Neutral Citation Number: [2022] EWHC 28 (Admin)

Case No: CO/268/2020

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 11/01/2022

Before :

THE HONOURABLE MRS JUSTICE STEYN DBE

- -

Between :

The Queen on the application of LINDA GINN	**Claimant**
- and -	
HM SENIOR CORONER FOR INNER LONDON	**Defendant**
-and-	
MINISTRY OF JUSTICE	**1st Interested Party**
-and-	
CARE UK	**2nd Interested Party**

- -
- -

Stephen Simblet QC and Sarah Hemingway (instructed by **GT Stewart**) for the **Claimant**
Saara Idelbi (instructed by Government Legal Department) for the **First Interested Party**
The **Defendant** and **the Second Interested Party** did not appear and were not represented

Hearing date: 10 November 2021

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Approved Judgment

Mrs Justice Steyn :

A. Introduction

1. This claim arises out of the inquest held into the death of Mr Robert Ginn, the claimant's brother. Mr Ginn entered HMP Pentonville on 5 November 2018, having been sentenced that day to one year's imprisonment. He was 56 years' old and this was his first custodial sentence. Tragically, about three weeks later, Mr Ginn was found in his prison cell hanging by a ligature, having taken his own life.

2. Following an inquest into Mr Ginn's death before HM Senior Coroner for Inner London ("the Coroner") and a jury, on 29 October 2019 the jury recorded a narrative determination in these terms:

> "Mr Robert Thomas Ginn died in his cell F1-21 at HM Prison Pentonville, between the hours of 11pm on 28 November 2018 and 1.05am in the morning of 29 November 2018.
>
> We find the cause of death was suicide by hanging.
>
> A contributory factor to his death by suicide was his chronic depression."

3. The claimant seeks judicial review, with permission granted by Lang J on 25 June 2020, of the Coroner's directions and decisions on the following grounds:

   i) The Coroner failed to properly direct the jury to elicit the full circumstances of the death and to record their findings of fact on the central issues;

   ii) The Coroner failed to clearly direct the jury on the test for causation and how to record matters that they concluded more than minimally or trivially contributed to Mr Ginn's death;

   iii) If the Coroner decided not to leave any of the central issues to the jury to determine whether they caused or contributed to Mr Ginn's death, other than the quality of the resuscitation attempts, then she failed to indicate that she had withdrawn those issues or to give reasons for that decision; and

   iv) The Coroner erred in not directing the jury to record admitted failures under the *Tainton* principle (derived from *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin), [2016] 4 WLR 157), and giving no reasons for that decision.

4. At the hearing, leading Counsel for the claimant, Mr Stephen Simblet QC, did not seek to maintain the allegation that the Coroner erred in the direction she gave on the test for causation. The remaining aspect of Ground 2, taken together with Ground 1, forms the principal ground of review pursued. In essence, the claimant contends that the Coroner failed to direct the jury as to the law in such a way as to elicit the jury's conclusions on the central factual issues at the inquest. Consequently, she failed to comply with her duty under rule 33 of the Coroners (Inquests) Rules 2013 (2013/1616); and so the jury

failed to make the determination required by s.10 of the Coroners and Justice Act 2009 (read with s.5(1)(a) and (b) and s.5(2)), and the inquest failed to meet the UK's obligations under article 2 of the European Convention on Human Rights to investigate Mr Ginn's death.

5. The claimant's skeleton argument raised an additional issue, not foreshadowed in the grounds on which permission was granted, as to whether the so-called "*Galbraith*-plus" test adopted by Haddon-Cave J (as he then was) in *R (Secretary of State for Justice) v HM Deputy Coroner for the Eastern District of West Yorkshire* [2012] EWHC 1634 (Admin) ("the *West Yorkshire* case") was *per incuriam* or alternatively, in view of the Supreme Court's judgment in *R (Maughan) v Oxfordshire Senior Coroner* [2020] UKSC 46, [2021] AC 454, should no longer be followed. I address the permissibility of raising this issue in paragraphs 119 to 125 below.

6. The Coroner has adopted a neutral stance in these proceedings, and so did not take part in the hearing. However, I am grateful to the Coroner for the note ("the defendant's note") that she provided for the assistance of the court, through counsel instructed on her behalf, Jonathan Glasson QC, and accompanying bundle of materials. I am also grateful to the claimant's and the first interested party's representatives for the assistance they have provided in their written and oral submissions.

B. The procedural history

7. The investigation into Mr Ginn's death was opened on 13 December 2018; and the inquest was opened on 19 December 2018. The inquest hearing took place from 21 to 29 October 2019.

8. The claim was filed on 23 January 2020 together with a statement of facts and grounds. Pursuant to a consent order approved on 11 March 2020, the claimant filed an amended statement of facts and grounds on 28 February 2020, and time for service of the defendant's acknowledgment of service was extended.

9. Having filed an acknowledgment of service on 19 February 2020, indicating an intention to make a submission, on 20 March 2020, the defendant provided the note and accompanying bundle, to which I have referred. Also on 20 March 2020, the first interested party, the Ministry of Justice ("the MOJ"), filed summary grounds of defence. The second interested party has played no part in these proceedings.

10. On 13 August 2020, following the grant of permission by Lang J on 25 June, the MOJ made a request, pursuant to CPR Part 18, for clarification of the "admitted failures" relied on in ground four. The claimant provided her Part 18 response on 8 September 2020, specifying various matters relied on as "admitted failings".

11. On 16 September 2020, the MOJ filed detailed grounds of defence. The Coroner has taken a neutral stance, and so she has not filed detailed grounds, but she relies on the note filed prior to the grant of permission and, on 18 September 2020, the defendant's solicitor filed a statement adducing the official transcripts of the inquest for the assistance of the court.

12. The claimant filed a reply on 2 October 2020, pursuant to the case management directions given by Lang J.

C. The legal framework

The key legislative provisions

13. Section 1 of the Coroners and Justice Act 2009 ("the 2009 Act") provides so far as material:

> "(1) A senior 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 person's death if subsection (2) applies.
>
> (2) This subsection applies if the coroner has reason to suspect that –
>
> (a) the deceased died a violent or unnatural death,
>
> (b) the cause of death is unknown, or
>
> (c) the deceased died while in custody or otherwise in state detention." (Emphasis added.)

14. Subsection 1(2)(c) applied, as Mr Ginn died in custody, and so the Coroner was under a statutory obligation to conduct an investigation into his death. If the senior coroner has reason to suspect that the deceased died while in custody and that the death was a violent or unnatural one, as was the case here, the inquest must be held – as it was – *with a jury*: s.7(2) of the 2009 Act.

15. Section 5 of the 2009 Act provides:

> "(1) The purpose of an investigation under this Part into a person's death is to ascertain –
>
> (a) who the deceased was;
>
> (b) how, when and where the deceased came by his or her death;
>
> (c) the particulars (if any) required by the 1953 Act to be registered concerning the death.
>
> (2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.
>
> (3) Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than –

> (a) the questions mentioned in subsection (1)(a) and (b) (read with subsection (2) where applicable);
>
> (b) the particulars mentioned in subsection (1)(c).
>
> This is subject to paragraph 7 of Schedule 5." (Emphasis added.)

16. Section 10 of the 2009 Act provides, so far as material:

> "(1) After hearing the evidence at an inquest into a death, the senior coroner (if there is no jury) or the jury (if there is one) must –
>
> (a) make a determination as to the questions mentioned in section 5(1)(a) and (b) (read with section 5(2) where applicable), and
>
> (b) if particulars are required by the 1953 Act to be registered concerning the death, make a finding as to those particulars.
>
> (2) A determination under subsection (1)(a) may not be framed in such a way as to appear to determine any question of –
>
> (a) criminal liability on the part of a named person, or
>
> (b) civil liability." (Emphasis added.)

17. Rule 33 of the Coroners (Inquests) Rules 2013 (2013/1616) ("the 2013 Rules") provides:

> "Where the coroner sits with a jury, the coroner must direct the jury as to the law and provide the jury with a summary of the evidence." (Emphasis added.)

18. Rule 34 of the 2013 Rules provides:

> "A coroner or in the case of an inquest heard with a jury, the jury, must make a determination and any findings required under section 10 using form 2."

19. The prescribed form on which the conclusions of the inquest must be recorded is the record of inquest (form 2). It is set out in the schedule to the 2013 Rules and provides:

> "Record of an inquest
>
> The following is the record of the inquest (including the statutory determination and, where required, findings) –
>
> 1. Name of the deceased (if known):
>
> 2. Medical cause of death:

> 3. How, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death: (see note (ii)):
>
> 4. Conclusion of the coroner/jury as to the death: (see notes (i) and (ii)):
>
> 5. Further particulars required by the Births and Death Registration Act 1953 to be registered concerning the death:

1.	2.	3.	4.	5.	6.
Date and place of birth	Name and surname of deceased	Sex	Maiden surname of woman who has married	Date and place of death	Occupation and usual address

> Signature of coroner (and jurors):"

20. Note (i) identifies nine "*short-form conclusions*" that may be adopted, including "*IX. suicide*". (The list is not exclusive, although the Chief Coroner's Guidance No.17 advises it will usually be unwise to stray from the list.) Note (ii) provides: "*As an alternative, or in addition to one of the short-form conclusions listed under NOTE (i), the coroner or where applicable the jury, may make a brief narrative conclusion.*" Note (iii) addresses the standard of proof, however, in *R (Maughan) v Oxfordshire Senior Coroner* [2021] AC 454 the Supreme Court held that at an inquest the standard of proof to be applied to the question whether the deceased had died by suicide should be the civil standard, regardless of whether the conclusion is expressed by way of a short form conclusion or by way of a narrative conclusion.

21. Article 2 of the European Convention on Human Rights (which is incorporated in domestic law by the Human Rights Act 1998) imposes a number of substantive obligations on the state: not to take life without justification; to protect life, in some circumstances; and to establish a framework of laws, precautions, procedures and means of enforcement which will, to the greatest extent reasonably practicable, protect life. In addition, article 2 imposes a procedural obligation to investigate any death for which the state may bear responsibility.

22. It is common ground that the procedural obligation on the United Kingdom under article 2 applied to this inquest and that this is a case in which s.5(1)(b) has to be read with s.5(2). The Coroner proceeded, correctly, on the footing that article 2 was engaged.

The key authorities

23. In *R (Middleton) v West Somerset Coroner (Chief Coroner of England and Wales and another intervening)* [2004] 2 AC 182, Lord Bingham (giving the opinion of the Judicial Committee of the House of Lords) held:

> "18. …a verdict of an inquest jury (other than an open verdict, sometimes unavoidable) which does not express the jury's conclusion on a major issue canvassed in the evidence at the

> inquest cannot satisfy or meet the expectations of the deceased's family or next-of-kin. … An uninformative jury verdict will be unlikely to meet what the House in *Amin*, para 31, held to be one of the purposes of an article 2 investigation: "that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others.
>
> …
>
> 20. The European court has repeatedly recognised that there are many different ways in which a state may discharge its procedural obligation to investigate under article 2. In England and Wales an inquest is the means by which the state ordinarily discharges that obligation, save where a criminal prosecution intervenes or a public inquiry is ordered into a major accident, usually involving multiple fatalities. To meet the procedural requirement of article 2 an inquest ought ordinarily to culminate in an expression, however brief, of the jury's conclusion on the disputed factual issues at the heart of the case." (Emphasis added.)

