



Neutral Citation Number: [2022] EWHC 1593 (QB)

Case No: CO/490/2021

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 22/06/2022

Before:

LADY JUSTICE MACUR
and
MR JUSTICE GARNHAM

Between:

THE QUEEN
ON THE APPLICATION OF
MRS FATMIRE GORANI

Claimant

and

HER MAJESTY'S ASSISTANT CORONER
FOR INNER WEST LONDON

Defendant

and

THE CENTRAL AND NORTH WEST ENGLAND NHS TRUST

First Interested Party

-and-

DR SAMANTHA SANGHERA

Second Interested Party

Phillip Rule (instructed by **Bindmans LLP**) for the **Claimant**
Jonathan Landau (instructed by **Direct Access Scheme**) for the **Defendant**
The First Interested Party was not represented and did not appear
Elaena Misra (instructed by **Medical Defence Union**) for the **Second Interested Party**
Hearing dates: 18 May 2022

Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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LADY JUSTICE MACUR AND MR JUSTICE GARNHAM

Mr Justice Garnham:

Introduction

1. On 19 December 2018 Mr Besim Sylaj fell to his death from the fifth floor balcony of his home in Westbourne Grove in London. Mrs Fatmire Gorani, the widow of the deceased and the Claimant in these proceedings, brings this claim for judicial review, challenging the conduct, findings and conclusion of the defendant, the Assistant Coroner for Inner West London, (hereafter “the Coroner”) at the inquest into the death of her husband. The Central and North West London NHS Foundation Trust, (“the NHS Trust”), which was the health authority responsible for Mr Sylaj’s medical care, and Dr Samantha Sanghera, a locum GP at his GP practice, are Interested Parties.
2. The coroner is a judicial office holder. The normal course for a judge or other judicial office-holder facing a judicial review is to adopt a neutral stance in the proceedings and to appear, if at all, not as a party to defend her decisions, but simply to offer the court her assistance on matters of procedure or specialist caselaw. By contrast, the Coroner here has not only appeared by counsel to oppose the application, but has submitted a witness statement in support of her case. A coroner who chooses to enter the arena in this way puts herself at risk of a costs order against her should the claim succeed (see *R (Davis) (No 2) v HM Deputy Coroner for Birmingham* [2004] 1 WLR 2739 at [47(ii)]).
3. I have approached the coroner’s witness statement with a little caution. When allegations of bias are made, as they are here, a court may consider the explanation of the judge (or coroner); see *R (Pounder) v HM Deputy Coroner for the North and South Districts of Durham and Darlington* [2010] EWHC 328 (Admin), at [12]. But the coroner’s witness statement does not address the question of bias. Instead, she seeks to explain her reasoning and to respond to the grant of permission to bring the proceedings. A coroner’s reasoning ought to be apparent from her decision. The court would only resort to some *ex post facto* explanation if the circumstances made that essential (compare *R (D) v Secretary of State for the Home Department* [2003] EWHC155 (Admin) at [18]). It has not been necessary to have regard to the coroner’s statement in this case.
4. Mrs Gorani was represented before us by Mr Philip Rule. The defendant coroner was represented by Mr Jonathan Landau and the second interested party by Ms Elaena Misra. The first interested party did not appear and was not represented before us. I am grateful to all counsel for their submissions.

The Statutory Scheme

5. S.5 of the Coroners and Justice Act 2009 (“the 2009 Act”) sets out the purposes of an inquest:
 - (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 (c. 42)), 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)...
6. Paragraph 7 of schedule 5 to the 2009 Act provides for the making of reports after an inquest:
- (1) Where—
 - (a) a senior coroner has been conducting an investigation under this Part into a person's death,
 - (b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and
 - (c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,the coroner must report the matter to a person who the coroner believes may have power to take such action.
 - (2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.
 - (3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner.

The Facts

- 7. Much of this history is taken from an agreed chronology prepared by the parties.
- 8. Prior to his death on 19th December 2018, the deceased lived in his family home in Westbourne Grove with his wife, the claimant, and their three daughters. In March 2017, he was diagnosed by his GP as suffering from depression, for which he was prescribed antidepressants (Citalopram 20mg once daily).
- 9. On 23 February 2018, the deceased's GP, Dr Patel, referred him to the emergency mental health team at St Mary's Hospital where he was prescribed further antidepressants (Mirtazapine, in addition to Zopiclone already prescribed). The GP recorded him as unfit to attend work.

