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R v Lincolnshire Coroner, ex parte Hay [1999] Lexis Citation 2313

CO/2155/97, CO/2210/98, (Transcript: Smith Bernal)

QUEEN'S BENCH DIVISION (CROWN OFFICE LIST)

BROOKE LJ, FORBES J

19 FEBRUARY 1999

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Coroner — Inquest — Prisoner known diabetic — Prisoner dying in custody — Coroner refusing to disclose witness list before hearing to prisoner's family's legal representatives — Medical officers in charge of the prisoner's case claiming privilege against self-incrimination — Coroner refusing cross examination of medical officers — Whether inquisition to be quashed

A Hewitt for the Respondent

E Fitzgerald QC and J Glasson for the Applicant

P Spink and S Leek for the Interested Party

Lincolnshire County Council, Lincoln; Strachan St George; Treasury Solicitor

BROOKE LJ

:

1. This is the judgment of the court, to which both its members have contributed.

A. The History

2. On 5 July 1996 Brett Andrew Hay was convicted of theft and sentenced to 20 months' imprisonment at Lincoln Crown Court. He was taken to Lincoln prison, and within three days he was dead. There is before the court an inquisition, signed by HM Coroner for the Lincoln District of Lincolnshire, Mr Roger Atkinson, and the jurors who sat with him at an inquest conducted on 18th and 19 March 1997, which shows that he was aged 31 when he died, and that he died of diabetic keto-acidosis, from natural causes. His widow Annette Hay applies for a judicial review of this inquisition and also, pursuant to a fiat granted by the Attorney-General, for orders under s.13(2) of the Coroners Act 1988 to quash the inquisition on that inquest and to order another inquest. At the end of the hearing we announced that we had decided to grant Mrs Hay the relief she sought and in this judgment we are setting out the reasons for our decision.

3. Mr Hay was born in May 1965. He was an electrician by trade and lived with his wife and children in Ipswich. When he was 17 diabetes was diagnosed, and since then he had been dependent on insulin. He controlled his condition reasonably well with daily injections of Actrapid and Insulatard.

4. When he first arrived at the prison he was admitted to the hospital wing for observation and stabilisation of his diabetes. He was keen to join his friend Stephen Warner, with whom he had been convicted and

sentenced, and on the following morning, which was a Saturday, he joined Mr Warner in his cell. The prison regime involved him in going back to the prison wing for his twice-daily injections, the afternoon injection being administered before he had his prison tea at 4pm. On the Saturday morning his blood glucose level reading was 6.8, which he told a doctor was his normal level. That afternoon it was recorded as being 20.5, and on the Sunday morning the test showed a result of 19.2. The normal range is between 5 and 10, but the evidence showed that readings of 19 or 20, or even higher, are much less dangerous than readings of 3 or less, and that a high blood glucose level can be rectified reasonably quickly once it has been identified.

5. In a statement which was read at the inquest Mrs Hay said that her husband rang her on the Saturday afternoon to say that everything was all right and that he was sharing with Steve. He had served several prison terms in the past, when she knew that he had accommodated his diabetes without any problems. On the Sunday afternoon he rang again at about 3.50pm. This time he was in a nasty mood, shouting down the telephone that his diabetes was not right, his blood was 40, and he had had his injection which they had given him too early, at 3pm. He went on to say that they were not listening to his concerns and that they did not care. Mrs Hay said that she tried to reassure him and said that she would contact his solicitor. He replied “you better: I'm going to die in here”. She never spoke to him again.

6. This evidence was to a certain extent in conflict with the evidence given by Mr Warner. He told the inquest that Mr Hay had not been concerned about his health on the Saturday and that he felt fine when he returned to his cell after his injection on the Sunday afternoon: he was just a bit concerned about the change of time for his second injection of the day. He had his tea at 4pm which consisted of mixed salad and chicken.

7. It was between 7 and 8pm that evening that he started to feel unwell. He initially complained of indigestion and stomach pain. At about 9pm he went to the toilet and was sick. He was then complaining of indigestion and a bit of heartburn. Later on he drank some water and then went to bed. A little later he went to the toilet and was sick again.

8. Mr Warner then dropped off to sleep and when he woke up again between 11pm and midnight Mr Hay told him he had been sick quite a few times and that he had also had diarrhoea as well. He would vomit if he drank water, but he remained thirsty. Although he was a bit hot, he did not look too bad, and he declined Mr Warner's suggestion that a member of the prison staff should be called. He did not see any reason for this, as he thought he was suffering from a tummy bug, unconnected with his diabetes.