24. The requirement that the jury's conclusions on the central issues be explicitly stated, however briefly, applies to cases "*in which a defective system operated by the state may have failed to afford adequate protection to human life*" (*Middleton*, [19]), not just cases where an agent of the state may have used lethal force without justification. For example, in *Edwards* (2002) 35 EHRR 487 and *Amin* [2003] UKHL51; [2004] 1 AC 653, the jury needed to be able to express their conclusions on the major issue, namely the procedures which led in each case to the deceased and his killer sharing a cell: *Middleton*, [31].

25. Accordingly, the House of Lords held that article 2 requires the word "*how*" (in the predecessor to s.5(1)(b)) to be interpreted as meaning "*not simply 'by what means' but 'by what means and in what circumstances'*" (*Middleton*, [35]). The legislation was subsequently amended to include this requirement, which is now contained in s.5(2) of the 2009 Act.

26. Where the jury are required, by s.5(2) and article 2, to ascertain in what circumstances the deceased came by his death,

> "…it must be for the coroner, in the exercise of his discretion, to decide how best, in the particular case, to elicit the jury's conclusion on the central issue or issues. … It may be done, and has (even if rarely) been done, by inviting a narrative form of verdict in which the jury's factual conclusions are briefly summarised. It may be done by inviting the jury's answer to factual questions put by the coroner. If the coroner invites either a narrative verdict or answers to questions, he may find it helpful to direct the jury with reference to some of the matters to which a sheriff will have regard in making his determination under section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976: where and when the death took place; the

> cause or causes of such death; the defects in the system which contributed to the death; and any other factors which are relevant to the circumstances of the death. It would be open to parties appearing or represented at the inquest to make submissions to the coroner on the means of eliciting the jury's factual conclusions and on any questions to be put, but the choice must be that of the coroner and his decision should not be disturbed by the courts unless strong grounds are shown." (*Middleton*, [36])

27. *R (Sacker) v West Yorkshire Coroner* [2004] 1 WLR 796, which was heard by the House of Lords at the same time as *Middleton,* was a case, like this one, concerning a death by suicide in a prison cell. The claimant sought judicial review of the coroner's refusal to leave to the jury the issue of whether her daughter's death had been contributed to by neglect. The House of Lords held at [28]:

> "The coroner in this case did not have an opportunity of inviting the jury to consider the issues in the way which Lord Bingham has now identified. This deprived the inquest of its ability, when subjecting the events surrounding Ms Creamer's death to public scrutiny, to address the positive obligation that article 2 of the Convention places on the State to take effective operational measures to safeguard life: *Osman v United Kingdom* (1998) 29 EHRR 245, 305-306, paras 115-116. The inquest was not able to identify the cause or causes of Ms Creamer's suicide, the steps (if any) that could have been taken and were not taken to prevent it and the precautions (if any) that ought to be taken to avoid or reduce the risk to other prisoners. The most convenient and appropriate way to make good this deficiency is, as the Court of Appeal did, to order a new inquest." (Emphasis added.)

28. In *Maughan,* Lady Arden JSC (giving the leading majority judgment) observed:

> "8. Longer, more judgemental narrative conclusions, as used by the coroner's jury in this case, are relatively new. They result from the recent transformation of many inquests from the traditional inquiry into a suspicious death into an investigation which is to elicit the facts about what happened, and in appropriate cases identify lessons to be learnt for the future. This is the position in inquests which the state is now required to carry out because of the European Convention for the Protection of Human Rights and Fundamental Freedoms (enforceable in the domestic law of England and Wales since 1 October 2000). Article 2 of the Convention protects the right to life. One of the consequences of this is that there must generally be an effective investigation of deaths which occur while a person is in the custody of the state ("state-related deaths"), and one of the ways in which this obligation may be discharged is by holding a coroner's inquest, in which the next of kin of the deceased can participate. The relevant principles of domestic law have been

established by decisions of the courts, including in particular, the decision of the House of Lords in [*Middleton*].

9. In his written submissions, the Chief Coroner states that an article 2 inquest:

> "opens up the field for conclusions about underlying or contributory causes, such as failures to prevent suicide in prison. It may require a coroner to deliver (or elicit from a jury) a more extensive and judgemental form of narrative conclusion. The manner of eliciting such a conclusion in a jury case is for the coroner's discretion but it is often done by means of questions (as in this case)" (para 19).

10. This is confirmed by the case of *Scholes v Secretary of State for the Home Department* [2006] HRLR 44, which came before Pill LJ and myself in the Court of Appeal. … This case illustrates a point also made by the Chief Coroner that the family of the deceased often want findings to be made at an inquest so that steps can be taken to ensure that the same tragedy does not occur again.

…

12. After the evidence is given, the jury must make their determination as to how, when and where the deceased died (2009 Act, section 10). … The coroner will determine which facts are at the centre of the case. A narrative statement of facts will often be necessary to express the findings of the jury on these facts (*Middleton* [2004] 2 AC 182, para 36, and Guidance No 17 issued by the Chief Coroner). The coroner may formulate some questions to help the jury, and their answers will form the narrative conclusions recorded at the end of the inquest. The conclusion in such a narrative is of a factual nature (*Middleton*, para 37). …

13. … Guidance No 17 issued by the Chief Coroner sets out a three-stage process for arriving at a conclusion, namely: (a) that the facts should be found (on the evidence); (b) that the manner in which the deceased came by his death should then be distilled from the narrative findings; and (c) the conclusion flowing from (a) and (b) should then be recorded." (emphasis added)

29. The test for establishing causation is not in dispute. As Sir Brian Leveson P observed in *Tainton* at [41], giving the judgment of the Divisional Court:

> "…it is common ground that the threshold for causation of death is not the same thing as the standard of proof required to prove causation of death. In cases such as this, the latter is proof on the balance of probabilities. It is agreed that the threshold that must be reached for causation of death to be established, is that the

> event or conduct said to have caused the death must have "more than minimally, negligibly or trivially contributed to the death" (see e.g. *R (Dawson) v HM Coroner for East Riding and Kingston upon Hull Coroners District* [2001] EWHC Admin 352; [2001] Inquest LR 233, per Jackson J at paras 65-67). Putting these two concepts together, the question is whether, on the balance of probabilities, the conduct in question more than minimally, negligibly or trivially contributed to death." (Emphasis added.)

30. In *R (Lewis) v Mid and North Shropshire Coroner* [2010] 1 WLR 1836 the Court of Appeal considered the issue whether a coroner is obliged to leave to the jury a fact or circumstances which could have caused or contributed to the death but cannot be shown probably to have done so. The court held that the coroner has a power but not a duty to leave such possible, but not probable, causes to the jury in an article 2 inquest (see per Sedley LJ at [29] and Etherton LJ at [40]-[41]).

31. Guidance regarding the use of written directions in inquests was first given by the Court of Appeal more than 20 years ago in *R v Inner South London Coroner, ex parte Douglas-Williams* [1999] 1 All ER 344. Lord Woolf MR advised at 355d-e:

> "*The future*
>
> The coroner very sensibly in the course of his summing up encouraged the jury to take notes. This did not however go as far as it should to help the jury. In future coroners faced with a complex case of this sort would be wise to prepare, in advance of their summing up, a written statement of the matters which the law requires in relation to each possible verdict and hand to the jury that statement prior to commencing the summing up. If this is done it can, beforehand, be considered by any lawyers attending the inquest and be the subject of submissions. …"

32. Hobhouse LJ gave a very short judgment, agreeing with Lord Woolf MR, in which he added at 355f-g:

> "I also indorse the need for legal direction to be given to juries in a clear and usable form. The use of written directions should be further considered in any case which is not wholly straightforward."

Thorpe LJ agreed (355g).

33. In *R (Wilkinson) v HM Coroner for the Greater Manchester South District* [2012] EWHC 2755 (Admin) Foskett J and HHJ Peter Thornton QC (the (then) Chief Coroner) stated at [18]:

> "In passing we comment that it is (or at least should be) standard practice for the coroner to prepare a draft written statement of the matters which he/she believes the law requires in relation to the possible verdicts. After submissions the coroner should rule

> on the verdicts that are to be left or not left and, where there is a dispute about them, give short reasons for the decision. Once discussed and ruled upon the coroner can then amend the draft, if necessary, and prepare the final directions of law for handing to the jury: see *R v Inner South London Coroner, ex parte Douglas-Williams* [1999] 1 All ER 344, 355."

The Chief Coroner's Guidance No.17

34. Guidance has been issued by the Chief Coroner in the form of a document entitled "*Guidance No 17 - Conclusions: Short-Form and Narrative*" ("Guidance No.17"). It was first issued on 30 January 2015 and then revised on 14 January 2016. The latter ("2016 Guidance") was the version in existence at the time of the inquest into Mr Ginn's death. Subsequently, on 7 September 2021, a further revised version has been published ("2021 Guidance"). The guidance focuses primarily on the matters to be included in Boxes 3 and 4 of the record of inquest (see paragraph 19 above).

35. Guidance No 17 states: "*It is for the coroner to decide whether a short-form or a narrative conclusion is more appropriate to the case in question.*" (2016 Guidance, para 22 and 2021 Guidance, para 12). It is common ground that a narrative conclusion was appropriate in this case, and the Coroner proceeded correctly in directing the jury to give a narrative conclusion.

36. The 2016 Guidance includes the following advice (omitting footnotes):

> "23. In more complex cases where interested persons are represented, the coroner will invite submissions on the following:
>
> - the type of conclusion, short-form or narrative;
> - the short-form conclusions the coroner is considering leaving to the jury;
> - what written directions (if any) will be given to the jury; and
> - what questions (if any) may be asked of them.
>
> The coroner should 'prepare a draft written statement of the matters which he/she believes the law requires in relation to the possible verdicts'. (Legal representatives could be invited to submit a first draft.) The coroner must give a ruling about these matters with 'short reasons'.
>
> **Written directions of law**
>
> 24. In jury cases of any complexity, a coroner should draft written legal directions, which should be circulated to interested persons to allow any submissions to be made. Those directions

> should include directions as to the order in which the jury should consider conclusions, and the standard(s) of proof. …
>
> 25. It is good practice, where time permits, for the coroner to hand to the jury the directions of law in full and then to read them out 'for the record'. In this way, particularly in complex cases, the jury will be able to revisit any of the directions when they have retired without having to rely on their memory or notes." (Emphasis added.)