10. On 27th February 2018, the deceased attempted to take his own life by overdose (15 Mirtazapine tablets and 5 Zopiclone tablets). An ambulance was called by his family and he was taken to St Mary's Hospital, where he was assessed by the "Crisis Team".
11. On 28th February 2018, Dr Philip Nwachuku recorded the deceased as having told him that "*he had felt low in mood and anxious and panic and had the sudden thought of killing himself. He had thought of wanting to jump from a height but then said it may be easier to die from OD.*" The deceased was assessed by the Crisis Team at St Mary's and discharged home under the care of the North Kensington Home Treatment Team ('HTT'). He was given a 24-hour helpline to contact.
12. Initially, the HTT attended his home on a twice daily basis and his wife and daughters were with him 24-hours-a-day. On 5 March 2018, the HTT visits reduced to once daily; by mid-March 2018, they had reduced to every other day.
13. On 3 April 2018, care responsibility was transferred from the HTT to the deceased's GP and HTT involvement ceased. The deceased remained unfit to work and was continuing to receive prescription treatment by way of anti-depressants (Mirtazapine) and sleeping pills. During a consultation in July 2018, he was observed by his GP to be "*slightly overactive*" and his Mirtazapine dose was reduced to 30mg daily. Referral was made to the GP based counselling service "Community Living Well" ("CLW").
14. On 17 April Mr Sylaj saw his GP about stress at work, anxiety and sleep difficulties. Dr Patel suggested he referred himself to primary mental health services for psychology services, which he did.
15. On 11 July Mr Sylaj attended an appointment with CLW. He was discharged from the service and there was no further contact after that day.
16. Between September and December 2018, the deceased reported increased anxiety and distress due to disciplinary proceedings against him at work. He was reviewed by his GP on 14 September 2018, but was offered no other assistance.
17. On 6 December 2018, Mr Sylaj was seen by Dr Patel. He complained of feeling tired and reported a loss of appetite. His mood was "*up and down*". Dr Patel booked a follow-up appointment for a fortnight later, 20 December.
18. The following day, 7 December, the deceased's employers began disciplinary investigation against him.
19. On 12 December, Mr Sylaj's family were concerned about the deterioration in his mental health and phoned the NHS Trust's "Single Point of Access" (SPA). The call was not triaged by a clinician as it should have been according to the SPA policy. Mr Sylaj was advised to attend the Accident & Emergency department, but was unwilling to do so.
20. On 13 December, Mr Sylaj attended an emergency GP appointment with Dr Sanghera, who agreed to refer him to the Mental Health Team, "*for further psychotherapy*". She also planned to increase his anti-depressant medication. Ultimately, however, no referral was ever made and no change to his medication was put into effect. Dr Sanghera, however, did write to Mr Sylaj's employers.

21. On 14th December 2018, the deceased attended a disciplinary meeting at work and was dismissed.
22. On 19th December 2018, the deceased, who was then aged 50, jumped to his death from the balcony of his family's fifth floor home.

The Inquest Procedure

23. The inquest into the deceased's death was opened on 24th December 2018.
24. A number of pre-inquest reviews were conducted. On 12 December 2019, following written and oral submissions as to the applicability of Article 2 ECHR, the Coroner determined that Article 2 did not apply. She summarised her reasons for that decision in a later ruling:

It was my view that that Mr Sylaj was not detained, not sufficiently vulnerable for state assumption of responsibility and there was no basis that the relevant health care professionals ought to have known of a real and immediate risk to his life. He had had a face to face consultation with his GP in the days before his death when he denied any thoughts of self harm. I also noted there was no systemic failing apparent in the health care system.

25. On 25th June 2020, the family legal representatives made further submissions referring to the fact that the MHT did not have a clinician available to talk to Mr Sylaj when he and his family rang the SPA on 12th December 2018. The coroner responded by referring to her earlier decision and to the fact that Mr Sylaj had had face to face contact with a GP, after the contact with the SPA, and that that GP, Dr Sanghera, did not suggest he was at risk of suicide or self harm. But she said that she would keep the matter under review.
26. Yet further representations were made by the family's representatives by way of a pre-action letter and a proposed claim for judicial review of her decision. It was submitted that there was a system failure on the 12th December 2019 when the deceased was unable to speak to a clinician at the SPA, because of a lack of an available clinician, and his telephone number was not taken to ensure a clinician could ring him back. It was argued that Mr Sylaj should have been viewed as especially vulnerable and at risk of suicide. The submissions also highlighted the fact that, absent an Article 2 ruling, the family would be unrepresented at an inquest where they allege arguable breaches of Article 2 right to life and that the other parties would be legally represented.
27. Having considered those submissions, the Coroner held that it was at least arguable that there was a system failure on 12 December which constituted a breach of Mr Sylaj's Article 2 rights. As a result, on 13 September 2020, she ruled that "*the inquest is now an Article 2 inquest*". In consequence, pursuant to s.5(2) of the 2009 Act, it was necessary for the Defendant to determine not only who the deceased was, how, when and where he died, but also "*in what circumstances*" Mr Sylaj came by his death. There was no ruling that Article 2 was engaged by the events of 13 December, the occasion of Mr Sylaj's last GP appointment.
28. In passing, I would express some surprise that the Coroner held that any of the events surrounding this death engaged Article 2 of the ECHR. It is far from obvious why the events on the 12 December 2018 engaged the state's systems duty, even arguably. The

systems duty is a “*high level structural duty*” rather than an obligation of result (see *R (Gardner) v Secretary of State for Health and Social Care* [2022] EWHC 967 Admin) at [226]). Its content and effect in the healthcare context has been the subject of a consistent line of authority; (see for example *Powell v United Kingdom* (2000) 30 EHRR CD 362, at 364; *Savage v South Essex Partnership NHS Foundation Trust* [2009] 1 AC 681 at [45]; *R (Humberstone) v Legal Services Commission* [2011] 1 WLR 146; (*R Long*) *v Secretary of State for Defence* [2015] EWCA Civ 770, [2015] 1 WLR 5006, at [25]; *R (Parkinson) v HM Senior Coroner for Kent* [2018] EWHC 150 at [86] – [90]; *Fernandes De Oliveira v Portugal* (2019) 69 E.H.R.R. 8 at [106] and [186]-[196]) and *R (Boyce) v Teesside and Hartlepool Senior Coroner* [2022] EWHC 107 at [41]. Farby J put the essential point neatly, if I may say so, at [57] in *R (Dove) v HM Coroner for Teesside and Hartlepool* [2021] EWHC 2511 (Admin)

“The systems duty is not concerned with errors of individual state actors or with the failure of co-ordination among individual state actors.”

