If this Transcript is to be reported or published, there is a requirement to ensure that no reporting restriction will be breached. This is particularly important in relation to any case involving a sexual offence, where the victim is guaranteed lifetime anonymity (Sexual Offences (Amendment) Act 1992), or where an order has been made in relation to a young person.

This Transcript is Crown Copyright. It may not be reproduced in whole or in part other than in accordance with relevant licence or with the express consent of the Authority. All rights are reserved.

IN THE HIGH COURT OF JUSTICE

KING'S BENCH DIVISION

ADMINISTRATIVE COURT

Neutral Citation Number: [2024] EWHC 1366

No. AC-2022-LON-003421

Royal Courts of Justice

Wednesday, 15 May 2024

Before:

LORD JUSTICE LEWIS
MRS JUSTICE FARBEY

HM SENIOR CORONER FOR SEFTON
KNOWSLEY AND ST HELENS — Applicant

(1) MICHAEL KAY
(2) STEPHEN FRIAR
(3) ST HELENS & KNOWSLEY TEACHING HOSPITALS NHS TRUST

MS S MILLIGAN (instructed by Weightmans) appeared on behalf of the Applicant.

J U D G M E N T

LORD JUSTICE LEWIS:

INTRODUCTION

1 This is an application made by His Majesty's Senior Coroner for Sefton, Knowsley and St Helens with the permission of the Attorney General, seeking to quash an inquest, and the determination made at that inquest, into the death of Michelle Ann Kay and ordering a fresh inquest.

THE FACTUAL BACKGROUND

2 The facts are as follows. Michelle Kay, whom I refer to as Michelle without, in any way, intending any disrespect, was born on 21 January 1982. Michelle was sadly found dead at her home on 2 October 2020. She had been found in bed by her husband but was unresponsive. There were empty packets of prescription medication nearby.

3 On 7 October 2020, the coroner opened an investigation into the death. On 3 February 2021 an inquest was held. The record of the inquest shows that the medical cause of death was "bronchopneumonia and mixed-drug toxicity". At section 3 of the record of the inquest, in response to the questions how, when and where Michelle came by her death, the following is recorded:

> "Michelle Kay was sadly found deceased on 2 October 2010 (sic) when she was found unresponsive on her bed by her husband at 119 Exeter Street, St Helens, W10 4HP. Several packets of medication were found at the address, notably dihydrocodeine and mirtazapine. There was no indication of suicide. The post-mortem findings showed a cocktail of drugs had been taken. Both the bronchopneumonia and the mixed-drug toxicity led to the death of Michelle Kay."

In section 4, headed "Conclusion of the Coroner as to the death", the same words are repeated.

4 Following the inquest, Michelle's family requested her medical notes from the NHS Trust. Michelle had been admitted to a hospital run by the Trust about seven weeks or so before her death on, we understand, 8 August 2020. The medical notes for 8 August 2020 indicated that Michelle had been admitted following an intentional overdose of prescription medication and noted suicidal intent. The notes are dated 8 July 2020, but that is likely to be a mistake and it should be a reference to 8 August 2020.

5 Among the records provided by the Trust were handwritten notes found at the side of Michelle's hospital bed and addressed to family members or loved ones. On one reading of the notes, they may be taken to have indicated suicidal intention on the part of Michelle in August 2020. There is also a psychiatric referral document dated 8 August 2020, noting that there had been an overdose taken of certain medication and what are described as "suicide notes" had been found at the side of the bed. It noted that there was a past medical and psychiatric history of overdoses.

6 There is also an extract of a note dated 11 August 2020 taken, it appears, from the medical notes of Michelle. That note records that Michelle planned to continue with her current medication and to engage with certain services. It stated that Michelle is "an ongoing risk due to history and impulsive overdose as a reaction to social and physical health stresses," but the note also says that Michelle denied further thoughts and displayed future planning to return home to access services and to continue with her current medication.

7 There are also what is described in the coroner's witness statement as "medical notes". It is a document headed "Integrated Care Gateway". The nature of that document and who produced it is not explained. That document records that there had been an intentional overdose of prescription medication on 8 April 2019, an overdose of drugs on 20 April 2019, a deliberate overdose on 2 May 2019 and a deliberate overdose on 7 May 2019.