37. In the 2021 Guidance, paragraph 13 advises in broadly similar terms to paragraph 23 (quoted above) that "*in more complex cases, the coroner should invite submissions from interested persons*" on the matters referred to in the four bullet points. Notably, however, in the third bullet point the words "*if any*" no longer appear, the current advice being to invite submissions in such cases on "*what written directions will be given to the jury (including in what order the jury should consider the conclusions)*". Paragraph 14 of the 2021 Guidance states:

> "In jury cases, it is good practice for the coroner to give the jury a copy of the directions of law, as well as reading them out. This allows the jury to revisit the directions when they have retired, without having to rely on their memory or notes." (emphasis added)

I note that in the above paragraph the reference to "*jury cases*" is not qualified by the words "*of any complexity*" (*cf* paragraph 24 of the 2016 Guidance).

38. Under the heading "*(1) short-form conclusions*", the 2016 Guidance states:

> "26. Wherever possible coroners should conclude with a short-form conclusion. This has the advantage of being simple, accessible for bereaved families and public alike, and also clear for statistical purposes.
>
> …
>
> 28. Even in a complex case a short-form conclusion in Box 4, in combination with the answer to 'how' in Box 3, will often be sufficient to 'seek out and record as many of the facts concerning the death as the public interest requires', per Lord Lane CJ in *Thompson*. …
>
> 29. Where a short-form conclusion is left to a jury in a complex case, the coroner should normally help the jury: (i) identifying key questions of fact for them to decide, when they come to answer the 'how' question (Box 3); and (ii) providing written directions of law with assistance on their conclusion (Box 4)." (Emphasis added.)

(Paragraphs 15, 18 and 19 of the 2021 Guidance are in almost identical terms.)

39. Under the heading "*(2) narrative conclusions*", the 2016 Guidance states (omitting footnotes):

> "34. In a non-Article 2 case a narrative conclusion should be a brief, neutral, factual statement; it should not express any judgment or opinion. By contrast, a conclusion in an Article 2 case may be judgmental: see paragraphs 51-52 below. The difference in some cases may be slight and not much more than a matter of words. For example, in a non-Article 2 case judgmental words such as 'missed opportunities' or 'inadequate failures' should probably be avoided. But rather than, for example, saying that 'There was a missed opportunity when the registrar failed to seek advice from the consultant', the coroner could say just as effectively: 'The evidence leads me to find that the registrar did not seek advice from the consultant who was nearby and available at the time and the registrar knew that. The registrar acted on his own.'
>
> 35. The requirement of brevity for a narrative conclusion has been emphasised repeatedly: see *Jamieson*, *Middleton*, *Clayton* and *Scholes*. A few sentences or one or two short paragraphs at the most will be sufficient. In *Jamieson* the Court of Appeal stated that 'It is not the jury's function to prepare detailed factual statements.'
>
> There has been a tendency for narrative conclusions from coroners to become lengthy and far-reaching both as statements and in questionnaires to juries (see below). That is not what the authorities envisage. Long narratives should not be given. They achieve neither clarity nor accessibility in that form. They make it difficult to assess for statistical purposes.
>
> …
>
> 38. Narrative conclusions must be directed to the issues which are 'central' to the cause of death, nothing more: Allen; or to the 'disputed factual issues at the heart of the case' or 'core issues which the inquest raised': Cash; 'the important issues': Smith. The coroner does not have to state a conclusion on every issue raised (only those above): Allen.
>
> 39. Where a jury is invited to write a narrative, the coroner may elicit the conclusion by a number of different methods. Normally the coroner will identify the issues or areas of fact which the jury needs to address, guiding them with examples of possible narrative conclusions, without of course telling them what to find.
>
> 40 As an alternative, the coroner may choose to provide the jury with written questions in the form of a questionnaire. In such cases the questions and answers will stand as the narrative

> conclusion. They will become part of the Record of Inquest and will be read out in public. …" (Emphasis added.)

40. The 2021 Guidance is in similar terms: see paragraphs 23-25 and 28-30. However, even greater emphasis is placed on brevity in paragraph 25 (which replaces paragraph 35 of the 2016 Guidance) which reads:

> "The higher courts have repeatedly emphasised the need for brevity in a narrative conclusion. A sentence or two, or a single short paragraph, will be sufficient. Longer narrative conclusions are neither clear nor accessible and should not be given."

41. In the 2016 Guidance, under the heading "*article 2 inquests*", the guidance states:

> "46. In an Article 2 inquest, the coroner must record 'in what circumstances' the deceased came by his or her death (section 5(2), 2009 Act). The inquest must enable the coroner or jury to express their conclusions on the central issue(s) canvassed at the inquest.
>
> …
>
> 49. What should be included in an Article 2 narrative conclusion? Narratives can include, following *Middleton*, 'causes of death, defects in the system which contributed to death and any other factors relevant to the circumstances of the death'. They must culminate in an expression of the jury's conclusions on the 'central issues'. The jury must be directed to the 'disputed factual issues at the heart of the case' or 'core issues which the inquest raised': *Cash*." (Emphasis added.)

42. The 2021 Guidance notes at paragraph 32 that:

> "In any Article 2 inquest, a short-form conclusion may be sufficient to enable the jury to express their conclusion on the central issues. However, frequently a narrative conclusion will be required in order to satisfy the procedural requirement of Article 2, including, for example, a conclusion on the events leading up to the death, or on relevant procedures connected with the death."

D. The facts

43. Mr Ginn entered HMP Pentonville on 5 November 2018, having pleaded guilty to indecent images offences and been sentenced to one year's imprisonment. Mr Ginn was then 56 years old. He had no previous experience of custody.

44. Mr Ginn had a significant history of mental health problems. He had diagnoses of a recurrent depressive disorder and an emotionally unstable personality disorder. He had made suicide attempts in the past and he had been consistently negative about his desire

to live, expressing hopelessness and helplessness. The records indicated he had a significant history of being abused as a child and in adulthood.

45. During his secondary screening on 6 November 2018, Mr Ginn said he had thoughts of suicide and an Assessment, Care in Custody and Teamwork ("ACCT") plan was opened that morning. The first ACCT review took place the same day, led by Senior Officer Williams. The primary care mental health team were invited to attend, and the clinical lead, Ms White, and one other member, Ms Vicianova, did so. During the first review, Mr Ginn spoke about his mental health difficulties and said that he was under a psychiatrist in the community who he was due to see for review in February. He said that he had experienced "suicidal ideology" for a long time, which he described as an active belief that he should kill himself, and said that he wanted to kill himself but that he was not going to because he could not do so in his cell. Mr Ginn was referred to the In-reach Mental Health team, a secondary care team made up of psychiatrists, mental health nurses and a social worker, for assessment. He was offered cognitive behavioural therapy which initially he was not keen to take up, but to which he later agreed.

46. The risk of harm he posed towards himself was assessed as "raised", which was defined as:

> "**When**
> - Suicidal ideas are frequent but generally fleeting
> - No specific plan/immediate intent
> - Evidence of mental disorder (e.g. depression, psychosis, panic attacks) acute or ongoing
> - Situation experienced as painful but no impending crisis
> - Previous, especially recent suicide attempts
> - Current, self-harming behaviour".

The immediate action plan involved hourly observations, three conversations a day and remaining in a double cell. The next ACCT review was set for 12 November.

47. On 7 November 2018, Mr Ginn's sister, the claimant, telephoned the prison and spoke to one of the prison's residential governors, Mr Young. She told PO Young that she thought Mr Ginn was at risk of suicide and that he might fool them. The prison officer's evidence was that she had described him as suicidal, that he had a heart condition and sleep issues, and had tried to buy a gun. PO Young recorded that information on the prison system, P-NOMIS. At the inquest, he expressed regret that he had not sent an email to healthcare to provide them with that information.

48. Also on 7 November, Mr Ginn's case was discussed at the daily health and wellbeing referral meeting. The In-reach Mental Health Team did not accept the referral because it was thought Mr Ginn did not have a severe and enduring mental illness. The manager of the In-reach team, Mr Roberts, had obtained information from Tower Hamlets Community Mental Health Team that confirmed Mr Ginn had seen a psychiatrist on 11 October 2018 as an outpatient, he had a diagnosis of chronic depression, and was to be managed in primary care with a psychiatry follow up in February 2019. They were still waiting for his medical records from the community mental health team.

49. The second ACCT review took place on 12 November. No member of the primary care mental health team was invited to attend. The second ACCT review was led by a

custodial manager at HMP Pentonville, Ms Byfield-Johnson. The observation frequency was changed from hourly to two hourly observations (with two conversations daily) because she thought Mr Ginn was in a better place and assessed the risk as low. She said she had nothing to indicate otherwise from the wing officer, although she had not asked. Low risk is defined as:

> "**When**
> - Suicidal ideas are fleeting and soon dismissed
> - No plan
> - No/few symptoms of depression
> - No psychotic mental illness
> - No self-harming behaviour
> - Situation experienced as painful but not unbearable".

The next ACCT review was set for 19 November.

50. On 13 November, Mr Ginn was referred for a psychiatric assessment on 26 November 2018.

51. Mr Ginn suffered from sleep apnoea and needed a Continuous Positive Airway Pressure (CPAP) machine to sleep. On 18 November 2018, his CPAP machine was brought into the prison for him to use.

52. The third ACCT review took place on 19 November 2018, led by Senior Officer Williams. The risk level was recorded as unchanged and the observation frequency remained two hourly. No member of the primary care mental health team attended, but the In-reach team fed in verbally to the review.

53. On 20 November 2018, a couple of days after he had received his CPAP machine, which was very noisy, Mr Ginn was moved into a single cell, a written request for a single occupancy cell having been completed by a doctor.

54. On the same day, Mr Ginn was seen by a Health and Wellbeing worker, Ms Williams (a senior mental health practitioner). He was found to be suffering from severe depression and moderate anxiety. He said that he had plans to take his life, but would not tell Ms Williams what they were as that would put a stop to his plans. A prison officer informed Ms Williams that Mr Ginn would be offered a single cell. She planned to see him again on 4 December 2018.

55. Ms White, the clinical lead for the primary care mental health team in HMP Pentonville gave evidence that Mr Ginn should have been brought back to the health and wellbeing meeting on 21 November by Ms Williams, but that did not occur. In the event, Mr Ginn had no further contact with the primary care mental health team after 20 November.

56. At 3am on 26 November 2018, the prison officer on observation duty, PO Green, recorded in the wing diary:

> "Mr Ginn said he felt isolated, he didn't want to go back to living on the outside, he doesn't feel like he should be in jail as his crime wasn't that bad, he went on to state that he didn't tell his family about his case but assumed they will know by now as his

> story was in the papers. Mr Ginn states his defence team didn't fight for him in court… Mr Ginn stated all of the above are making him have suicidal thoughts. …"

57. Later on 26 November 2018, Mr Ginn attended his appointment with Dr Butt, a psychiatrist. Mr Ginn told Dr Butt he was first diagnosed with depression and suicidal thoughts at the age of 13 and he talked about treatment from the age of 30. He referred to an overdose in September 2018 and to cutting himself. Mr Butt said he spoke about this in a jovial manner, apologising for having a dark sense of humour. He described his daughters and friend as protective factors, said that he was scared of dying and he would not act on his thoughts of self-harming. However, he wanted someone to kill him and referred to the possibility a prisoner might do so if his offence details were known. Dr Butt increased his dosage of antidepressant medication, offered CBT which Mr Ginn agreed to, and suggested to the prison officer finding a job for Mr Ginn to do on the wing. Dr Butt thought Mr Ginn had an adjustment reaction. He did not form the opinion that there was an imminent risk of self-harm. He said if he had heard about Mr Ginn's presentation two days later, on 28 November, he would have thought that was a very different, gloomier picture and would have gone to see him immediately. Dr Butt planned to see Mr Ginn again in early December.