29. On the face of it, there was a perfectly adequate system in place here, as the Coroner had concluded on 25 June 2020; the problem was with the operation of the system on this particular occasion, a circumstance that will generally *not* engage Article 2. However, the coroner’s ruling was not challenged and is not an issue before us on this application. Accordingly, we proceed on the basis that the Article 2 systems duty was engaged by the events of 12 December.
30. On 11 and 12 November 2020, the defendant conducted the inquest hearing. The transcript of the inquest runs to some 71 pages of closely-typed text. She read and heard the evidence of Fatmire Gorani, the deceased’s widow; Donna Sylaj, the deceased’s daughter; Dr Gaurang Patel, his GP; Dr Samantha Sanghera, a locum GP at the deceased’s GP practice; PC Rishav Neupane, a police officer who attended the scene; Mr Gorman, the company secretary of the deceased’s employers, Halfords Auto Centre; Sarah Hards, an employee relations adviser at Halfords; Simon Manning, a regional general manager at Halfords; Michael Alem, the Single Point of Access administrator at the NHS Trust; Selena Cox, the Single Point of Access manager at the Gordon hospital, and Dr John Lowe, consultant psychiatrist to the North Kensington HTT.
31. She also read into the evidence the statements of Concilia Chitate, a registered mental health nurse with the NHS Trust, Reyard Boudali, a paramedic who attended the scene after the deceased’s death, Matthew Burton, an employment relations adviser with Halford, and Dr Lucy Wilson-Shaw a consultant clinical psychologist and clinical lead of Community Living Well.
32. The coroner then heard submissions on the law from the representatives of those attending the inquest. She rejected a submission from Mr Rule that she should recuse herself on grounds of bias.
33. She then set out, over the course of some five pages of text, her findings of fact. She described the deceased’s medical and psychiatric history, and the care Mr Sylaj had received from his GP practice, St Mary’s Hospital and the HTT. She set out her finding as to events on 12 and 13 December and as to the disciplinary hearing on 14 December. She described the circumstances of his death. She then said this:

“[A]s we know on 19 December 2018, he came off the balcony of his flat on the fifth floor I believe it was at Longland Court in West 11 sustaining fatal injuries and was pronounced life extinct at the scene. Police attended and pronounced the death to be nonsuspicious. No note of intent was found. The pathologist gave the cause of death as multiple trauma. There was the presence of mirtazapine in his system at the time of his death. No other drugs, no alcohol in his system that would have influenced his behaviour or decision-making. There’s been an admitted failure by the Trust, and I was very pleased the family and Mr Rule praise Ms Cox for the rapidity with which they recognised what had gone wrong; the fact that they were open about what had gone wrong with the family; and that they, as quickly as possible, put in a process to safeguard a repeat of what went wrong.

However I don’t think we can say on the balance of probabilities that the outcome would have been different if he had had a clinical triage. It’s a missed opportunity. It’s possible there may have been a referral to secondary mental-health services, but we know that he was seen by an experienced GP the following day who did not consider he needed referral to secondary mental-health services. If he’d been triaged by a clinician on the 12th, there was quite a significant range of options available between referring back to the Home Treatment Team, and we know that his presentation on the 13th December, when put to Dr Lowe, he felt it would be unlikely that the referral would reach the Home Treatment Team level. He could have been referred to community mental-health services, a community mental-health outpatient appointment, and we’ve looked at all the timelines. Without the triage, we don’t know what sort of timeline would necessarily he’d have followed for an assessment He could indeed have been referred to his GP, as he was when he had thoughts of self-harm and presented in a crisis to Dr Patel in February and was referred to St Mary’s and assessed by liaison psychiatry at that point. He was referred back to his GP.

So it’s my view that, yes, there was admitted failure, but I can’t say that we can say on the balance of probabilities would have made any difference.

As far as evidence of Dr Sanghera goes, it was very clear that she did not deem him in need of a referral to secondary mental-health services and that assessment was by a fully qualified GP with some experience in general practice.

As we know from looking at the documents, the policies, the particular SPA policy, it is the usual assumption that cases of anxiety and depression are managed within a primary-care setting by general practice, unless there is an elevated risk of harm to self, or others, or health, and Dr Lowe explained that to us, that clearly, we know how to assess a risk of harm. He was directly asked if he had any thoughts of self-harm and he said no. He had never shown any disposition to be a risk of harm to others. And as to a risk of health, clearly, he was presenting as anxious and low mood because of a very specific matter which Dr Sanghera felt that she might be able to assist with by providing him with a letter, increasing his mirtazapine and referring him to psychological therapy, safety netting him, and providing him with a follow-up in a very traumatic meeting.”

34. Her Record of Inquest recorded the deceased’s name and the medical cause of death, “*Multiple Trauma*”. The question “*how, when and where....and in what circumstances the deceased came by his...death*” was answered as follows; “*On 19th December 2018*

Besim Sylaj died outside Longland Court, Westbourne Grove, W11". The "Conclusion of the Coroner as to the death" was as follows:

"Besim Sylaj developed a depressive illness in March 2017 and following an overdose in February 2018, was under the care of the Home Treatment Team. His mental health was relatively stable following discharge back to his GP. He returned to work requesting no adjustments be made to his working pattern. A disciplinary matter arose at work causing him stress, anxiety and a lowering of his mood. On 12th December he rang the Single Point of Access (SPA) service but was not triaged by a clinician as per SPA policy. It is not possible to say if he had been triaged, it would have prevented his death. His death was due to suicide."