9. Mr Warner woke up again between 2.30 and 3am. He found that Mr Hay was still being sick. He was a bit pale and dehydrating. He was also gasping for breath. Mr Warner summoned a prison officer, who in turn summoned Mr Hopkinson, a trained nurse, who was the health care officer on duty that night. According to Mr Warner, Mr Hay told Mr Hopkinson that he was dehydrating and suffering from chest and stomach pains, and that he was having difficulty in breathing. He explained that he was a diabetic. Mr Hopkinson went off to fetch a blood level meter, and Mr Warner described how while they were waiting for him, Mr Hay stood by the cell window panting and gasping for breath.

10. According to Mr Warner, the medical orderly tested Mr Hay on his machine. He was surprised by the response, turned the machine off and on, tapped it and then said “That's better”. He gave Mr Hay a glucose

type drink. Mr Warner said at the inquest he did not know why he was getting a glucose drink, as Mr Hay had told him that if he drank water he was vomiting it back up again. He did not remember saying in the first statement he made that Mr Hay had said he needed some form of sugar-rich drink. He said that he had been with Mr Hay on some previous occasion when he had known he needed a Lucozade drink and took one: in his experience, if Mr Hay felt low he usually had a Lucozade to boost himself.

11. For reasons which we will explain in due course, Mr Hopkinson gave evidence fairly briefly at the inquest. Before he joined the prison service in 1988 his training and experience had been connected with nursing people with learning disabilities. These included diabetics. Since 1988 he had been mainly concerned with assessing and treating prisoners suffering from mental illness, but when he was on night duty in the hospital wing, he was also liable to be called to deal with any medical problems that might arise either in that wing or in the main prison.

12. At 2.35am he went and saw Mr Hay who was complaining of stomach pains. He said that his temperature was normal and his respiration rather higher than normal at 24 inhalations per minute. His pulse rate was normal. He knew he was a diabetic and carried out a blood sugar test, with a result of 11.5 which was a bit on the high side but not unduly so.

13. Mr Hay told him he had been sick and that he had also had diarrhoea, although there was no evidence of this in the cell. He decided to move him into the hospital wing where he was placed in a cell with Mr Firman. Visual checks were made through the hatchway every 15 minutes either by Mr Hopkinson or by Mr Lyons, the Discipline Officer who was on duty with him. When Mr Hopkinson checked, Mr Hay was always awake. He was either lying down, sitting down, or standing. He sometimes saw him holding his stomach and once he saw him drinking water from a cup at the sink in his cell.

14. At 4.40am he contacted Dr Sen, the medical officer on call, who directed him to do a blood pressure check, to give Mr Hay a strong painkiller, and a medicine (to be taken three times a day) to prevent vomiting, and another medicine to deal with heartburn. He carried out these instructions: Mr Hay's blood pressure was found to be normal. The 15-minute checks continued. Mr Lyons made a check just before he went off duty at 6am, and at 6.02am Mr Hopkinson was summoned to the cell by Mr Firman to find that Mr Hay was dead. All attempts to resuscitate him failed.

15. Mr Hopkinson explained that he gave Mr Hay what he described as a meal replacement drink called Fortisip on arrival at the Health Care Centre at about 3am. He said that it contained vitamins and a certain amount of sugars, and it was used in Mr Hay's case because he had lost fluids through dehydration and diarrhoea.

16. Mr Firman, an inmate of Rampton Hospital, told the inquest that in July 1996 he was in Lincoln Prison. Mr Hay had shared a cell with him on the Friday night, and he knew he was a diabetic. He was then transferred to the main prison. Some time on the Sunday night Mr Hay was brought back to his cell. Mr Firman was awake, and Mr Hay appeared to be really ill. He kept saying he was in pain and breathing “dead heavily”. Mr Firman said that his breathing was indeed really heavy and irregular. He then went to sleep and when he woke up again he found Mr Hay to be dead, and rang the bell in his cell to summon assistance.

17. Mr Lyons gave evidence on the second day of the inquest. He had never worked on the hospital wing till

he was posted for duty there that night, and he had had no training at all as a health care officer. He recalled Mr Hopkinson being summoned at 2.30am and returning with Mr Hay at 3am. Mr Hay was then complaining of pain in his stomach. He was put into Mr Firman's cell, and Mr Lyons or Mr Hopkinson checked him every 15 minutes. When Mr Lyons checked, Mr Hay was still complaining of pains in his stomach. He was also groaning a little. He was always awake when a check was made. Just before 4am Mr Lyons thought that as he did not seem to be getting any better or settling down, he should call Mr Hopkinson to have a look. Mr Hopkinson decided to telephone a doctor, and after he had called the doctor Mr Lyons went into the cell with Mr Hopkinson and another officer. Mr Hay said he was suffering from pain in his stomach, and Mr Hopkinson gave him two small white tablets which he took with a glass of water. His pulse and blood pressure were then checked. Mr Lyons thought that his breathing was quite normal: there was no sense of his panting or gasping.