58. Also on 26 November 2018, the fourth ACCT review took place. It was led by Ms Byfield-Johnson and, again, no member of the primary care mental health team was invited to attend. Mr Ginn had good eye contact. He said that sometimes life is good and sometimes he had thoughts of ending his life. Ms Byfield-Johnson asked him if he had a plan to kill himself and he would not say. He said he did not have enough medication in his cell to self-harm. The risk he presented to himself remained assessed as low and no change was made to the frequency of observations and conversations. Ms Byfield-Johnson thought he was better because he had opened up about his housing situation and was looking to the future and she thought he was getting to trust the staff. But she acknowledged the likelihood was that she did not look at the wing diary or speak to the wing officer before conducting the ACCT review. The next ACCT review was set for 5 December.

59. At 3.30pm on 28 November 2018, the prison officer on observation duty, PO Sampson, wrote in the wing diary:

> "Spoke to Ginn, he is in a very bad way. Incredibly withdrawn and didn't leave cell all day. Said that he had nothing to live for and that he felt it would be better off if he was dead. Received a letter from a friend who says that he has lied to her about his crimes. Spoke about his crimes and also how people he knows perceives him. Very concerning."

60. At 5.30pm, PO Sampson observed that Mr Ginn had not eaten any food, so he asked another prisoner to get some for Mr Ginn, but when PO Sampson checked on Mr Ginn when he went off duty at 6pm, Mr Ginn had not eaten anything. PO Sampson was very new in service and, at the time, he did not speak to his supervising officer or seek to involve anyone from healthcare. He did not perceive Mr Ginn to be immediately at risk of harming himself.

61. Later that evening, PO Tilley was on duty. He observed Mr Ginn at 7pm on 28 November, sitting and reading paperwork, and then Mr Ginn asked PO Tilley to turn the light off. PO Tilley observed Mr Ginn again at 8.25pm and thought he was still in a good mental state. He was watching a quiz show with the light turned off. They had a light hearted conversation. Mr Ginn asked PO Tilley if he would post a letter for him to social services, which PO Tilley said he would. Mr Ginn was observed again just after 11pm when he was sitting on his bed watching television.

62. At around 1.05am on 29 November 2018, Mr Ginn was found hanging in his cell by an operational support grade. She called for a colleague who called a code blue on the radio. An ambulance was also called. Two nurses who were on duty for emergencies and the custodial manager who was in charge of the prison that night entered Mr Ginn's cell. Mr Ginn was brought down and out of the cell and an attempt was made to resuscitate him. At 2.10am, the paramedics in attendance recognised that further attempts at resuscitation would be futile. Mr Ginn had died.

E. The admitted failure with respect to the resuscitation attempt

63. On the afternoon of the fifth day of the inquest, prior to summing up the following day, the Coroner canvassed with counsel the approach to be taken to an admitted failure, namely, the evidence that the attempt made to resuscitate Mr Ginn was inadequate.

64. The following morning, 29 October 2019, the Coroner informed counsel:

> "I have given consideration overnight to the question of admitted failures and I'm of the view that it would be unsafe to leave to the jury the admitted failure on the basis that there was a possibility that could have affected the outcome. Having considered all of the evidence, my view is that there was no realistic possibility that that could have affected the outcome, and so I'll deal with that by way of a prevention of future deaths report."

65. After the inquest had concluded, the following day, 30 October 2019, the Coroner made a Prevention of Future Deaths Report, pursuant to regulation 28 of the Coroners (Investigations) Regulations 2013. She reported:

> "CIRCUMSTANCES OF THE DEATH
>
> Mr Ginn hanged himself in his cell at HM Prison Pentonville. He was discovered by an operational support grade at around 1.05am on 29 November 2018. She raised the alarm and the two Care UK nurses on call for emergencies overnight (Hotel 7 and Hotel 12) attended to lead the resuscitation attempt.
>
> CORONER'S CONCERNS
>
> During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths will occur unless action is taken. In the circumstances, it is my statutory duty to report to you.

The MATTERS OF CONCERN are as follows.

I was able to view via body worn camera (BWC) footage part of the resuscitation attempt, and I had the benefit of evidence from a senior London Ambulance Service (LAS) paramedic who had also viewed it.

1. The nurse (Hotel 12) who gave evidence at inquest said that Mr Ginn was cold when she got to him, but the LAS paramedic who arrived later was confident that he was still warm, and his temperature was recorded as 34.7°C.

2. Throughout the resuscitation attempt captured on BWC, no staff member checked Mr Ginn's breathing.

It is possible that the breathing was checked before the commencement of the bodycam footage, and indeed one of the prison officers said he checked it at the outset, but the footage ran for nearly eleven minutes before the London Ambulance Service arrived and took over, and it was not checked in that time.

3. At inquest, one of the nurses said she looked at Mr Ginn's chest at the outset, but she did not put her cheek to his mouth to listen and feel for breath in order to confirm he was not breathing.

4. After the first two minutes of footage, the oxygen mask that had been in place was taken off and no further efforts were made to oxygenate Mr Ginn.

5. Given that Mr Ginn's heart had stopped beating, he must have stopped breathing as well. A full, effective, nurse led resuscitation attempt should have included an attempt to oxygenate throughout.

Hotel 12 said that she did not do this because Mr Ginn's jaw was too stiff to insert an airway, but the LAS did so without any difficulty. And if he had been cold and stiff when they arrived, the LAS paramedics would not have commenced resuscitation.

In any event, an oxygen mask can be applied even if there is stiffness (as it was here, but then it was removed two minutes into the resuscitation and nearly nine minutes before LAS took over).

6. Chest compressions given by different members of staff were variable and some, including those of one of the nurses, were sub optimal.

> At one point, chest compressions were given by a staff member sandwiched between Mr Ginn and the wall, where there was not enough space to be effective.
>
> 7. No attempt was made by either of the nurses to coach the prison officer to improve the quality of chest compressions.
>
> 8. One of the nurses (Hotel 7) did not administer chest compressions at all. She did not give evidence at inquest and so the reason for this is unclear.
>
> 9. The defibrillator pads were incorrectly applied by the nursing team, rendering the defibrillator reading unreliable.
>
> In fact, it was highly unlikely that Mr Ginn could have been saved, whatever the quality of resuscitation attempts, but that might not be the case for another prisoner – or visitor, or member of staff."

F. The Coroner's summing up and directions

66. Prior to the Coroner's summing up, in written submissions on behalf of the family, Ms Sarah Hemingway, submitted:

> "19. Whilst respecting the Coroner's indication that it is not her usual practice to leave to the jury a list of formal questions / issues to address, it is submitted that the jury may find it helpful to have some idea of the type of issues they should be commenting on in order to fulfil their role and satisfy the Article 2 investigatory requirement. No doubt the Coroner will already have in mind the issues to which she would wish to draw the jury's attention, yet in an effort to assist, the following list is suggested on behalf of the Family:
>
> a. Risk assessment and management by healthcare staff and prison staff.
>
> b. ACCT procedures (how staff use ACCT in practice)
>
> c. ACCT reviews, particularly on 12th and 26th November 2018.
>
> d. Observation levels and conduct of the observations.
>
> e. Communication: amongst prison staff; amongst mental health professionals; and between healthcare and prison staff.
>
> f. Record keeping and access to information (including information about bullying).
>
> g. Accommodation in cell F1-021.

> h. Steps taken by prison staff on the evening of 28 November 2018.
>
> i. Training of prison staff and healthcare staff on matters relating to ACCT procedures and emergency response.
>
> j. Resourcing, in particular the ability of prison staff to hold conversations with prisoners at risk.
>
> 20. It is respectfully submitted that these are all central issues that are properly part of the causal chain of events leading to Robert's death."

67. Counsel for the MOJ at the inquest, Ms Georgina Wolfe, addressed the proposed list of issues. She took no objection to (a), (b), (d), (e), (g), (h) or (i). In respect of (c), Ms Wolfe invited the Coroner to exercise care on the basis that there had been another ACCT review between the reviews on the 12th and 26th, and she suggested that the letter received on 28th November was perhaps a break in the chain of causation. In relation to (f), Ms Wolfe expressly took no objection to the jury being asked to consider "*record keeping*", but invited "*extreme caution when talking to the jury about bullying*", on the basis that there was evidence that he was not being bullied and there was nothing to link his actions with any bullying. Ms Wolfe objected to (j), submitting "*resourcing is an extremely difficult and complex issue and is not something on which the jury are in any way able to make any sort of decision*".

68. The Coroner gave her summing up and directions on the sixth and final day of the inquest. She chose not to give the jury any written directions, or to pose questions in the form of a questionnaire, or to give them a list of issues to consider.

69. She assisted the jury with the information required to complete Boxes 1 and 2 and the formal requirements in relation to Box 5; and they duly completed these parts of the record of inquest with the required information as directed. Then the Coroner summed up the evidence. The inquest had heard evidence from 27 witnesses, 14 of whom gave evidence orally, with statements from the other 13 witnesses being read. No criticism is made of the way in which the Coroner summed up of the evidence. I have drawn on her summing up in setting out the facts above and, as no complaint is made about the way she addressed the evidence, it is unnecessary to refer to it more extensively.

70. However, to deal with the grounds fairly, it is necessary to set out substantial parts of the Coroner's oral directions to the jury as to the law, as follows:

> "[1] Firstly, I want to remind you the purpose of an inquest: it's a fact finding inquiry. It's not designed to attribute blame, it's not a trial, it's not a question of criminal guilt or civil liability. Under Section 10.2 the Coroners and Justice Act 2009, a determination – which what we now call – what used to be called the verdict – may not be framed in such as way so as to appear to determine any question of criminal liability on the part of a named person or civil liability.

[2] What we're seeking to understand is who was the deceased, where did he die, when did he die, and how did he come by his death. And by how, we mean, in what circumstances. Under Section 5.3 of the Coroners and Justice Act neither the Coroner nor the jury shall express any opinion on any other matter.

[3] So it's for you, members of the jury, to decide upon any alternative theories as to how death came about based on the evidence that you've heard and the directions I give to you. …

[4] Once you have decided what actually happened, you have to consider which conclusion is appropriate for the facts. So agree upon the facts first, then turn your attention to the law. Once you've agreed upon the conclusion, then turn to the record of inquest.

…

[5] In terms of the conclusions open to you, I'm only going to leave one conclusion available to you because given the thrust of the evidence, it seems to me that this is the only conclusion that a reasonable jury properly directed may return. That is a narrative.