The Grounds of Challenge:

35. By her Amended Statement of Facts and Grounds dated 16th May 2021, the Claimant advances seven grounds of challenge against the Defendant.
- i) Procedural/substantive unfairness: The Claimant submits that, by her conduct, the Defendant failed to observe the rules of natural justice. It is said that on several occasions, she substituted her own evidence for those of the witness, and that the conduct of her questioning and general demeanour, gave the appearance of bias against the family or prejudgment or bias in favour of the Interested Parties;
 - ii) Failure to recuse: The Claimant submits that the Defendant therefore erred in not recusing herself from the proceedings;
 - iii) Article 2 ECHR: The Claimant submits that the Claimant failed to discharge the investigative obligation in Article 2 ECHR, by (i) failing to adhere to rigorous procedural fairness; and/or (ii) conducting an insufficiently extensive/effective inquiry; and/or by (iii) failing to apply the correct legal test for causation for an Article 2 ECHR operational breach to be found.
 - iv) Failure to satisfy the common-law/statutory enquiry duty: The Claimant submits that the Coroner failed to conduct an enquiry sufficient to discharge the obligations of the common law, the *Tameside* duty; and the statutory duty under section 5 of the Coroners and Justice Act 2009.
 - v) Material error of fact/failure to properly deal with the available evidence: The Claimant submits that the Coroner's conclusions are vitiated by fundamental errors of fact and that she failed to properly consider the available evidence;
 - vi) Wednesbury unreasonableness: The Claimant submits that the Coroner reached findings that were not properly open to her;
 - vii) Error of Law (Regulation 28): The Claimant submits that the Coroner made an error of law, by deciding that a Regulation 28 (Preventing Future Deaths or "PFD") report was not required, without first hearing any submissions from the interested parties.
36. Mr Landau disputes each of those grounds, arguing that the coroner conducted the inquest entirely appropriately. Ms Misra supports Mr Landau's arguments on grounds 3 to 6.

Grounds 1 and 2

The competing arguments

37. Mr Rule sensibly addressed the first two grounds together. The failure of the coroner to recuse herself was obviously linked to her alleged bias and the alleged unfairness in the conduct of the inquest.
38. Mr Rule submits that the inquest suffered from procedural/substantive unfairness and the Defendant's failure to observe the rules or principles of natural justice. The Claimant submits that the Coroner ignored the witness evidence of Drs Patel, Sanghera and Lowe and Mr Alem, and substituted their accounts with her own evidence or views, and conducted her questioning in a manner which gave the appearance of bias against the family or prejudgment/bias in favour of the Interested Parties.
39. He says that throughout the inquest the Coroner failed to demonstrate either impartiality to the matters of inquiry or an open mind as to the findings to be drawn and conclusions reached about points of evidence. He says she repeatedly put leading questions to witnesses. He submitted that her conduct revealed an inappropriate elision of roles as coroner or witness; and a hostile animus to the case being advanced adverse to the medical witnesses. He said that inappropriate conscious or unconscious bias in favour of the clinicians was demonstrated by frequent interruptions of the family's questions to the witnesses, the tone of voice when doing so, and, most readily demonstrated, by substituting her own evidence or views at times for that given by Drs Patel and Sanghera, Dr Lowe and Mr Alem.
40. On behalf of the Coroner it is submitted that any intervention on her part was for an appropriate, impartial purpose, including to maintain procedural regularity, to maintain focus on the relevant points, to make enquiries as to relevance, on one occasion because she was concerned about the tone of the questioning, to clarify questions, to avoid repeating an issue that had already been covered in evidence, and to avoid questioning of one witness that could better be put to another.

Discussion

41. The context for considering these allegations is worth emphasising. A coroner's inquest is unlike a trial in a number of important respects. As it was put in *R v South London Coroner, Ex p Thompson* (1982) *The Times*, 9 July 1982; [1982] Lexis Citation 1288.

There are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use."

42. More recently, in *R (Hambleton) v Coroner for Birmingham Inquests (1974)* [2018] EWCA Civ 2081, the Court of Appeal held (at [46]):

A coroner's investigation, whether it culminates in an inquest or not, is an inquisitorial process for which the coroner is entirely responsible. There are no parties to an inquest. The rules allow various people to participate as interested

persons. There are no pleadings in cases whose facts might engage civil liability; and no indictment in cases where criminal responsibility is suspected or clear. The inquest is not an adversarial proceeding. A coroner is a judicial officer working within a statutory framework. His responsibility is to discharge the statutory duty imposed upon him, with a jury in appropriate cases, by conducting an investigation and inquest in accordance with the 2009 Act.

43. This first ground amounts primarily to an allegation of apparent bias. The test to be applied to such an allegation was articulated by Lord Hope in *Porter v Magill* [2001] UKHL 67, [105]. It is whether:

a “fair-minded informed observer, having considered the facts, would conclude there was a real possibility that the tribunal was biased” (Lord Hope).

44. In *R (on the application of Smith) v HM Assistant Coroner for North West Wales* [2020] EWHC 781 (Admin), at [74], the fair-minded and informed observer was said to be

“... neither unduly sensitive nor suspicious yet he is not complacent. He is assumed to have taken the trouble to acquire knowledge of all relevant information before coming to a conclusion... The fair-minded and informed observer is also expected to be aware of the law and the functions of those who play a part in its administration...”