8 The possible suicide notes and the medical records had not been seen by the coroner at the time of the inquest. In the light of that information, the coroner considered that she would apply for a fresh inquest. The court would have been assisted by a fuller explanation from the coroner as to what evidence was before the coroner at the time of the inquest, and what steps had been taken to obtain Michelle's medical records prior to the inquest. The court would also have been assisted by a clearer explanation of the various documents exhibited to her witness statement, explaining what they were, and whether they are the complete and full records provided to her. The court would also have been assisted, and indeed would have expected, an explanation of the apparent delay between at least May 2021 and December 2021 in applying to the Attorney General or permission to make this application.

9 The Attorney General granted his permission for the coroner to apply to the High Court for an order quashing the original inquest and directing a new inquest.

10 Solicitors acting on her behalf wrote to Michelle's father, her husband, and the NHS Trust who were all named as interested parties to the application. At that stage, by email dated 20 December 2022, Michelle's father replied, indicating that the family had discussed the matter and would have liked the original decision to stand. The email referred to the fact that the notes refer to an earlier incident in August 2020, seven weeks before Michelle's death, and asked if it were really necessary for another inquest to take place. The email concluded by stating that, of the options offered by the coroner – that is to agree with a new inquest, to disagree or to stay neutral – "We accept a new inquest taking place, but we need to attend to give our feelings and assist the coroner to reach her finding." The NHS Trust indicated that it would take a neutral position. Michelle's husband did not reply.

11 We are satisfied that the application was properly served on Mr Kay at his last known address in accordance with the provisions of CPR 6. We understand why the husband may

not have wished to reply to letters in these circumstances. It is fully understandable given the tragedy that has affected this family.

12 In March 2023, solicitors for the coroner provided a draft consent order to the interested parties providing for the quashing of the original inquest. Michelle's father replied, explaining that he and Michelle's mother had discussed the matter and they did not think it was in the public interest to have a second inquest. In their dignified and thoughtful letter, they set out their reasons why, pointing out again that the suicide notes were written on one occasion, seven weeks before Michelle's death, and she had seen the mental health team and been discharged on the later occasion and had no thoughts of suicide. They made other points as to why a second inquest was not necessary. No reply was received from Michelle's husband. The NHS Trust continued to be neutral.

13 On 4 April 2024 Michelle's father wrote again to the solicitors, explaining that they would be unable to attend court, but asking for the points made in their letter to be put before the court. These are the points, quoting from the letter, which Michelle's father wished the court to take into account:

> "1. For context, Michelle's life was very complicated. She always suffered from mental health issues and was diagnosed with bipolar years before her death.
>
> 2. Michelle also took additional prescription medication to which she was addicted to and, despite attempts to intervene and help, our attempts were not successful. We would like to ask the court to **not** reopen the inquest into Michelle's death, as we believe the initial inquest to be more than sufficient. Losing Michelle has already been very painful and traumatic on the family, and we feel this process is adding to that. Furthermore, a new decision of a suicide verdict is not one that we would relish.
>
> 3. It is important that the court understands the decision to quash the initial coroner's reports revolves around letters that the hospital have submitted to the coroner after the hearing. These letters were dated some two months prior to her death. They had been written around 8 August as she was taken into hospital as a suspected

overdose. These are noted in the hospital records dated at the same time (August).

4. On that particular visit to hospital, again in August, she was seen by the mental health team who note in the hospital records that she was no longer feeling suicidal and was now looking forward to life. There was also the signing of the release at the end of the hospital notes.

5. Michelle was then taken into hospital on 26 September after collapsing in Asda. She was unconscious when the mental health team went to visit her, and yet they returned some six hours later and, at that time, she had, sadly-- had already been released, which we believe to have been detrimental.

6. After the post-mortem, it was noted on the report that she did not have enough additional medication in her system to end her life but she did have a chest infection, therefore it was recorded that bronchopneumonia and mixed-drug toxicity was the probable cause. Referring to point 5, we believe Michelle was severely poorly and it was not a suicide attempt. We also know that the letters were dated prior to her last hospital visit and believe these should be excluded in this new matter.

7. For your reference, the hospital record regarding intake of the letters is also dated in August."

14 Today, 15 March 2024, we had an oral hearing to determine the coroner's application to quash the determinations and findings of the original inquest and to order a new inquest.

LEGAL FRAMEWORK

15 I deal first with the legal framework. First, s.13 of the Coroner's Act 1988 provides, so far as material, as follows:

> "(1) . This section applies where, on an application by or under the authority of the Attorney-General, the High Court is satisfied as respects a coroner ('the coroner concerned') either—
>
> ...
>
> (b) where an inquest or an investigation has been held by him, that (whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise) it is

necessary or desirable in the interest of justice, that an investigation (or as the case may be, another investigation) should be held.

