regard to their wishes.

Police investigation of serious crime

- **Commissioner of Police of the Metropolis v DSD and another***
  [2018] UKSC 11,
  21 February 2018

The claimants were victims of sexual offences committed by black-cab driver John Worboys. They brought civil claims for damages against the commissioner for failings in the investigation of the offences.

The Supreme Court concluded that the state was obliged by ECHR article 3 to conduct an effective investigation into allegations of crime involving serious violence against a person. 'Obvious and significant' or 'serious' errors by the police in the investigation would violate article 3, and compensation is available in principle for such failings. There was no requirement for the errors to be systemic rather than operational, nor for there to be state complicity. The award is geared principally to the upholding of standards concerning the discharge of the investigative duty.

European Court of Human Rights

Deaths following medical negligence

- **Lopes de Sousa Fernandes v Portugal**
  App No 56080/13,
  19 December 2017

The applicant's husband, who had been in good health, underwent a routine operation in hospital and ended up suffering from medical complications that led to his death three months later.

The Grand Chamber set out to 'reaffirm and clarify the scope of the substantive positive obligations of states' in cases of allegations of medical negligence in the treatment of those in ordinary hospitals (para 162). The court emphasised that this case did not involve the medical treatment of persons deprived of their liberty or of particularly vulnerable persons under the care of the state, where the state has direct responsibility for the welfare of those individuals, and that different considerations arose in those contexts.

In the context of ordinary alleged medical negligence, the states' substantive positive obligations under ECHR article 2 relating to medical treatment are limited to a duty to regulate, that is to say, a duty to put in place an effective regulatory framework compelling hospitals, whether private or public, to adopt appropriate measures for the protection of patients' lives. Even in cases where medical negligence was established, the court would normally find a substantive violation of article 2 only if the relevant regulatory framework failed to ensure proper protection of the patient's life. In very exceptional circumstances described below, article 2 may be violated by acts and omissions of healthcare providers.

The first type of exceptional circumstance concerns a specific situation where an individual patient's life is knowingly put in danger by denial of access to life-saving emergency treatment. It does not extend to circumstances where a patient is considered to have received deficient, incorrect or delayed treatment.

The second type arises where a systemic or structural dysfunction in hospital services results in a patient being deprived of access to life-saving emergency treatment and the authorities knew about or ought to have known about that risk and failed to undertake the necessary measures to prevent that risk from materialising, thus putting the patients' lives, including the life of the particular patient concerned, in danger.

To establish a breach of article 2 in this context, the following factors, taken cumulatively, must also be met. First, the acts and omissions of the healthcare providers must go beyond a mere error or medical negligence, in so far as those healthcare providers, in breach of their professional obligations, deny a patient emergency medical treatment despite being fully aware that the person's life is at risk if that treatment is not given. Second, the dysfunction at issue must be objectively and genuinely identifiable as systemic or structural in order to be attributable to the state authorities, and must not merely comprise individual instances where something may have been dysfunctional in the sense of going wrong or functioning badly. Third, there must be a link between the dysfunction complained of and the harm that the patient sustained. Finally, the dysfunction at issue must have resulted from the failure of the state to meet its obligation to provide a regulatory framework in the broader sense. Applying those factors, there was no substantive violation in this case.

The Grand Chamber went on to consider the article 2 procedural duty in this context. It noted that a state must set up an effective and independent judicial system so that the cause of death of patients in the care of the medical profession, whether in the public or the private sector, can be determined and those responsible made accountable. This is a type of positive obligation that applies to all deaths. It is not the enhanced procedural duty considered in *Middleton* [2004] UKHL 10; [2004] 2 AC 182.

In some exceptional situations, where the fault attributable to the healthcare providers went beyond a mere error or medical negligence, the court has considered that compliance with the procedural obligation must include recourse to criminal law.

In all cases, a requirement of independence of the domestic system set up to determine the cause of death of patients in the care of the medical profession is implicit in this context. This requires not only a lack of hierarchical or institutional connection but also that all parties tasked with conducting an assessment in the proceedings for determining the cause of death of patients enjoy formal and de facto independence from those implicated in the events. This requirement is particularly important when obtaining medical reports from expert witnesses, as the medical reports of expert witnesses are very likely to carry crucial weight in a court's assessment of the highly complex issues of medical negligence, which gives them a particularly important role in the proceedings. Proceedings must be completed in a reasonable time. The state is not obliged to initiate the investigation of its own motion.

There was a violation of the article 2 procedural duty. That was in part because criminal proceedings initiated against a doctor were concerned only with a narrow issue and 'did not deal with any of the other instances of alleged medical negligence complained of by the applicant. This in itself is sufficient to consider that they were deficient' (para 233). The action for compensation also did not discharge the article 2 duty. That was in part because 'for the purposes of the procedural obligation of article 2, the scope of an investigation faced with complex issues arising in a medical context cannot be interpreted as being limited to the time and direct cause of the individual's death. The court cannot speculate on the reasons why the origin of the bacterium which caused the applicant's husband to contract meningitis could not be established at domestic level. It finds however that, where there is a prima facie arguable claim of a chain of events possibly triggered by an allegedly negligent act that may have contributed to the death of a patient, in particular if an allegation of a hospital-acquired infection is concerned, the authorities may be expected to conduct a thorough examination into the matter' (para 237). The breach of the procedural duty led to an award of €23,000 for distress and frustration.

Comment: The case is significant for three reasons. First, several previous decisions of the court had suggested that some individual (as opposed to systemic) failures in ordinary medical treatment could violate article 2. This Grand Chamber decision rows back from those decisions. Second, it indicates that, even in the context of the reduced investigative obligation that comes about in the context of ordinary cases of medical negligence, the investigation must extend to arguable failures that possibly caused, or may have caused, the death. Third, the damages awarded were considerable, even though this related only to the breach of the article 2 procedural duty.

* See also page 25.

Leslie Thomas QC is a barrister at Garden Court Chambers, London. Daniel Machover is a partner at Hickman and Rose Solicitors, London. Adam Straw is a barrister at Doughty Street Chambers, London.