45. During the course of the hearing, the court invited Mr Rule to show us, by reference to the transcript of the hearing, the occasions on which, in his submission, the Coroner ignored the evidence of a witness, or substituted a witness’ answer for one of her own, or questioned a witness in a manner that demonstrated an appearance of bias in favour of medical witnesses or an interested party, or against the family of the deceased.
46. Mr Rule took us to a number of extracts from the transcript. None of them gave any grounds for concluding that the coroner was biased in any way, whether in favour of some witnesses or against others, or otherwise. None suggested that the coroner was ignoring the evidence of any witness. None suggested she was substituting her own views for those of witnesses. When pressed, Mr Rule was left with a bald assertion that the Coroner’s demeanour and tone of voice suggested these deficiencies in her management of the hearing. Despite a careful reading of the entire transcript, we could detect absolutely nothing to support such a conclusion.
47. The coroner was obliged to approach the inquiry with an open mind, but not with an empty one. She was entitled to form preliminary views on the basis of the evidence she had read and heard, and to test that against the witnesses evidence before her. When the coroner put what Mr Rule called “leading questions” to witnesses, she was, in our view, simply seeking to understand a witness’ evidence, to summarise it, to test it or to put it in context. There can be no complaint about a coroner conducting an inquisitorial process asking any such questions.
48. We found no occasions on which the coroner ignored the witness evidence of Dr Patel, Dr Sanghera, Dr Lowe or Mr Alem, and no occasion on which she “substituted” their evidence with her own. We could detect no “animus” against any witness and when we asked Mr Rule for evidence of such an approach he was unable to help us.

49. There were occasions when the coroner interrupted Mr Rule as an exercise of case management, to “*maintain procedural regularity*” as Mr Landau puts it in his skeleton argument. So, for example, on page 186 of the transcript the following appears:

Rule: Madam, the last matter is in relation to 13 December, please, and that meeting. You have already, Ms Sylaj, indicated in trying to assist your mother you have recollection about whether or not your father did deny active suicidal thoughts at that time. Can you help us with that recollection please?

Coroner: Well I don’t know that I actually want to go down in the GP consultation at this point. I think it’s unfortunate that there wasn’t a suitable witness statement that could have been prepared for the purposes of today that could have covered all of this. I mean, I think now that we need to revert back to how it ought to be done. We’re going to hear from the GP. We’ve heard the evidence to some extent about the consultation from Mrs Gorani who was present. I’m uneasy about carrying on into that so I’m going to stop you there.”

50. Subsequently, the Coroner interrupted Mr Rule in order to ensure that the witness remained focused on relevant points. At page 201 the transcript reads as follows:

“Rule: so, this is your exhibit for the referral that the GP would make, yourself, to the mental health team. As opposed to self-referrals to community living well or that type of referral, correct?”

Patel: Yeah. This is a referral to secondary mental health team, SPA.

Rule: Thank you. This is the type that would have come through—or usually you would do yourself, isn’t it? You mentioned that there’s the self-refer type...

Coroner: yes, we understand all that, Mr Rule, I’ve got it. Okay. Let’s focus on the SPA referral form.

Rule: Thank you.

51. Later (at page 202), the Coroner interrupted Mr Rule to ask “*where are we going with this?*” It seems to us that this was simply an inquiry as to the relevance to the question. Similarly, at page 203, the Coroner interrupted Mr Rule and said “*I’m going to pause you there actually because we’ve got to bring ourselves back to what Dr Patel has said on two different occasions to these transgressions.*” In my view, that too was a proper interruption to ensure the evidence was adduced in a sensible order and was relevant to the issue in the case.

52. On another occasion Mr Rule was asking Dr Sanghera about a letter she had written on 13 December. The Coroner interrupted the exchange and the following appears at page 218

“Coroner: Can we just hold on a moment? Just hold on. Just let’s be pleasant about it. So let’s be more—just calm down. Doctor Sanghera, I can appreciate that you feel there is a certain tone but if you just let Mr Rule ask his questions and I’ll intervene if they feel they are not giving you an opportunity to answer them

adequately. If you feel that you want to add on something to an answer then let me know rather than be interrupted. Okay?

53. In my judgment, in that passage the Coroner was properly interrupting to ensure that the witness remained calm and polite and answered the question that Mr Rule had put.
54. A little later Mr Rule asked Dr Sanghera the following: *“If you’re saying that you are prepared to say things that are not quite true in order to emphasize what you consider to be a position that that should be emphasized I’m sure that I’m misunderstanding. Is your evidence that this is true and you were writing what is true and you were using those words to make sure a layperson understood the truth? Is that the correct position?”* The following exchange then took place:

Coroner: Mr Rule I’m going to pause you there. I understand exactly what Dr Sanghera has said. She said if she had thought it was severe in her consultation, face to face that day, that would have been reflected in her contemporary’s medical records. The fact is, it’s clear that Dr Sanghera wishes to be as helpful as possible to an individual who needs some help with their employment so she may exaggerate or not necessarily provide a clear description of her consultation, which, of course, is confidential so I ... Do take some objection about the suggestion that this doctor was willing to say one thing and mean another in any form of her evidence other than what she said she has put in a letter, alright?

Mr Rule: well I’m sure that’s a helpful answer Madam for the witness...”

Coroner: yes, exactly what was meant by that because it was my understanding that I was just summarising evidence she had already given. I was not providing [her] with an answer I was telling her what I understood from her answer.

Rule: Well I apologise Madam.