(2). The High Court may—

(a) order an investigation under Part 1 of the Coroners and Justice Act 2009 to be held into the death either—

(i) by the coroner concerned; or

(ii) by a senior coroner, area coroner, or assistant coroner in the same coroner area;

(b) order the coroner concerned to pay such costs of and incidental to the application as to the court may appear just; and

(c) where an inquest has been held, quash any inquisition on, or determination or finding made, at that inquest."

16 The proper approach to the power conferred by s.13 has been considered by the courts on a number of occasions. For present purposes, it is only necessary to set out the following observations from the case law.

17 In *Sutovic, R (on the application of) v HM Coroner Northern District of Greater London* [2006] EWHC 1095 (Admin), the Divisional Court said this at para.54:

> "The power contained in s.13(1)(b) stated in very broad terms. The necessity or desirability of another inquest may arise by reason of one of the listed matters 'or otherwise'. Notwithstanding the width of the statutory words, its exercise by courts shows that the factors of central importance are an assessment of the possibility (as opposed to the probability) of a different verdict, the number of shortcomings in the original inquest, and the need to investigate matters raised by new evidence which has not been investigated at the inquest…"

18 Further, in *Attorney General v Coroner of South Yorkshire (West) & Anor* [2012] EWHC 3783 (Admin), Lord Judge CJ said this at para.10:

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

19 One factor therefore pointing towards it being necessary or desirable in the interests of justice to order a fresh inquest includes circumstances where new evidence has been obtained which gives rise to the possibility that a different conclusion may be reached by the coroner. Such a situation occurred in the matter of the *Inquest into the Death of Michael Vaughan* [2020] EWHC 3670 (Admin). There, after a finding of death by misadventure, a suicide note written by the deceased was drawn to the attention of the coroner, as there was a possibility of a different conclusion or verdict being returned. That is a factor in favour of ordering a new inquest. It is not, however, a pre-condition that the new evidence creates a possibility of a different conclusion. It may still be desirable in the interests of justice in appropriate circumstances to hold a fresh inquest, even if there is no possibility of a different verdict: see, for example, *Dove v HM Assistant Coroner for Teesside and Hartlepool & Anor* [2023] EWCA Civ 289 at [72]-[74] and [99].

20 Another factor is the wishes of the family of the deceased. Their views, if known, should be taken into account – see *Vaughan*. Other factors include the period of time that has elapsed

since the inquest and any delay in applying for a fresh inquest. It is clear from the case law that other factors may be relevant in deciding whether a new inquest is necessary or desirable in the interests of justice. The particular facts of each case will need to be considered.

THE PRESENT CASE

21 In the present case, it is necessary, in my judgment, in the interests of justice that the findings of the original inquest be quashed and a fresh inquest ordered. There is here evidence which the coroner may find amounts to evidence pointing to Michelle's likely state of mind on the day of her death. There are the previous occasions when it is said that Michelle intentionally took an overdose and there are the notes from the August 2020 incident which, on one reading, may indicate a suicidal intent at that date. It is possible, therefore, that the coroner might reach a different conclusion on how Michelle died. Even if that were not the case, it may be the finding that there was no indication of suicide might need to be reconsidered.

22 I stress that it is not for this court to reach a conclusion on those issues. Those are matters for the coroner. The coroner will want to consider the evidence and the submissions of Michelle's father as to why the medical notes and the handwritten notes relate to Michelle's state of mind in August 2020, seven weeks or so before the day on which she died, and why the fact that Michelle took overdoses of a prescription drug did not, in this case, indicate a suicidal intent in October 2020. There is, however, a possibility that the coroner may reach a different conclusion or express the conclusion differently, and that is a powerful factor indicating that it is desirable in the interests of justice to hold a new inquest.

23 I have considered the wishes expressed by Michelle's father on behalf of him and Michelle's mother. I well understand why they would not wish to have the matter reopened now. I also take into account the passage of time, as it is now more than three and a half years since the death of Michelle. Moreover, there has been unexplained delay, at least between May and December 2021, on the part of the coroner in bringing these proceedings.

24 Nevertheless, taking these factors and all the facts of this case into account, I am satisfied that it is necessary in the interests of justice that the determination and findings of the inquest on 3 February 2021 be quashed and a new inquest be held to consider the issues specified in s.5(1) of the Coroners and Justice Act 2009.

25 If my Lady agrees, I would therefore quash the inquest, I would quash the record of the inquest of 3 February 2021, I would order a fresh inquest. That should take place before a different coroner – not the senior coroner who dealt with the original inquest – in the same area.

MRS JUSTICE FARBEY:

26 I agree.