18. Mr Lyons continued with his 15 minute checks. He said there was no change in Mr Hay's condition. He was still complaining about pain in his stomach, but nothing else. He did not notice any sign of difficulty in breathing. So far as he was aware, Mr Hay's breathing was normal. He checked him for the last time just before he left the hospital wing at about 5.55am, and there was no change: he was still lying on his bed.

19. Dr Sen's evidence was even briefer than Mr Hopkinson's, for reasons we will also explain. She said that she was a qualified medical officer working at Lincoln Prison. She had examined Mr Hay when he was first admitted, and she saw him again the following morning when he was discharged into the main wing of the prison. She directed that a blood/sugar level test should be carried out daily for one week.

20. On the Monday morning she received a telephone call from Mr Hopkinson, who told her that Mr Hay had been admitted to the hospital wing complaining of abdominal pains, diarrhoea and sickness. She was also told that the observation results were within normal limits, and that Mr Hopkinson had given Mr Hay medication which had not had much effect. She told him to check the blood pressure, and she also prescribed various medication to relieve the diarrhoea and stomach pains. She told Mr Hopkinson to continue observing him. At about 7am Mr Hopkinson telephoned her again to say that Mr Hay had died at about 6am.

21. The only other witness of fact (apart from the Prison Governor and the Senior Medical Officer, on whose evidence nothing turned) was Mr Moore, another health care officer in the prison wing. He had seen Mr Hay in reception when he arrived at the prison on the Friday, and he also saw him with Dr Sen when he came over to the prison wing that evening. He explained what had happened both then and on the following morning, and he told of the blood and urine tests that were carried out on the Saturday morning. He also answered some general questions about the care of diabetics in the prison wing.

B. The expert evidence

22. The inquest received evidence from two experts in diabetes, Professor Vincent Marks, who was an emeritus professor of clinical biochemistry in the University of Surrey, and Professor Harry Keen, who was an emeritus professor in the unit for metabolic medicine at Guy's Hospital. They both gave evidence on the first day of the inquest, and Professor Marks returned the following morning to complete his evidence.

23. Professor Marks explained to the jury why a diabetic

needs to take insulin to keep the right levels of glucose in his blood. He spoke about the danger to the brain from hypoglycaemia, if the blood sugar level falls too low, but most of his evidence was concerned with hyperglycaemia, when the level is too high. Symptoms of this condition appear when the sufferer is seen to pass a lot of urine and becomes very thirsty. Ketone fats begin to accumulate in the blood, and in an extreme case ketoacidosis may set in, which may eventually lead to death, after many, many hours. The loss of water in the urine, with the accompanying dehydration, leads to a loss of sodium chloride and a disturbance of the potassium in the blood, and these factors, coupled with the high blood-sugar level and the high ketones, lead to coma if the condition lasts for long enough. The patient then fades away unless the water, the salt and the insulin are all restored.

24. Professor Marks said that if a diabetic was sick and suffering from stomach pains and diarrhoea, diabetic ketoacidosis ('DKA') was a possible diagnosis: so, too, was food poisoning, particularly as diarrhoea is not a feature of DKA. He explained that gasping for air is also a symptom of ketoacidosis. As the ketone bodies build up, they cause the blood to become more acidic, and the body then tries to blow off carbon dioxide, which is an acid. If a doctor was confronted with the problem which faced Mr Hopkinson, he would do a blood glucose sugar test 30-60 minutes after the initial test. Professor Marks was clearly very puzzled by the reading of 11.5 on the only test taken by Mr Hopkinson, but he said that in any event this was a high reading and it was not good practice to administer more sugar in a drink in those circumstances. He also said that he had learned to be wary of readings from what he called “patient-friendly instruments” because of reports of erroneous results in the medical literature.

25. Professor Keen's evidence was then interposed. He said that the fairly high level of glucose in the drink was very likely to have contributed substantially to the level of glucose found in Mr Hay's blood post mortem. His understanding was that Mr Hay had asked for a sugary drink, and he explained that diabetics are taught to seek sugar if they think they are risking hypoglycaemia. He said that Dr Sen was told that the blood glucose, the blood pressure, the pulse rate and the respiratory rate were all normal, so that there was nothing very much to create alarm, although if he had been Dr Sen he would probably have wanted to have a look.