55. In my view, the Coroner here was properly managing the progress of the evidence. She was fairly summarising what the doctor had said and attempting to take some heat out of the exchange between counsel and the witness. She was met with what was an impertinent response from Mr Rule for which she was entitled to reprimand him and for which he properly apologised. I detect no impropriety in the Coroner’s conduct there.
56. On a later occasion the coroner interrupted Mr Rule to prevent him repeating a question that had already been asked. At page 222 the following appears:

Rule: In the course of the conversation that you had in the consultation, did you become aware of the previous attempts to call the crisis team, the SPA?

Coroner: I asked this question I think and it was answered Mr Rule

Rule: very well, I withdraw the question

57. Again, this was a proper interruption by the Coroner to ensure that there was no repetition of a line of questioning that had already occurred.
58. Looking at the transcript as a whole, I accept Mr Landau’s submission that these were proper occasions for the Coroner to intervene in questioning, and I see no ground for

complaint either generally or in any of the examples given to us by Mr Rule. In those circumstances, I see no merit in ground 1 and, accordingly, the argument that the coroner should have recused herself on those grounds also falls away.

59. In his skeleton argument, when addressing Grounds 1 and 2, Mr Rule refers to the case of *R (Nguyen) the Assistant Coroner of Inner West London 2021 EWHC 3354 (Admin)* which he says “*concerns the requirements for a fresh inquest found in the face of an enquiry which had been conducted by the very same assistant coroner whose conduct of the instant inquest is challenged.*” In my judgment, that was a wholly improper submission to advance. *Nguyen* has no relevance in the present proceedings. As Mr Landau properly points out, the decision in *Nguyen* is neither evidence nor legal argument. It would not have been relevant even if bias had been found in that case (which it had not). Certainly, it does not provide logical support for the claims advanced in the present case.
60. The bulk of Mr Rule’s oral submissions were taken up with ground 1, and my ruling against him on that ground has obvious consequences for a number of his other arguments. I turn to consider each next.

Ground 3 and 4 – Failure properly to investigate the death

The competing arguments

61. Mr Rule addressed grounds 3 and 4 together. I follow suit.
62. By ground 3, the Claimant submits that the Defendant failed to satisfy the State’s investigative duty under Article 2 ECHR in three ways. First, Mr Rule submits that the Defendant failed to adhere to rigorous procedural fairness in conducting the inquest.
63. Second, he submits that the Coroner failed to conduct a sufficiently extensive or effective inquiry into the deceased’s death, and the role the State may have had to play in it. He submits that the Coroner failed to investigate “*thoroughly and adequately*” the state’s failures to “*put in place a system and procedures to ensure to the greatest practicable extent protection of individuals from risk of death in circumstances relevant to this case*”; to “*adopt necessary and reasonable preventative measures to diminish the opportunity for or likelihood of suicide (or serious self-harm endangering life)*”; to “*adopt appropriate and adequate preventive measures to secure effective protection for the life of Mr Sylaj against the risk*”; and “*to take reasonable steps to provide or make available to Mr Sylaj appropriate prompt support safeguarding against the risks that arose.*”
64. Third, Mr Rule submits that the Coroner failed to apply the correct legal test for causation for an Article 2 ECHR operational breach to be found. Article 2 ECHR’s positive duty requires the State to take measures to prevent, or to avert the *real risk* of, violation. Thus, the Claimant submits that the investigative duty under Article 2 ECHR is not only to investigate conduct which is *probably* a cause of death, but also to investigate that conduct without which there is a “*substantial chance*” or “*real prospect*” that the outcome would be different. Thus, submits the Claimant, by failing to pose and answer the question of whether the SPA’s failure to triage the deceased *might* have resulted in a different outcome (as well as whether it *would* have), the Defendant failed to sufficiently investigate the case before her, and as result, breached the investigative duty in Article 2 ECHR.

65. In response, Mr Landau submits that the minimum procedural requirements set out in *Jordan v UK* [2003] 37 EHRR 2 were met. The relevant fact in issue was the one which prompted the Coroner to declare that this was an Article 2 inquest, namely the alleged systems failure on 12 December, and on that the Coroner made appropriate findings. The Coroner went on to investigate the consultation of the 13 December and made findings of fact on that topic that were properly open to her. The authority on which the claimant relies on causation is, when properly understood, against him; there was no duty on the Coroner to include in the record of inquest matters that were only possibly be causative.

Discussion

66. I turn in a moment to address the three particular criticisms advanced by Mr Rule under ground 3. But I deal first with Mr Rule's approach to Article 2 generally. Inherent in his submissions is the argument that once the coroner had declared that the inquest was to be "*an Article 2 inquest*", all aspects of the Article 2 jurisdiction were in play. I would reject that suggestion, and would make the following five points.

67. First, the fact that a coroner declares that an inquest will serve to meet the state's obligation to investigate the death, and that s5(2) of the 2009 Act applies, does not trigger an obligation on the coroner to investigate every aspect of the case to the standards of Article 2. The obligation imposed by s5(2) requires an investigation "*where necessary*" to ensure compliance with the Convention. A coroner's ruling as to the particular issues in respect of which Article 2 requires investigation delimits the scope of the Article 2 inquiry. Here, the scope of the investigation necessary to discharge the Article 2 obligation – namely to determine whether there was a breach of the system duty on 12 December – was never amended or challenged. And it was on that issue that the coroner properly focused her conclusions.