[6] So let me explain what a narrative is. A narrative is telling the story. It's a factual account as to how death came about. So remember, when I say it's a factual account, it's not about expressions of opinion, it's about conclusions of fact, which is quite an important distinction. So you have to make it understandable to someone who has not attended this inquest and has no idea who Robert Ginn was. So it has to, however short it is, and it may be very short, and in fact, both juries and coroners are encouraged to be brief in their conclusions. I'm not going to give you a word count, it's a matter for you, but I can tell you that it can be very brief.

[7] So I'll give you some examples in a moment, but you need to at some point, record the fact that Robert was in prison, for example, this happened in his cell at Pentonville. So you've got to say when it has happened, and by when, I mean when the [act] that caused his death happened. So you might say between the hours of 11.00pm on the 28th and 1.00am on the 29th, you might say that. You have to say where it has happened, so in his cell, in HM Prison Pentonville. And then you have to say [what] happened.

[8] You can't say in your narrative, 'One witness said this and another witness said that, they said something different'. Please don't do that because it doesn't help anyone. You have to decide what actually happened, so if there's a conflict of evidence you have to resolve that between you and say, 'Right, what do we

think actually happened here?' Please don't name individuals except Robert. So you might want to say the officer who last checked on him, or the psychiatrist who saw him two days before, or his close friend, or his sister, but say that rather than saying Mr Thing or Ms Thing.

[9] Now what you have to decide in your narrative is whether Robert died by suicide. So when I say to you that a narrative is about telling the story, it's not about a way of getting out of that question. That is a question that you must answer.

[10] Suicide has a very particular definition in law, so it's the voluntary doing of an act that results in death for the purpose of taking one's own life whilst being conscious of what one is doing. Suicide, as with the whole of your conclusion, as a standard of proof of the balance of probabilities; so more likely than not. …

[11] It is open to you to say something like, 'Robert hanged himself in his cell between the hours of 11.00pm and 1.00am at HMP Pentonville whilst suffering from – and you can record any of his diagnoses, so remember that he had been diagnosed with emotionally unstable personality disorder, depression and anxiety, and an adjustment reaction to conviction and imprisonment. You could say – you could simply say, 'Whilst depressed', it's a matter for you. I'm not telling you what to say, I'm just giving you alternatives.

[12] You may wish in the narrative – so as I say, it can be very short, it can just be he hanged himself in his cell on this date at Pentonville, his intentions were unclear. That can be it. But if you want to, you can go on further and you may wish to talk about some of the other events, some of the events which led up to this, particularly in terms of the care he received in prison.

[13] Now, if you do that you can talk about failures, but there are words that you must not use. You cannot use words like 'careless', 'negligent', 'reckless', 'reprehensive', 'foolish' or 'showing a lack of care'. You may, if you find these, use words like 'failure', 'inadequate', 'inappropriate', 'insufficient', 'unsuitable' or 'unsatisfactory'. However, and here's the thing; if you find that there was something inadequate, for example, for that to go in your narrative, it must have caused or contributed to death.

[14] So let's choose an easy example. The resuscitation. You might easily find that the resuscitation was inadequate, but we know from the evidence that there wasn't a realistic prospect of the resuscitation saving Robert. So it can't be said to have caused or contributed to death, so it doesn't belong in your narrative, it does not belong in there. So there must be a clear and direct

> causal connection between the event, or the conduct, or the failure and death, and that will be given the totality of the evidence.
>
> [15] The conduct or the failure that you're looking at does not have to be the sole cause of death, it doesn't even have to be the predominant cause of death, but it must have contributed more than minimally, negligibly or trivially. If it's a trivial contribution, don't include that, it doesn't belong in that. It must be more than trivial.
>
> [16] What you can do, what sometimes juries find helpful, is you might say, that death was by suicide, Robert hanged himself. Contributory factors in this were, and then list factors. You can just list them, you can do that if you find those, and the factors may be failures or they may not, it's entirely a matter for you. But remember, there must be a causal connection and remember that you're talking about the balance of probabilities. So if something only possibly happened, it didn't happen. If you find that it was possibly contributory, it wasn't contributory. It has to have been probably contributory. …" (Numbering and emphasis added.)

71. Counsel for the family, Ms Hemingway, asked to address the Coroner before the jury were sent out to deliberate. In the absence of the jury, she submitted that in order for it to be an article 2 compliant conclusion, it should at least address "*those central issues that have been explored within the course of the inquest, provided that they find, on the balance of probabilities, that the issues were more than minimally contributive*". She asked the Coroner to give the jury a little more direction as to their approach to the central issues.

72. Counsel for the MOJ, Ms Wolfe, disagreed, submitting:

> "I think you've very clearly explained to them that where they find that something is more than minimally causative or contributory, that they can record – should record that on the record of inquest; in my submission that is more than adequate."

Counsel for Care UK, Mr Connolly, agreed with Ms Wolfe.

73. Ms Hemingway replied:

> "Can I just pick up on something that Ms Wolfe said there? Because I think she quite rightly stated the law in that if they do find there's something more than minimally or trivially contributed, that they should record that, and I think just the way you've given your directions at the moment, you've said they don't need to. So even if they find that something is probably causative, and there is of course, a link there, they don't need to, because of course, that can just be their finding, that he hanged himself between the hours – these hours in his cell. But I think

> there's just perhaps a need just to say, 'If you do find that something is probably causative, then it does need to be included within the conclusion'." (Emphasis added.)

74. Ms Hemingway reiterated, in discussion with the Coroner and by reference to her written submissions in which she had set out the law:

> "there must be some commentary on the central issues. To not have any findings on those central issues would fall below the standard required."

75. The Coroner rejected Ms Hemingway's submissions that any further directions were required, observing:

> "I see your point, but perhaps I have confused matters by only leaving them a narrative, but in fact – and the reason I've left them a narrative was practicalities, because I just don't want them to be confused and I think it's very easy to get confused and there's a lot to think about, but the reality of this is that I'm leaving them suicide as a standalone conclusion, that's the reality of it. So if that's what they choose – obviously they've to put the date, time and place and circumstances, but the reality of that is, if they choose to say that Robert hanged himself in Pentonville in his cell between the hours of 11 and one, they can. And in my view, that doesn't mean that this inquest is not an Article 2 compliant. It is still Article 2 compliant.
>
> …
>
> Well, I saw your submissions, but it's also the case that it's for the Coroner to – within the Coroner's discretion, to decide how to elicit – how best to elicit the conclusion from the jury. And my view is that this is the best way of doing it." (Emphasis added.)

G. The submissions

The claimant's submissions

76. The claimant's principal ground is, in essence, that the Coroner's directions failed to elicit the jury's conclusions on the central factual issues at the inquest and, consequently, failed to comply with the procedural requirements of article 2. The *obligation* is to make a determination with respect to the questions identified in s.5 of the 2009 Act and to produce a public document, the record of inquest, which shows the statutory questions have been properly addressed and determined. It is not sufficient that the issues are aired at an inquest; the jury has to express a conclusion on the central issues. The claimant contends that did not happen because the jury were not properly directed.

77. This was not a case where there was any doubt that Mr Ginn took his own life. And there was plentiful evidence of suicidal ideation. The central issues on which the inquest

focused, summarised in paragraph 19 of the family's written submissions (see paragraph 66 above), all concerned the care Mr Ginn had received in prison. It is not suggested, Mr Simblet submits, that those were not the central issues or that any issue, other than resuscitation, was taken from the jury. The Coroner did not say that a properly directed jury could not find probable cause in respect of those central issues. She summed up the evidence with respect to these issues, but failed to direct the jury how such evidence fitted into their duty to determine "*in what circumstances*" Mr Ginn died.

78. Nowhere did the Coroner instruct the jury that they *should* address the central issues. She did not provide sufficient assistance to the jury to enable them to properly appreciate their task under s.5(2) of the 2009 Act. She did not identify the core issues that required explicit consideration by the jury or explain how these should be fitted into their fact-finding function. The claimant submits that she was deflected in her task, when the need for further directions was raised by Ms Hemingway, by the submissions of the interested parties.

79. The claimant submits that for the purpose of explaining to the jury their task, these were complex proceedings to which the guidance regarding written directions given in *Douglas-Williams, Wilkinson* and Guidance No 17 (2016) applied. In an inquest, particularly an article 2 inquest such as this one, where the jury were asked to give a narrative conclusion, the task of the jury is in many respects more complicated than in a criminal trial, and the responsibility on the court to assist the jury is, if anything, greater given that counsel do not have an opportunity to address the jury on the facts or make speeches.

80. Mr Simblet does not go so far as to suggest that not providing written directions, a questionnaire or a list of issues itself constitutes a public law error. The claimant acknowledges that it is within the discretion of the coroner to determine whether to craft written questions for the jury or to elicit their answers to the central questions in some other way. But the claimant submits that if, in such a case, a coroner chooses only to give oral directions as to the law, the need for clarity is all the more important.

81. There is, the claimant submits, no basis on which it can be inferred that the jury decided, on the balance of probabilities, that none of the central issues more than minimally, negligibly or trivially contributed to Mr Ginn's death. Mr Simblet submits that such an inference is unwarranted in circumstances where they were not directed to make a determination in relation to those central issues and, on the evidence, a conclusion that none of those matters contributed to Mr Ginn's death is unlikely. It is readily apparent that the jury followed the Coroner's directions loyally.

82. Ground 3 is raised by the claimant in the alternative. In short, the claimant submits that if, contrary to the claimant's primary submission, the Coroner decided not to leave the central issues identified by Ms Hemingway to the jury, on the basis that there was insufficient evidence, or it would be unsafe, for the jury to conclude that any of those matters probably contributed to Mr Ginn's death, then the Coroner erred in failing to give a ruling or reasons for that decision. The claimant submits that it would be wrong to reject this ground on the basis that the family's counsel did not request reasons given the stage at which the exchanges took place (that is, after the summing up and directions), the lack of clarity that a ruling withdrawing the central issues had been given (if it was), and the inquisitorial nature of the jurisdiction.

83. The claimant alleges, in her fourth ground, that the Coroner unreasonably failed to direct the jury, in accordance with the *Tainton* principle, to record any non-contributive but "admitted failures" in Box 3. In the detailed grounds, the claimant relied on the admission made by Mr Ryan Burfoot, the Head of Healthcare of Care UK (which was responsible for the health care provided at HMP Pentonville), that the resuscitation attempt was not adequate, and the evidence of Mr Ian Evans, the governor of HMP Pentonville, that the ACCT process did not work as he would have liked, particularly the communications with healthcare, and the lack of recognition and escalation of risk.