26. The professor explained to the jury that experience had showed that a diabetic can go from being in a reasonably secure state to sudden death without any indication that this is going to happen. This was a fairly well recognised phenomenon in young people with diabetes. About 30 to 40 people die like this each year in the United Kingdom, and the experts do not really understand why. He was surprised that this young man had died: possibly a rapid change in potassium in the blood had caused a cardiac arrest. He said that deaths like this are reported from other European countries, North America and Canada, and they are an awful mystery. He would find it very difficult to say that the death was absolutely nothing to do with the rapid rise in glucose. He said that if someone was standing on a table trying to breathe air from a window, vomiting and clutching his stomach, this would be a description of DKA, but this would be difficult to reconcile with a blood glucose level of 11.5. The history of diarrhoea until 1am (contained in the medical notes) did not fit into a picture of DKA, either.

27. Professor Keen said that he was very surprised indeed by this death. The signs normally associated with progressive DKA were not present and by the time death supervenes in a DKA case the sufferer is usually unconscious and deeply so.

28. When Professor Marks resumed his evidence on the second day of the inquest, he said he could not fault Dr Sen if she was not told that Mr Hay was desperately thirsty, or that he was panting for breath (a matter which was in dispute).

29. He said that overnight he had bought the drink called Fortisip which Mr Hopkinson had mentioned. It contained about 36 or 37 grams of glucose. That amount of glucose could not raise the blood glucose level from 11.5 to the level of at least 40 which had probably existed at Mr Hay's death, so that if that figure of 40 was correct, the blood glucose must have been very, very much higher than that before this drink was taken. The drink undoubtedly would have made a substantial contribution but it would not account to more than a third of the increase between 11 and 40. If he had been given two drinks, it would then be nearer to explaining the discrepancy. It was an inappropriate drink to give him in any case.

30. Dr Bouskill, a consultant histropathologist, told the inquest that the cause of the deceased's death was DKA, and he, too, explained what this condition entailed. He found no signs at all of a gastro-intestinal illness. Dr Griffiths, a consultant chemical pathologist, said that his laboratory analysed the samples of blood and vitreous humour taken from Mr Hay's body. The plasma glucose level was found to be about 75 millimoles per litre and the vitreous humour glucose level was between 29 and 32 millimoles per litre. Professor Marks had previously explained the meaning of this evidence.

C. The Summing up

31. Since complaint is made of some of the coroner's directions to the jury, it is convenient to set them out now before proceeding to consider the various grounds on which the challenge to this inquisition was made.

32. The coroner summed up the case quite briefly to the jury: the transcript covers about 11 A4 pages. After directing them on the findings they might make on formal matters, such as the name of the deceased and the time and place of death, he reminded them of the evidence they had received about the injury or disease which caused the death. He then summarised "the facts and circumstances of what happened" and told the jury they had to decide the sort of verdict they had got to give in the circumstances. He continued:

> "A possible verdict which you might consider is one of accidental death but I would suggest to you that that is not really a proper verdict in this case because accidental death is normally when somebody suffers death as a result of a road accident or an accident at work, that kind of thing, so it is not really an accidental situation. I think it is right that I should mention that to you but suggest that it is not really the right kind of verdict in these circumstances."

33. The coroner then told the jury that if they were not sure as to the disease or injury, it would be proper for them to bring in an open verdict, but he suggested that the proper verdict for them to bring in the circumstances was one of natural causes "which is death as a result of a disease". He added that this was not quite an end of the matter. If, and only if, they brought in a verdict of death by natural causes, it might be possible for them to add a rider to it to say that that was contributed to by neglect. He then summarised the evidence which might be relevant to such a finding and quoted to them the passage in the judgment of Sir Thomas Bingham MR in *R v Coroner of North Humberside and Scunthorpe, ex parte Jamieson*[1995] QB 1, *[1994] 3 All ER 972* at p.25 of the former report which is numbered (9). The coroner then added:

> "I think it is important, members of the jury, for me to stress to you, it says there:

> 'Neglect in this context means a gross failure to provide adequate nourishment or liquid'
>
> so we are talking about a *very* bad example of somebody making a mess of things if you are to find this rider, if I can put it that way, 'contributed to by neglect', but I feel it is proper to mention it to you and it is a matter for your decision at the end of the day."

34. The coroner then reminded the jury of a few more of the facts, reminded them of their duty to make a decision about the injury or the disease that caused the death, and concluded his summing up in these terms:

> "If you decide that the cause of his death is unknown then I would suggest to you that the proper verdict is an open verdict, which simply means we don't know. If you decide on the other hand that the injury or disease causing his death was diabetic ketoacidosis you then need to consider the alternatives which I suggest to you of accidental death or death by natural causes and I would suggest to you natural causes is the proper verdict. You have then got to go on and consider whether it was contributed to by neglect and my advice to you is to find that contributed to by neglect it has to be something which is very gross and very bad and therefore in my view it would not be appropriate but it is a matter for you, members of the jury, to make your own decision considering all the facts."