68. Second, the scope of the inquest is, and remains throughout, a matter for the coroner. In *Hambleton*, Lord Burnett, LCJ, giving the judgment of the Court of Appeal, said (at [47])

It has become commonplace in advance of inquests for coroners to rule on their scope, including whether possible state responsibility requires an article 2 compliant inquest. That latter aspect will involve a question of law, albeit in circumstances which may be evolving during the course of an investigation and even at an inquest itself. If article 2 is engaged in this way it remains for the coroner to decide what evidence to call at the inquest, to determine what the central issues for determination are and, if there is a jury, the way in which to elicit their conclusion on those central issues:

69. The effect of the Coroner's ruling as to the application of Article 2 in this case was that the statutory purposes of the inquest were expanded to include ascertaining whether there was a breach of the state's *system* duty towards those in the community with psychiatric difficulties.

70. Third, the significance of the ruling that Article 2 applies lies in the conclusion that will be reached at the end of the inquest. The "*scope of the investigation and thus evidence called at the inquest is unlikely to be affected by the question whether the article 2 procedural obligation applies*", (*Maguire v HM Senior Coroner for Blackpool & Fylde* [2020] EWCA Civ 738). The Coroner here determined that Article 2 required an investigation into the alleged breach of the systems duty on 12 December 2018.

71. Fourth, the Coroner is not obliged to investigate every issue raised by an interested party. In *R (Allen) v HM Coroner for Inner North London* [2009] EWCA Civ 623 Dyson LJ, giving the judgment of the Court of Appeal said:

it was 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...The coroner was, therefore, required to do no more than focus the investigation and the inquisition on the central issue or issues in the case.

(See also in this context *R (Le Page) v HM Assistant Deputy Coroner for Inner South London* [2012] EWHC 1485 (Admin) and *R (Speck) v HM Coroner for York* [2016] EWHC 6 (Admin).)

72. Fifth, Mr Rule's skeleton argument made frequent reference to caselaw relating to the *operational* duty owed to prisoners and those held in psychiatric hospitals; (*R (Takoushis) v Inner North London Coroner* [2005] EWCA Civ 1440, *Mitchell v Glasgow CC* [2009] 1 AC 874, *Sacker v Coroner* [2004] 1 WLR 796 and others.) But these have little or no relevance to cases such as the present, where what is in issue is the systems duty in respect of healthcare in the community.
73. I turn next to the Claimant's particular complaints.
74. In my judgment, there is no merit in the first of the claimant's points. *Jordan v UK* identified the minimum procedural requirements for an Article 2 inquest. At [106] – [109], the ECtHR indicated that the authorities must act of their own motion; the investigation must be independent; the investigation must be effective in the sense that it must be conducted in a manner that does not undermine its ability to establish the relevant facts; this is, as it was described in *Jordan* "an obligation of means rather than results"; the investigation must be reasonably prompt; there must be a "sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory; the degree of public scrutiny required may well vary from case to case": and there must be involvement of the next of kin "to the extent necessary to safeguard his or her legitimate interests".
75. Here the state established the inquest; it was conducted by an independent coroner; it was conducted in a manner which allowed the coroner to establish the relevant facts – by calling and questioning the relevant witnesses and reviewing the relevant documents; it was reasonably prompt; it was conducted in public; and the family of the deceased were directly involved and represented by counsel.
76. I have already addressed the detailed complaints about procedure advanced by Mr Rule when dealing with ground 1 and rejected them. They fare no better in the context of Article 2.
77. As to the second point, as explained above the central issue in this case was the one which the coroner ruled required the application of s5(2), namely the alleged system failure on the 12 December 2018 when the deceased was unable to speak to a clinician at the SPA because of a lack of available staff, and his telephone number was not taken so as to enable a clinician to ring him back. That was addressed at length in the inquest and was the subject of a conclusion in the Record of Inquest.

78. Even if, contrary to my conclusion above, it could be said that the coroner was obliged to investigate the events of both 12 and 13 December to the standards of Article 2, I would reject the claimant's criticism. As the Coroner's summary at the end of the inquest (see [34] above) illustrates, her inquiry was much broader than the events of 12 December and encompassed the events on the following day.
79. As to the third issue in respect of the ECHR, the correct legal test for causation under Article 2, the answer lies in the Court of Appeal's decision in *R (Lewis) v HM Coroner for Mid and North Shropshire* [2009] EWCA Civ 1403. The Court of Appeal held that while a Coroner has the *power* to take a jury's verdict on whether a breach of Article 2 is a possible cause of death questions, she is not under a *duty* to do so. This approach applies equally to inquests without juries: the Coroner need only determine probable causes of death, although she may also chose to express a view on other possible causes.
80. It follows, as Mr Landau submitted, that the coroner was under a duty only to determine potential probable causes of the deceased's death (namely, the SPA's failure to triage him), rather than potential possible causes (Dr Sanghera's failure to refer the deceased to psychiatric services after assessing him or to change his prescriptions). She might have considered making a finding as to whether there was a *risk* that Dr Sanghera's failure in these respects caused his death, but she was not obliged to do so. In any event, she did in fact consider the events of 13 December for their potential relevance to the deceased's death.
81. By ground 4, the Claimant submits that the Defendant failed to conduct a sufficient inquiry discharging his obligations under the *Tameside* duty, section 5(2) of the Coroners and Justice Act 2009, and the "common law".
82. The Claimant advances this ground by reference to the same alleged errors as are referred to under ground 3, and makes no submission on what these alternative duties add to the investigative duty under Article 2 ECHR. In my judgment the Coroner conducted a careful and thorough review of the circumstances of Mr Sylaj's death, complied with her common law obligations and made findings on the facts that were properly open to her. I would reject ground 4.