84. In the Part 18 response, the claimant stated:

> "These admitted failings include:
>
> 1. Ms Hipwell, who conducted one weekly quality assurance checks (note these should have been conducted every week but it seems only one was done), gave evidence that the ACCT documentation was incomplete. She also said that there had not been enough meaningful conversations with Robert. She said the ACCT did not address/reflect the current risk that Robert posed to himself and she accepted that was a failure on behalf of the officers conducting the review. Ms Hipwell accepted there was a failure to conduct observations as required by the ACCT which, she said, gave rise to a level of concern. She accepted that this was a failure to implement one of the protective support features of the ACCT process.
>
> 2. Ms White noted in her evidence that Ms Katie Williams failed to bring back Robert to the Health and Wellbeing team meeting on 21 November 2018, as required. On a separate note, Ms White stated that she attended Robert's ACCT first review but was not aware of the interview/ assessment conducted just before the Review, nor did she have any say in the determination of level of risk (healthcare were not asked for their opinion on risk level – there was no discussion around that) and in any event she had not been trained on how to mark the risk level.
>
> 3. Mr Young failed to make a note in the ACCT documentation regarding concerns about Robert raised in a phone call he received.
>
> 4. Ms Byfield-Johnson failed to invite relevant healthcare staff to the two Reviews she conducted on 12 & 26 November 2018. She also admitted failing to speak to a landing officer to obtain relevant information / check PNOMIS / read the wing book. There were matters of concern raised in the course of the Review meeting about which she failed to ask appropriate questions (i.e. in order to properly assess risk). She accepted that the review was inadequate.
>
> 5. Dr Butt gave evidence that the ACCT documentation often failed to travel with the patient to healthcare appointments with

> him. As abovementioned, he admitted that he failed to appreciate the importance of completing the ACCT documentation.
>
> 6. Mr Sampson had difficulty in recollecting the content of his ACCT training. He admitted there was a failure to escalate concerns to a senior officer on 28 November 2018.
>
> 7. Mr Mostyn stated that he had not had any ACCT training since its first inception many years ago. That is notwithstanding the evidence of Mr Evans that all officers receive some form of rolling refresher training.
>
> It is submitted that comments made by Governor Evans that the ACCT process did not work as it should have is an acknowledgement of the various failings made throughout the inquest as particularised above."

85. The claimant submits that the evidence was essentially all one way and so it was required to be recorded. However, at the hearing, the only non-contributive "admitted failure" that Mr Simblet maintained ought to have been recorded in the record of inquest was the inadequate resuscitation attempt. The claimant's essential submission, at the hearing, in respect of the other matters raised as admitted failures in her pleadings and skeleton argument was the failure of direction alleged in ground 1.

The MOJ's submissions

86. Counsel for the MOJ, Ms Saara Idelbi, emphasised the width of the Coroner's discretion to determine how best to elicit the jury's conclusion, the courts having repeatedly declined to prescribe a mandatory process. In this regard, Ms Idelbi relied particularly on paragraph 36 of *Middleton* (see paragraph 26 above); and *R (LePage) v HM Assistant Deputy Coroner for Inner South London* [2012] EWHC 1485 (Admin), a case concerning a coroner's decision not to call a witness, at [44] to [53]. The complaint must be considered in the context of the summing up as a whole, and "*it is incumbent upon a coroner to direct the jury as to the issues and the evidence fully and fairly. However, the way in which he or she structures the summing up is [a] matter for them. There is no set formula they are obliged to follow*": *R (Sreedharan) v HM Coroner for the County of Greater Manchester* [2013] EWCA Civ 181 at [62].

87. The Coroner was entitled to exercise her discretion, the MOJ submits, not to provide written directions. The advice in paragraph 24 of the 2016 Guidance to draft written legal directions is expressly made with reference to "*jury cases of any complexity*" (see paragraph 36 above). The advice is derived, as is made clear from the citations in the relevant footnote (fn.11) from *Douglas-Williams* and *Wilkinson* (see paragraphs 31 to 33 above). Ms Idelbi submits that both authorities are concerned with complex, or at least "*not wholly straightforward*", inquests. *Wilkinson* was a case in which the coroner left three possible short form verdicts (as they were then called) to the jury: unlawful killing, accident or open verdict. In *Douglas-Williams*, the inquest took three weeks and forty witnesses were called to give evidence, including three medical experts. The jury returned a verdict of accidental death, having had to consider two species of unlawful killing (namely, unlawful act manslaughter and gross negligence manslaughter). And

Lord Woolf's guidance was expressly given with respect to "*a complex case of this sort*".

88. This was not, the MOJ submits, a complex inquest. It took place over six days. The issues were not particularly complex, especially when compared to a case such as *LePage*. Ms Idelbi acknowledged that it was not a totally straightforward inquest, but nonetheless submits it was appropriate, and the Coroner did not err, in giving directions only in oral form.

89. Ms Idelbi submits the Coroner gave the jury full latitude, enabling them to list all the possible causes raised by the family as contributory factors, if they found them to be probably causative. There is no requirement in an article 2 inquest to seek to elicit from the jury matters which were possible, but not probable, causes of death: *Lewis* (see paragraph 30 above). The jury clearly understood, the MOJ submits, that they had to record in their narrative all the factors that they concluded were probably causative of, or more than minimally contributed towards, Mr Ginn's death.

90. There is no obligation to record matters that are *not* found to be causative (applying the causation test referred to in paragraph 29 above); only to record the facts insofar as they are relevant to the statutory questions in s.5 of the 2009 Act. The jury were not obliged to state a conclusion on every issue canvassed in the evidence considered: *R (Allen) v HM Coroner for Inner North London* [2009] EWCA Civ 623, at [33]. The clear inference that should be drawn from the absence of any reference in the jury's narrative to the other factors canvassed in evidence is that the jury found that none of those other factors caused or contributed to Mr Ginn's death. An inquest, even in the absence of any error on the part of those involved, will not always succeed in laying to rest all the concerns of the family of the deceased: see *Shaw v Leigh Day* [2018] EWHC 2034 (QB), [2019] PNLR 2, per Andrews J (as she then was) at [14].

91. The reliance on passages in the directions where the Coroner spoke in terms of what the jury '*could*', rather than '*should*' or '*must*', record amounted, Ms Idelbi submitted, to the kind of detailed analysis of the summing that was deprecated by Collins J in *R (Anderson) v Inner North London Coroner* [2004] EWHC 2729 (Admin) [2004] Inquest LR 155 (at [22]), where he stated

> "The absence of any opening or closing speeches at inquests means that the need for clarity in a summing-up becomes all the more important. This is not to say that a summing-up should be subjected to a close analysis or that the absence of a particular form of words or indeed of particular directions will necessarily be fatal."

92. The MOJ submits that the standard the claimant contends for, by giving the jury an array of examples, would involve the coroner micromanaging the jury in a way that would curtail the jury's role and gainsay their own assessment of the significance of the issues in the inquest.

93. The short answer to ground 3 is, Ms Idelbi submits, that the Coroner did not withdraw any issue from the jury, other than the resuscitation attempt. She gave reasons for her decision not to leave the issue of resuscitation for the jury to consider and the challenge to that ruling is not maintained.

94. Ms Idelbi submits that ground 4 must fail. There was only one matter that was an admitted failure in the sense in which that term was used in *Tainton*, namely the admitted inadequacy of the attempt to resuscitate Mr Ginn. The decision not to include reference to that failure in the record of inquest did not breach article 2, in circumstances where the Coroner addressed it in her prevention of future deaths report. Ms Idelbi also relied on the fact that there was in this case a published PPO report. I address below the application, after the hearing, to adduce a copy of the PPO report (see paragraphs 135 to 142 below). Governor Evans' comment that the ACCT process did not work as he would have liked is not, she submits, comparable to the formal admission made by the Trust to the coroner, following an internal clinical review, in *Tainton.*

The defendant's note

95. The defendant has adopted a neutral stance in these proceedings. Addressing the relevant case-law and guidance, the defendant's note referred at paragraph 17 to the *Galbraith*-plus test, in the following terms:

> "In applying the *Galbraith plus* test, the coroner must have regard as to whether a sufficient causal connection has been established on the evidence. In *R (Lewis) v Mid and North Shropshire Coroner* [2010] 1 WLR 1836 the Court of Appeal held that the coroner has a power but not a duty to leave to the jury in *Middleton* inquest circumstances which were possible but not probable causes of death. Sedley LJ was "unable to find a reason of principle for making it a duty". Etherton LJ (as he then was) concluded that only matters which probably had a causal connection to death could form part of a verdict. There is therefore no requirement in a Middleton inquest to leave questions to a jury in respect of matters which possibly caused or contributed to the death."

96. The defendant's note addresses the nature of the admitted failings in *Tainton* as follows:

> "The "admitted failings" that were considered in *Tainton* were set out at [18] of the judgment of Sir Brian Leveson P:
>
> > "The Trust accepted the conclusions of these various investigations and, on 4 March 2015, wrote to the coroner in terms:
> >
> > > "the Trust accepts, as does Nurse Makoni, that she ought to have referred Mr O'Neill to one of the prison GPs when he presented to her in January [2013] complaining of haemoptysis.
> > >
> > > "It is further accepted that had a GP referral been made, the GP would have made a two-week referral to hospital for Mr O'Neill to undergo additional investigations—which would probably have involved endoscopy—with a diagnosis of cancer being made around mid-February [2013].

> "The Trust is, of course, unable to say how advanced the cancer was in mid- February [2013]."
>
> 27. The Divisional Court concluded that those admitted failings should have formed part of the findings in that case. It emphasised however that "We are not suggesting that any admitted failings have to be included in every case. The manner in which the state discharges that obligation will, as Ms Dolan correctly submitted, vary from case to case."
>
> 28. As noted above, the court is asked to consider the evidence of Mr Evans and Mr Burfoot by reference to the admitted failings in Tainton."

H. Analysis and decision

Ground 1

97. The task of directing a jury in an article 2 inquest is, as Mr Simblet readily acknowledged, inherently difficult: see *R (P) v HM Coroner for the District of Avon* [2009] EWCA Civ 1367, [2009] Inquest LR 287 ("the *Avon* case"), Maurice Kay LJ at [25]. The claimant has, rightly in my view, eschewed any criticism of the Coroner's summing up of the evidence. Ultimately, the target of this principal ground of challenge is one aspect of her directions as to the law.

98. The case-law and the guidance to which I have referred strongly encourage coroners to give jurors some form of written directions, at least if the inquest is not wholly straightforward or of any complexity: see *Douglas-Williams*, Lord Woolf MR at 355d-e and Hobhouse LJ at f-g, *Wilkinson*, Foskett J and HHJ Peter Thornton QC at [18], the 2016 Guidance, para 24 and the 2021 Guidance, paras 13-14 (paragraphs 31 to 33 and 36 to 37 above).

99. I reject the MOJ's submission that this guidance was inapplicable because this was not a complex inquest. I acknowledge that, in one sense, this could be said to have been a straightforward inquest, given that there was never any real doubt that the cause of death was suicide. But in considering the application of the guidance to which I have referred, the primary focus must necessarily be on the complexity of the jury's task, and the directions needed to guide them in discharging their responsibilities.

100. This was an article 2 inquest that lasted six days, the jury having heard evidence from 27 witnesses. Evidence regarding numerous arguably contributory issues (such as the way in which the risk Mr Ginn posed to himself was assessed and the communication of information amongst and between healthcare and prison staff) was heard. There was no dispute that the issues identified in paragraph 19 of the family's submissions were central issues in the inquest, save to the limited extent that the MOJ took issue with item (j) (resources) and invited caution in the way the jury were directed about (c) (the ACCT reviews) and an aspect of (f) (bullying) (see paragraphs 66 to 67 above). In *Maughan*, Lady Arden JSC observed that the "*coroner will determine which facts are at the centre of the case*" (see paragraph 28 above).