35. The jury retired for just over an hour before returning their verdict in the terms that were described earlier in this judgment.

D. The failure to disclose a witness list

36. Mr Fitzgerald's first complaint was that the coroner wrongly refused to disclose a witness list before the hearing to those acting for the deceased's family. The coroner had told Mrs Hay's solicitors on 14 February 1997 that it was not his practice to provide a list of the witnesses he intended to call, and he took this stance again in a letter written on 17 March, the day before the inquest started. Mr Fitzgerald submitted that the adoption of this practice was both contrary to the rules of procedural fairness and contrary to the practice now adopted by other coroners, and that it led to avoidable difficulties at the inquest both because the family did not know whether the coroner wished to call two other prisoners who were at Lincoln Prison at the time whom he did not in fact call, and because the family's advisers would have liked to have had the opportunity to make suggestions about other witnesses the coroner might call.

37. Mr Fitzgerald called in aid in support of his submissions an affidavit sworn by Deborah Coles, the Co-Director of an organisation called INQUEST, which advises families whose members have died in controversial circumstances. This organisation focuses particularly on deaths in custody. Ms Coles said that in her experience it was highly unusual for a coroner not to disclose the list of witnesses in advance of the inquest, and that with a death in custody a coroner will almost invariably circulate such a list well in advance. Usually when a witness list is served, the coroner or his/her officer will briefly explain the evidence that each witness will give, and it is, she said, increasingly common for coroners to hold pre-inquest hearings, particularly where there has been what she called a serious death in custody inquiry. She points out that the benefit of this practice is that it allows the coroner to summarise the evidence that he/she proposes to call and gives all parties the opportunity to be heard as to whether there are any other witnesses that the coroner may wish to consider calling.

38. Her affidavit was filed just before the hearing started, and when we read it we told Miss Hewitt, who appeared for the coroner, that we would welcome it if we could be provided with more evidence about contemporary practice among coroners. This was provided the following morning in the form of an affidavit

sworn by Mr Michael Burgess, who is the Honorary Secretary to the Coroners' Society of England and Wales, and who has had 20 years experience as a coroner, first as the Deputy Coroner and since 1986 as HM Coroner for Surrey. In the time available to him he had had the opportunity of discussing the contents of Ms Coles's affidavit with three other coroners as well as with the Respondent. We are very grateful to Mr Burgess for his assistance.

39. He said that he and the other coroners he had had time to consult all agreed that it was misleading to say that it was highly unusual for a coroner not to disclose the list of witnesses in advance of an inquest. It was not the practice of every coroner to disclose a list of witnesses in advance, even in inquests concerned with deaths in custody. Mr Burgess knew of no coroner who routinely published a witness list in advance of the hearing, without being asked. Some coroners have told him that they have never circulated lists in advance in any death in custody case, while others have done so when requested. He explained how sometimes families split into factions, or do not come to the hearing, and that coroners may have difficulty in identifying the relations who have the right to participate under r.20 of the Coroners Rules.

40. He reminded us that an inquest is a non-adversarial process which has been entrusted by Parliament to the coroner, sitting in some cases with a jury. There is no provision in the Act or the Rules for pre-inquest disclosure of witnesses of statements, or indeed of any other documents. There is no statutory obligation imposed on anyone to volunteer any information to the coroner or to co-operate with him in advance of the hearing. Indeed, there is no power for the coroner to require any person to give a statement or to deliver up any documents in advance of the hearing.

41. Mr Burgess described the limited resources available to a coroner, who has no right to reimbursement if he spends money on copying documents, and is at his own risk in relation to any infringement of third party rights arising out of issues relating to copyright or medical confidentiality, for instance. Thus the whole structure of the coroner system at present, he said, is directed towards the coroner and his inquiry, not at the interested persons who might attend. It is the public hearing which at present constitutes the notification to interested persons - and others - of the evidence relevant to the case. A practice of pre-hearing disclosure as a matter of routine would, in Mr Burgess's opinion, make profound changes to the whole concept of an inquest. It would not then be an independent public inquiry carried out by a non-partisan judicial officer, bringing out the facts at a public hearing, but instead would tend to become a set-piece battle between two sides, each seeking to prove their own pre-formed case.