Grounds 5 and 6 – Material error of fact/failure to take into account material evidence and Wednesbury Unreasonableness

Competing Arguments

83. By ground 5 the Claimant submits that the coroner made material errors of fact and failed to deal properly with the evidence. By ground 6 he alleges the coroner made findings that were Wednesbury unreasonable. These can conveniently be considered together.
84. The Defendant responds that "*the appropriate test for quashing findings of fact is ... Wednesbury unreasonableness*" and that no such unreasonableness is made out. Ms Misra submits that the Coroner's conclusions on the facts were unimpeachable.

Discussion

85. The Court of Appeal laid down the test by which an error of fact amounts to a justiciable error of law in *E v SSHD* [2004] EWCA Civ 49. Carnwath LJ at [66] said this:

“... First, there must have been a mistake as to an existing fact, including a mistake as to the availability of evidence on a particular matter. Secondly, the fact or evidence must have been "established", in the sense that it was uncontentious and objectively verifiable. Thirdly, the [claimant] must not have been responsible for the mistake. Fourthly, the mistake must have played a material (not necessarily decisive) part in the Tribunal's reasoning.”

86. Mr Rule has failed to point to any factual errors inherent in the Defendant's findings and I can detect none. His case here, as elsewhere, amounts to no more than disagreement with the Coroner's conclusions on the appropriate inferences to be drawn from the facts. I would reject this ground.
87. The claimant alleges the coroner failed to take into account relevant evidence in making her findings or reaching her conclusions. Again, I disagree.
88. As to events on 12 December, the claimant criticises the coroner's finding that “*it was not possible to say that if Mr Sylaj had been triaged it would have prevented his death*”. But, as Mr Landau correctly submits, in determining that issue the coroner took into account all the relevant evidence before her. She pointed out that the deceased was unlikely to have been referred to the HTT and might well have been referred back to his GP. As she said, as it turned out, the deceased was assessed by Dr Sanghera the following day. Furthermore, it was impossible to know how long it would have taken for the deceased to have been assessed for community mental-health services. These were perfectly rational conclusions for the Coroner to reach on the evidence.
89. Mr Rule further argues that the Coroner failed properly to take into account relevant evidence, including the failure to refer the call received by the SPA to the HTT crisis team, failures of training within the SPA and insufficiency of clinician staffing levels in the SPA. For two reasons, that argument goes nowhere.
90. First, as Mr Landau submits, this evidence went to the issue of why the SPA failed to triage the deceased, not to whether, if the deceased had been triaged by the SPA, he would not have died. Second, and more fundamentally, while the question of what is a relevant consideration is a question for a reviewing court, the matter of how much *weight* to apply to a relevant consideration is a matter for the decision-maker, a decision with which I would decline to interfere. The Defendant's decision in this case – that, based on the evidence before her, it was “*not possible to say [that] if [the deceased] had been triaged, it would have prevented his death*” – cannot sensibly be regarded as “perverse” or “absurd”. The Defendant's reasoning in the passage set out at [34] above is entirely cogent.
91. As to her conclusions about events on the 13 December, we accept Ms Misra's submissions. It was open to the coroner to find that Dr Sanghera had given truthful evidence as to her clinical impression and judgment, that she did not consider the deceased to be at risk of deliberate self-harm and, in the light of the fact that he had a consultation with his regular GP, Dr Patel, arranged for 20 December 2018, as to the five-point plan she said she had formulated for his future care. These were conclusions on the facts which were properly open to the coroner.

Ground 7 – Error of Law (Failure to issue a Regulation 28 report):

Competing arguments

92. In ground 7, the Claimant submits that the Coroner was required (by Schedule 5 of the 2009 Act) to hear submissions of interested persons before reaching a decision whether to issue a Regulation 28 “*preventing further deaths*” report and that therefore, it was “*outside of the proper decision making ambit*” not to issue a report.
93. Mr Landau submits that the duty in Schedule 5 is conditioned on the Coroner first deciding herself that “*action should be taken*”. The Schedule makes the Coroner’s “*opinion*” determinative, and, submits Mr Landau, while there is a power to hear submissions from interested parties in these circumstances, there is no obligation on the Coroner to do so.

Discussion

94. The Chief Coroner has issued guidance on this topic. Guidance number 5 states (at [14]) that “*It was not the intention when changes were made to Rule 43 in 2008, nor is it the intention under the 2009 Act, that inquests should be lengthened or their scope widened for the purpose of hearing representations.*” Furthermore, at [15] “*Coroners may hear and give weight to representations by interested persons at the inquest as they see fit.*”
95. Schedule 5 imposes a duty to issue a report when the criteria set out in the schedule are met. In this regard, the 2009 Act changed the previous procedure; under the 1984 Rules, there was a power, but not a duty, to do so. But there is nothing in the wording of Schedule 5 which imposes a requirement on the Coroner to hear submission from interested persons before deciding whether or not the duty to report arises.
96. Further, I can see no grounds to imply such an obligation, or for rejecting the Guidance of the Chief Coroner on the topic. An inquest remains an inquisitorial process and the duty here is one imposed on the coroner. It is in circumstances where she forms the opinion, in the light of the facts revealed by the investigation, that action is required that she is required to make a report. No doubt it will often be the case that a coroner will find it helpful to invite such submissions, but there is no obligation on her to do so.
97. Given her findings and conclusions, her decision not to do so here was entirely reasonable.

Conclusion

98. For those reasons, if my Lady agrees, I would dismiss this application.

Lady Justice Macur

99. I agree.