101. Amongst other matters, the jury had to be directed not only as to the standard of proof required to prove causation of death but also the *threshold* for causation of death. The concept that a fact or circumstance which more than minimally, negligibly or trivially contributed to the death meets the threshold for causation is not simple, and is likely to be unfamiliar to most jurors. The jury were required to express their conclusion in narrative form, applying the requisite standard and threshold of causation, on the disputed factual issues at the heart of the inquest. The explanation of this responsibility, which may involve giving a judgemental narrative, and how it fits with the statutory prohibition against framing the conclusion in such a way as to appear to determine any question of criminal liability on the part of a named person or civil liability (s.10(2)), or of expressing any opinion on any matter other than the s.5(1)(a) and (b) and 5(2) questions (s.5(3)), is far from straightforward: see the *Avon* case at [25].

102. I consider it would have been advisable to give written directions in this inquest, in the absence of any good reason to depart from the guidance to which I have referred. Where nothing is provided to the jury in writing, whether in the form of written directions or a questionnaire, errors are liable to occur. The advice given by the Court of Appeal in *R v Atta-Dankwa* [2018] EWCA Crim 320, [2018] 2 Cr App R 16 at [30]-[31], albeit adapted from the criminal context in which it was given, is apt: one should never be too quick to assume that written directions would be superfluous. Experience shows that problems can arise even in cases which seem straightforward.

103. However, I accept Ms Idelbi's submission that the decision not to give written directions was not, in itself, a public law error. As I have indicated, the claimant does not contend otherwise. The absence of written directions is no more than the context in which the question whether full and fair directions as to the law were given falls to be determined.

104. In my judgement, the Coroner fell into error in the directions that she gave in precisely the way identified by Ms Hemingway immediately before the jury were sent out to make their determination (see paragraph 73 above). The jury were *required* to make a determination, inter alia, as to the circumstances in which Mr Ginn came by his death: see s.10(1)(a) of the 2009 Act (and in particular the use of the word "must") (paragraph 16 above). They were *required* to determine whether the core issues which the inquest raised caused or contributed to Mr Ginn's death. And they were *required* to record in their narrative any facts or circumstances that they determined caused or contributed to his death.

105. The judgment in *Allen* at [33], on which the MOJ relies, does not detract from these conclusions. The court observed that it is "*not incumbent on the coroner to investigate, still less to state his conclusion in relation to, every issue raised by the claimant, however peripheral to the main questions to be determined*" (emphasis added). It was not disputed at the inquest or before me that the issues the claimant contends needed to be considered were central.

106. The Coroner made clear that there were certain matters the jury had to determine and record. They had to say when and where his death happened (see [7] of the directions, quoted in paragraph 70 above). They had to answer the question whether Mr Ginn died by suicide (see [9] of the directions, paragraph 70 above: "*That is a question you must answer*"). By contrast, she directed the jury that they could, if they *wished,* include in their narrative reference to some of the other events in the lead up to his death,

particularly his care in prison (see [12], [13] and [16] of the directions, paragraph 70 above). In saying this, the Coroner left it open to the jury to record any of the matters canvassed in evidence as contributory factors. But she did not identify the central issues, direct the jury that they must consider them or direct the jury that they must include in the narrative any such matters that they determined caused or contributed to Mr Ginn's death. On the contrary, the directions would have given the jury the clear impression that there was no need for them to make any determination in respect of any of the central issues canvassed in evidence (see [11] and [12] of the directions, paragraph 70 above). As the Coroner observed, albeit not in the presence of the jury, "*I'm really only leaving them suicide*". This was reflected in the directions she gave.

107. In my view, this conclusion does not involve an unwarranted close analysis of the directions given. There is a vital distinction between telling a jury that they must consider certain identified matters and giving them the option to address them (with the use of phrases such as "*if you want to*", "*you can*", "*you may wish to*", without identifying the issues other than as care in prison).

108. I also reject the contention that it can be inferred from the omission of any reference to the central issues that the jury were not satisfied that any of the alleged flaws in the system more than minimally, negligibly or trivially contributed to Mr Ginn's death. No such inference can be drawn in circumstances where the jury were not directed to determine whether those matters were causative, they were given a strong steer to keep the narrative very brief, and the narrative they adopted closely reflected the wording that the Coroner suggested (see the record of inquest and [7] and [11] of the directions, paragraphs 2 and 70 above). As Maurice Kay LJ observed in the *Avon* case at [25], it would not be surprising if a jury, having "*to navigate these confusing waters*", "*opted for the simplest solution*".

109. For the reasons I have given, and accepting the claimant's submissions as I have summarised them in paragraphs 76 to 81 above, I conclude that the Coroner did not adequately direct the jury as to the law. As a consequence, she failed to elicit the jury's conclusions on the central factual issues at the inquest and so the jury failed to make the determination required by s.10 of the 2009 Act, and the inquest did not comply with article 2.

Ground 2

110. The claimant sensibly did not seek to maintain the contention that the Coroner's direction as to the causation test was defective. It follows that I dismiss ground 2, save to the extent that the claimant raised in ground 2 (as well as ground 1) the matters I have addressed under ground 1.

Ground 3

111. In my judgement, ground 3, which was raised in the alternative, does not arise. It was common ground at the hearing, and it is evident from the summing up and directions, that the Coroner did not withdraw from the jury any issues other than the resuscitation attempt. She gave reasons for withdrawing the latter issue and that decision is not challenged. In relation to the other issues, as there was no decision to withdraw them from the jury, it follows that the contention there was a failure to give reasons does not arise. Accordingly, I dismiss ground 3.

Ground 4

112. In *Tainton* Sir Brian Leveson P held:

> "73. Although these facts were not disputed, we consider that the coroner should have directed the jury to include in the Record of Inquest a brief narrative of the admitted shortcomings of the health care staff responsible for the late diagnosis of Mr O'Neill's cancer. In the light of the fact that the coroner withdrew the issue of causation from the jury, such a statement would have to have been supplemented by an explanation that it could not be concluded that these shortcomings significantly shortened Mr O'Neill's life. In this case, such a statement would have completed the incomplete account of the circumstances in which Mr O'Neill met his death, which the Record of Inquest contains (Form 2, Schedule to the Coroners (Inquests) Rules 2013 (SI 2013/1616), and would have been a fair reflection of the issues that the inquest had focused upon even if the issue was left to the jury only on the basis of a choice between a conclusion of death by natural causes and an open conclusion.
>
> 74. Putting the point another way, in an inquest such as this, where the possibility of a violation of the deceased's right to life cannot be wholly excluded, section 5(1)(b) and (2) of the 2009 Act should require the inclusion in the Record of Inquest of any admitted failings forming part of the circumstances in which the deceased came by his death, which are given in evidence before the coroner, even if, on the balance of probabilities, the jury cannot properly find them causative of the death.
>
> 75. This was a matter of fairness to the family of the deceased, and was required in this case in order to discharge in full the obligation on the state imposed by article 2 of the ECHR and on the coroner by section 5(1) and (2) of the 2009 Act. Our conclusion is not altered by the fact that the coroner was not bound to decide to make a report with a view to the prevention of future deaths under regulation 28 of the Coroners (Investigations) Regulations 2013. The coroner properly decided that he did not need to make such a report, because the Trust had addressed the criticisms of its health care staff, which had emerged from Dr Bicknell's review and from the PPO report."

113. The court rejected a submission that the combination of the Prisons and Probation Ombudsman ("PPO") report, and the public admissions made at the inquest, sufficed to comply with article 2: *Tainton*, [76] to [78]. However, the court observed at [79]:

> "There are no doubt cases in which public acknowledgment of failures on the part of agents of the state in a forum other than an inquest can indeed form part of the means by which the state discharges its investigative obligation. We are not suggesting that any admitted failings have to be included in every case. The

> manner in which the state discharges that obligation will, as Ms Dolan correctly submitted, vary from case to case. The position may be entirely different if, for example, a public inquiry or a criminal prosecution has taken place."

114. At the hearing, the focus was on a single admitted failure: the inadequate resuscitation attempt. In my judgement, the Coroner's decision to address this failure in her Prevention of Future Deaths Report cannot be faulted. The Prevention of Future Deaths Report sets out the established and admitted failures in considerable detail (see paragraph 65 above). It is a published report. The record of inquest itself contains the Coroner's statement "*I intend to make a prevention of future deaths report*", alerting anyone who read the record of inquest to the existence of such a report. Unlike in *Tainton*, where there was no prevention of future deaths report, in my view, addressing the inadequacy of the resuscitation attempt in the Prevention of Future Deaths report rather than the record of inquest did not cause any unfairness to Mr Ginn's family.

115. Nor did it result in a failure to comply with article 2. As the court acknowledged in *Tainton*, the state's acknowledgment of failures in a forum other than the inquest is capable of forming part of the means by which the state discharges the article 2 investigative obligation. It cannot sensibly be said, in my view, that the Coroner's detailed published report, following the public inquest at which the evidence was given, addressing a failure that it has been established did not contribute to Mr Ginn's death, is inadequate to meet the state's article 2 obligation in relation to that failure. It follows that there was also no breach of s.5(2) of the 2009 Act.

116. As detailed above, in her pleadings and skeleton argument, the claimant sought to rely on various other matters as admitted failures that the jury ought - if they had rejected the family's contention that they caused or contributed to Mr Ginn's death - to have been directed to record pursuant to the *Tainton* principle. I can address this contention briefly, in view of the way it was addressed by Mr Simblet at the hearing.

117. In short, I accept the MOJ's submission that there is a distinction between the kind of formal admission made by the Trust in *Tainton* and the agglomeration of evidence cited in the Part 18 response and relied on in this case as, it is said, forming the basis for Governor Evans' acknowledgment that the ACCT review process had not worked in the way he would have liked it to have done. I do not consider that the Coroner was required to direct the jury that if they found these matters did not more than minimally, negligibly or trivially contribute to Mr Ginn's death, nonetheless, they were required to record them.

118. For the reasons I have given, ground 4 is dismissed.

I. ***Galbraith*-plus**

119. The defendant's note referred at paragraph 17 to the *Galbraith*-plus test, in the terms I have quoted in paragraph 95 above. The term *Galbraith*-plus derives from the West Yorkshire case in which Haddon-Cave J, having reviewed *R v Galbraith* (1981) 73 Cr App R 124 and *R (Bennett) v HM Coroner for Inner South London* [2007] EWCA Civ 617, held at [23]:

> "It is clear, therefore, that when coroners are deciding whether or not to leave a particular verdict to a jury, they should apply a dual test comprising both limbs or 'schools of thought', *i.e.* coroners should (a) ask the classic pure *Galbraith* question "*Is there evidence on which a jury properly directed could properly convict etc?*" (see above) plus (b) also ask the question "*Would it be safe for the jury to convict on the evidence before it?*". The second limb, arguably, provides a wider and more subjective filter than the first in certain cases. In my view, this extra layer of protection makes sense in the context of a coronial inquiry where the process is inquisitorial rather than adversarial, the rights of interested parties to engage in the proceedings are necessarily curtailed and coronial verdicts are at large."