42. Mr Burgess was not aware of any case where the coroner's officer had distributed lists of witnesses and explained the evidence to be given in advance of the hearing, unless perhaps the evidence was purely formal. He explained that until the late 1980s pre-inquest hearings never happened, and even today they remain rare, and do not happen in most death in custody inquests. He pointed out that there were in any event significant problems involved, such as sending representatives long distances for short periods. The purpose of such hearings was not simply (or even mainly) to deal with the identity of witnesses, but with a whole range of administrative issues, such as the arrangements for sitting, what court room is needed, what facilities will be required, and the arrangements for jurors, or for fitting in a witness with limited availability.

43. Ms Coles had said that the failure to disclose a

witness list at the commencement of an inquest was unprecedented in her experience. This evidence, even if confined to inquests relating to deaths in custody, did not accord with the experience of Mr Burgess or of the other coroners to whom he had spoken. On the other hand, he accepted that in many cases the need to call additional witnesses arises during the course of an inquest, and coroners frequently take steps to ensure their earliest attendance. Where this involves a prisoner witness, the coroner's officer works with the prison service to facilitate this.

44. At one point Mr Fitzgerald submitted that we should decline to follow the case of *R v Hammersmith Coroner, ex parte Peach*[1980] QB 211, *[1980] 2 All ER 7*, in which this court decided, for good practical reasons (see Lord Widgery CJ at p.218E-F of the former report), that the coroner was not obliged to require the police to disclose any witnesses' statements in their possession in advance of an inquest. Mr Fitzgerald said that this decision is no longer consistent with the contemporary approach to natural justice exemplified by the decision of the House of Lords in *R v Secretary of State for Home Affairs, ex parte Doody*[1994] 1 AC 531, *[1993] 3 All ER 92*. He did not, however, explain how in the absence of any statutory enabling power a coroner would be able to surmount the practical problems identified in *ex parte Peach*, and in any event that case was concerned with a quite different issue. In *ex parte Doody* the House of Lords ruled that if a prisoner sentenced to life imprisonment was now permitted to make submissions to the Secretary of State as to the length of the tariff part of his sentence, procedural fairness required that he should know the gist of the other submissions which were being made so that he might have the opportunity of dealing with them. A fact-finding inquiry into a death, which has no power or right to apportion blame, has no comparable features. In our judgment the decision of this court in *ex parte Peach* on the non-disclosure of statements taken by the police still represents authority which this court should follow.

45. Mr Fitzgerald then fell back on an alternative submission that at the very least the coroner should publish a list of witnesses beforehand, together with the gist of the evidence each witness was to give. He said that this was necessary to ensure fairness. Otherwise one of the interested parties at an inquest (the deceased's family) is placed at a significant disadvantage vis a vis the state, whether represented by the prison authority or the police. He drew our attention to the views recently expressed in this context to similar effect by the Police Complaints Authority and the Home Affairs Select Committee of the House of Commons.

46. We are unwilling, for our part, to fetter the discretion of a coroner by being at all prescriptive about the procedures he should adopt in order to achieve a full, fair and thorough inquiry. We have seen evidence that these matters are being considered by others, including a senior Home Office minister, and we would not wish to pre-empt the outcome of these discussions by ruling that procedural fairness requires that any particular pre-hearing procedure should be followed. Experience in other contexts, such as civil and criminal trials and planning and other inquiries, has shown that attention to points of detail in advance of a hearing often pays rich dividends, particularly by eliminating the need for avoidable adjournments. We are therefore sure that it would be helpful if the Coroners' Society were to publish guidance to coroners about the different pre-hearing techniques which have been found to have been useful in different contexts, including Mr Fitzgerald's idea of circulating a list of the witnesses the coroner provisionally intends to call, accompanied by a short summary of the gist of that witness's evidence. The adoption of this course would have avoided some of the difficulties which arose in the present case. We are not,

however, prepared to rule that any such procedures should be obligatory, even in an inquest of this kind. Subject to the need to obey the requirements of the Act and the Rules, it is for each coroner to decide how best he should perform his onerous duties in a way that is as fair as possible to everyone concerned, as well as doing his best to reduce the number of avoidable adjournments.

E. Dr Sen and Mr Hopkinson

47. Mr Fitzgerald's next submission was that there had been an insufficiency of inquiry by the coroner in relation to the evidence of Dr Sen and Mr Hopkinson, both of whom had been interviewed under caution by the police with regard to possible charges of gross negligence manslaughter.