120. The claimant responded to this reference to *Galbraith*-plus in her skeleton argument. Her primary submission is that *Galbraith*-plus should be nothing to the point in this case. This was not a case in which the Coroner determined that any of the issues identified as central in the family's submissions should not be left to the jury, save for the issue of resuscitation which is not contested by the claimant.

121. However, in the alternative, the claimant contends that *Galbraith*-plus reflects a wrong turn in coronial law, in circumstances where the judge's attention appears not to have been drawn to the reported case of *R (Cash) v County of Northamptonshire Coroner* [2007] EWHC 1354 (Admin). And in any event, it should no longer be followed as it is now established that the standard of proof in respect of all issues at an inquest is the balance of probabilities and the policy concern underlying the adoption of a judicial filter as an extra layer of protection has, the claimant submits, effectively been rejected by the Supreme Court in *Maughan* at [90] and [95]-[96].

122. I note that the submissions referred to in paragraph 120 above were foreshadowed in the claimant's reply, but the same cannot be said of the alternative submission that I have outlined in paragraph 121 above.

123. The MOJ's primary submission is that permission should not be granted to pursue this point in circumstances where it was not pleaded and has only been raised for the first time in the claimant's skeleton argument. In the alternative, the MOJ refutes the contention that the *West Yorkshire* case was *per incuriam*, or that *Galbraith*-plus should no longer be applied in light of *Maughan*.

124. In my judgement, this case is not concerned with any decision to withdraw an issue from the jury, still less with any decision to do so by reference to the second limb of the *Galbraith*-plus test. It is readily understandable that the defendant's note makes reference to this test because the Coroner withdrew the resuscitation issue from the jury and it appeared from the claimant's grounds that this was the subject of challenge. However, first, although in withdrawing this issue the Coroner used the word "unsafe", it is clear from her reasoning read as a whole that she withdrew this issue on the basis that the evidence was not capable of supporting a conclusion that the failure was probably causative / contributive (i.e. the first limb of the *Galbraith*-plus test applied). Secondly, the Coroner's decision to withdraw from the jury consideration of whether the inadequacy of the resuscitation attempt was a probable cause of Mr Ginn's death is not challenged.

125. I do not consider it appropriate to express any view on the claimant's alternative contentions regarding the second limb of the *Galbraith*-plus test in circumstances where the issue has not been raised and addressed in the pleadings (save in part in the claimant's reply), and it is unnecessary for the determination of this claim. Accordingly, I refuse permission to pursue this issue as a ground of review.

J. Relief

126. As the claimant has succeeded on ground 1 of the claim, the question as to what relief (if any) should be granted arises.

The rival submissions

127. The claimant submits that the jury's conclusion should be quashed and a fresh inquest should be held into Mr Ginn's death. The court has not heard the evidence and, in any event, it is not the court's role to substitute its own view as to the matters that caused or contributed to Mr Ginn's death. An inquest's conclusion "*can have a significant part to play in avoiding the repetition of inappropriate conduct and in encouraging beneficial change*": *Douglas-Williams* at 348a. It would not be hugely complicated to reorganise and it is not exceptional to hold an inquest three years after a death. The Coroner has not suggested that there would be any practical impediment.

128. The claimant relies on *Sacker* (at [28]) as an example of a case similar to this one in which the House of Lords held that the most convenient and appropriate way to make good the identified deficiency was, as the Court of Appeal had done, to order a new inquest. Lord Hope observed at [11] that an inquest into a suicide in custody "*has a vital part to play in the correction of mistakes and the search for improvements. There must be a rigorous examination in public of the operation at every level of the systems and procedures which are designed to prevent self-harm and to save lives*".

129. The claimant also draws attention to *R (Cash) v County of Northamptonshire Coroner* [2007] EWHC 1354 (Admin), [2007] 4 All ER 903, a case in which a verdict of unlawful killing should have been left to the jury, where the court considered that there was no alternative but to hold a new inquest (see [53]).

130. The MOJ submits that if the court is persuaded that the Coroner erred in her directions to the jury, nonetheless, a new inquest is not required to remedy any error. The MOJ contends that a new inquest would serve no useful purpose as there is no complaint about the scope of the evidence heard in the inquest, the evidence has already been ventilated and, if there was a failure to record information, that information will be recorded in the court's judgment. The MOJ also contends that the passage of time between Mr Ginn's death and any future listing is likely to be substantial and have an adverse impact on the memories of those required to give evidence.

131. The MOJ relies on the *Avon* case in which Maurice Kay LJ concluded that the defects in the inquest in question effectively disabled the jury from fulfilling its purpose (at [28]). Nevertheless, he declined to order a fresh inquest, observing at [33]:

> "It is also important to keep in mind that the procedural obligation of Article 2 is imposed not simply on the Deputy Coroner but on the state. To see whether the obligation has been

> discharged it is necessary to consider the entirety of investigative apparatus deployed by the state. This includes the Ombudsman's Report which, it seems to me, substantially filled the lacuna left by the limited nature of the jury's verdict and thereby rendered the totality of the investigative process Article 2 compliant."

132. The MOJ also relies on *Tainton* in which the Divisional Court, having found that the admitted failings should have formed part of the inquest findings, held at [83]:

> "However, a fresh inquest is unnecessary and would serve no useful purpose (as was decided, despite a misdirection, in *R (P) v HM Coroner for the District of Avon* [2009] EWCA Civ 1367, [2009] Inquest LR 287: see para 33 of Maurice Kay LJ's judgment). The present application before the court, and the court's judgment, suffice to make good the deficiency, without any further order or relief granted. The Record of Inquest should therefore not be quashed, and subject to hearing counsel, we do not consider that any further relief is required beyond a declaration that the application is well founded to the extent identified in this judgment."

133. Ms Idelbi submitted *Lewis* is a further example of a case in which a fresh inquest was not ordered.

134. The MOJ submits that this is not a case where article 2 requires a new inquest to be ordered. In its skeleton argument, the MOJ submitted that the state's obligation under article 2 has been satisfied by (i) the public inquest – in which the failings identified by the claimant, whether admitted or not, have been canvassed – (ii) the Prevention of Future Deaths Report and (iii) these proceedings.

135. During the hearing, in response to the MOJ's reliance on the *Avon* case, Mr Simblet submitted that the Prison Ombudsman's report was an important feature in the decision not to order an inquest. That prompted the response from Ms Idelbi that a Prisons and Probation Ombudsman ("PPO") report exists, although a copy had not been adduced in evidence. No application to adduce the PPO report was made at the hearing. Ms Idelbi was not able to confirm whether any failings identified in the PPO report were accepted.

136. Mr Simblet replied that there was no evidence before the court as to what is in the PPO report. It was available prior to the inquest. The MOJ had not sought to adduce it in evidence prior to the hearing. Nor was it even available at the hearing. And the contents were not admitted by the MOJ. He submitted that an inquest is the primary way of complying with the article 2 investigatory obligation. In terms of public accountability, it would not be satisfactory to have to draw together, like pieces of a jigsaw puzzle, parts of the transcript of the inquest, the record of inquest, the Prevention of Future Deaths report, the PPO report and this court's judgment, in order to ascertain the conclusions.

137. Following the hearing, Ms Idelbi provided a copy of the PPO report and submitted that there would be nothing inappropriate in the court considering it as it is a publicly available document in the possession of both parties, and it was necessary to provide it

to respond to the claimant's submission that the *Avon* case could be distinguished because in that case there was a PPO report.

138. There followed a further exchange of emails. The claimant maintained that the court should not take the PPO report into account because it was not evidence and no formal application to adduce it as late evidence had been made. The MOJ suggested that the PPO report ought to have been adduced by the claimant pursuant to its duty of candour. The claimant has refuted that contention and further submits that the nature of a PPO report is such that it will not serve to determine any causal connection between poor practice and the death of Mr Ginn.

Reliance on the PPO report

139. The PPO report has not been adduced in evidence in these proceedings. It is dated 29 November 2018, and has been in the possession of the parties throughout these proceedings. Lang J made case management directions on 25 June 2020, including directions for filing of any written evidence by the interested party within 35 days of service of the order. The PPO report was not adduced in evidence pursuant to that order. No request was made to add it to the hearing bundle. Although a copy of the PPO report has been sent to the court, the MOJ has not filed an application seeking permission to adduce it in evidence.

140. I reject the contention that the PPO report is admissible on the basis that it ought to have been adduced by the claimant pursuant to the claimant's duty of candour. The PPO report has been in the MOJ's possession throughout. The MOJ did not seek to rely on it as part of the means by which the article 2 investigative obligation is discharged in its pleadings or skeleton argument.

141. Although I have considered it *de bene esse*, in my judgement, it would not be appropriate to take into account the PPO report in determining the issue of relief given that it is not evidence before me and no application has been made to put in evidence. The importance of procedural rigour in judicial review proceedings has been repeatedly emphasised: see e.g. *R (Talpada) v Secretary of State for the Home Department* [2018] EWCA Civ 841, [67] and para 2.1 of the Administrative Court Guide 2021. If such an application had been made, it would have been an application for relief from sanctions – namely, the sanction of not being permitted to rely on evidence that was not adduced in accordance with the directions set by the court.

142. In any event, I do not consider the PPO report would be determinative, if it were admissible, not least given that it does not determine the causation issues that the claimant submits the jury should have been directed to consider, and the MOJ could not confirm that the criticisms are admitted.

Decision

143. Although I recognise that a fresh inquest will incur further time and expense, and it is regrettable that it will take place a substantial period after Mr Ginn's death, I consider that it is necessary to order a fresh inquest in order to comply with article 2. There was a public interest in the jury being directed to express their findings on the central issues, and that did not occur. I am not in any position to make findings as to whether the central issues (or any of them) caused or contributed to Mr Ginn's death. This judgment

cannot fill the gap left by the misdirection that I have found. The Prevention of Future Deaths report addresses the resuscitation issue, but it says nothing about whether any of the central issues were causative, so it too cannot be relied on as filling the gap.

144. In *Tainton*, relief was not granted in circumstances where the error was a failure to record an admitted failure that had (unimpeachably) been determined to be non-causative. It was in those circumstances that the court's judgment sufficed to make good the deficiency. Even though the admitted failings were not causative, the PPO report was not capable of making up for the deficiency in the record of inquest. *Lewis* does not assist, as the appeal against the dismissal of the claim was dismissed, so no question of granting relief arose.

145. Although I accept that there are similarities between this case and the *Avon* case, and I acknowledge that there is a PPO report, albeit not one that has been adduced in evidence, the question whether the totality of the investigative process meets the article 2 obligation is fact specific. In my judgement, for the reasons I have given, the inquest failed to fulfil the state's investigative obligation and the other investigative processes relied on have not remedied the failure to address the central issues.

K. Conclusion

146. For the reasons I have given, the claim succeeds on ground 1 (and in part on ground 2), and I will order a fresh inquest. The other grounds are dismissed. I will hear from the parties on the precise form of order.