48. This submission by Mr Fitzgerald was primarily (but not exclusively) concerned with the coroner's failure to allow cross examination of Dr Sen and his significant curtailment of Mr Hopkinson's cross-examination. It was common ground that these restrictions and limitations were the consequence of each of these witnesses claiming privilege against self-incrimination. Mr Fitzgerald made it clear that he accepted that both Dr Sen and Mr Hopkinson were entitled to claim privilege against self-incrimination, both at common law and also pursuant to r.22 of the Coroners Rules 1984 ('the 1984 Rules') which provides:

> "22(1) No witness at an inquest shall be obliged to answer any question tending to incriminate himself.
>
> (2) Where it appears to the coroner that a witness has been asked such a question, the coroner shall inform the witness that he may refuse to answer."

49. Mr Fitzgerald's submission, stated shortly, was that the coroner erred both in the procedure which he adopted in dealing with the claims of privilege against self-incrimination made by both witnesses and in the consequential rulings which he made and which resulted in neither witness being subjected to any cross-examination of significance.

50. Mr Fitzgerald referred to the wording of r.22 and to the succinct statement of the relevant legal principles, which is to be found in *Jervis on Coroners* (1993 Edition) at pp.231-232:

> "Procedure for a witness claiming privilege against self-incrimination. A witness cannot refuse to go into the witness box on the ground that he might incriminate himself: he can only claim the privilege after he is sworn and the question put. The witness must pledge his oath that he honestly believes that that answer will, or may tend to, incriminate him.
>
> It is for the coroner to decide whether or not the witness is entitled to the privilege. He must first satisfy himself that the answer would tend to incriminate the witness . . .
>
> Procedure where witness is asked incriminating questions. Where it appears to the coroner that a witness has been asked an incriminating question, the coroner must inform the witness that he may refuse to answer. The witness or his representative must, however, take the objection himself, and, if he chooses to answer, he waives his privilege. However, if a series of incriminating questions is deliberately asked, then it is open to the coroner to forbid them to be put as not 'proper' questions.
>
> If objection is taken to a question, the coroner should make a note of the wording of the question and of the fact that objection was taken to it. It is the witness who is privileged, and not the evidence which he could give. Thus, the evidence which he is entitled to refuse to give may be proved in other ways, for example by other witnesses who are not covered by the privilege."

51. Mr Fitzgerald submitted that it is clear that a witness who wishes to assert privilege against self-incrimination cannot object to relevant questions being asked. This is because privilege against self-incrimination is concerned only with the answer to be given by the

witness. He emphasised that the privilege applies only to the giving of an answer by the witness. It does not prevent a relevant question being put. He further referred to and relied on the short statement of principle to this effect which appears of *Cross and Tapper on Evidence* (8 Edition) at p.461:

> "The privilege (against self incrimination) strictly applies only to answering; it does not prevent the relevant question being asked . . ."

52. Mr Fitzgerald therefore submitted that there was no proper basis for adopting a procedure, as this coroner did, whereby a witness is effectively given complete immunity from questioning, particularly when such a witness has already been allowed to give his or her own version of the facts in answer to questions asked by the coroner. He argued that by adopting this procedure the coroner fell into serious error.

53. In our view, it is clear from the transcript that, from the outset, the coroner expected that privilege against self-incrimination would be claimed by or on behalf of both Dr Sen and Mr Hopkinson. Having been told that there would be a claim of privilege in each case, the coroner then gave favourable consideration to the suggestion that some evidence from each witness could be given by, and limited to, reading out either their statements or the notes of their police interviews. He eventually decided that reading the latter was the appropriate way to deal with the matter. Having made that decision, he then called each of the witnesses very briefly to confirm that privilege against self-incrimination was being claimed by each of them. Having done so, each was then allowed to leave the witness box.

54. In the event, the notes of the police interviews were not read out as had been originally intended because, before this was done, some misgivings about that procedure were expressed by Mr Walker, who represented Mr Hopkinson. We will return to what Mr Walker said then at a later stage of this judgment. The coroner then decided that the appropriate method for dealing with the evidence of these witnesses was that each should be taken through his or her statement and, in effect, that he would not permit any further questions as to the facts of the case to be put to either witness. This is what was done. Although the coroner did permit Mr Glasson, who appeared on behalf of Mr Hay's family, to cross-examine Mr Hopkinson to some extent, he expressly limited him to questions about Mr Hopkinson's experience and training. In the case of Dr Sen, the coroner made it clear that there was to be no cross-examination at all and he invited none. The coroner simply led her through her evidence. In an affidavit sworn in these proceedings, the coroner dealt with his approach to this aspect of the inquest in the following terms:

> "14. Finally, in paragraphs 21 to 25 of the Grounds criticism is made of the fact that I limited the questioning of Mr Hopkinson and Dr Sen. To be clear, Mr Hopkinson gave evidence in answer to my questions about his training and experience and about the contents of his statement. He was cross-examined on his evidence concerning his training and experience. Dr Sen also gave evidence in answer to my questions concerning her statement but was not cross-examined at all. Both Mr Hopkinson and Dr Sen were represented and their representatives made it clear that they would be unwilling to answer questions in cross-examination on the basis of the risk of self-incrimination. When this point was raised, Counsel for the Applicant made no objection, indeed at page 50 of the bundle he stated:
>
> 'Sir, I obviously have no submissions to make on the fact that the witnesses have declined to give evidence on the advice of their Counsel, that is their right by law.'
>
> Although I am obviously aware that, procedurally, a witness's refusal to answer questions on this basis can be dealt with on a question by question basis, it seemed to me that the reality of this case was that the two

witnesses should not be forced to answer questions going beyond their statement. I was aware that both witnesses had been interviewed and investigated by the Police. Realistically, therefore, the above approach did not seem to me to be sensible."

55. In our judgment, Mr Fitzgerald is plainly correct in his submission that privilege against self-incrimination is concerned with the giving of an answer by a witness and that the procedure adopted when dealing with such a claim of privilege should not be such as to give the witness complete immunity against further questioning. We accept that the passages he cited from *Jervis* and *Cross and Tapper* state the relevant principles of law both succinctly and accurately. It seems clear, from the terms of para 14 of his affidavit, that these basic principles are not substantially disputed by the coroner, nor were any submissions to a contrary effect made on his behalf by Miss Hewitt. Accordingly, we are satisfied that the procedure which the coroner adopted in this case was wrong in principle. In effect, he imposed a blanket prohibition against any relevant questions being put by Mr Glasson to either of these two important witnesses. In doing so, he denied the family the rights to which they were expressly entitled by the terms of r.20 of the 1984 Rules which, so far as material, provides as follows:

"20(1) Without prejudice to any enactment with regard to the examination of witnesses at an inquest, any person who satisfies the Coroner that he is within paragraph (2) shall be entitled to examine any witness at an inquest either in person or by Counsel or Solicitor:

Provided that:

. . .

(b) the Coroner shall disallow any question which in his opinion is not relevant or is otherwise not a proper question.

(2) Each of the following persons shall have the rights conferred by paragraph (1):

(a) a parent, child, spouse and any personal representative of the deceased . . ."

56. In our judgment, Mr Glasson did not give unconditional agreement to the approach which was adopted by the coroner, nor did he accept that he was not entitled to ask relevant questions of these two witnesses. In the passage in the transcript to which the coroner referred in para 14 of his affidavit, Mr Glasson did no more than acknowledge that each witness was entitled to assert privilege against self-incrimination and, as a matter of law, the witness would not be obliged to answer the question if the claim of privilege was upheld.

57. This error by the coroner in his approach to the claims of privilege made by Dr Sen and Mr Hopkinson was the more serious, in our view, because he entirely failed to consider the legal significance of each witness having given evidence in accordance with his or her statement. Although this evidence was, in each case, relatively brief, in summary form, and largely led by the coroner's questions, each witness did give answers in which each gave an account of his or her involvement in the factual circumstances which preceded Mr Hay's death. We accept Mr Fitzgerald's submission that, in giving evidence as he or she did, each of the two witnesses waived privilege in respect of the factual matters about which he or she gave evidence, to the extent that any answer to a further relevant and appropriate question about such a fact might tend to incriminate. In our opinion, it is beyond sensible argument that Mr Glasson was entitled and should have been allowed to ask further relevant questions about the earlier testimony of each witness. Many of his questions would not have given rise to any proper claim of privilege against self-incrimination in respect of the answers in any event. However, there would have been nothing to prevent each witness asserting privilege

against self-incrimination, in the light of any relevant question put by Mr Glasson. It would then have been for the coroner to decide whether the answer would tend to incriminate the witness and, if so, whether privilege had been waived by reason of the answers given by the witness in the course of his or her earlier testimony. None of this happened, because of the procedure the coroner had adopted. As a result, the jury was wrongly deprived of the opportunity to hear a significant amount of further evidence from these two important witnesses.

58. A secondary (but nevertheless important) aspect of Mr Fitzgerald's submission, that there had been an insufficiency of inquiry by the coroner in relation to the evidence of Dr Sen and Mr Hopkinson, was concerned with his decision as to the admissibility in evidence of the notes of the interviews which each of these witnesses had had with the police.

59. As we have already indicated, there had been a stage during the course of the inquest when it had been the coroner's intention to have the notes of the police interviews of Dr Sen and Mr Hopkinson read to the jury, and counsel for each of those witnesses appeared to agree to that being done. In the event, before the notes of the interviews could be read out, Mr Walker had second thoughts about how the matter should proceed, because he was concerned about some of the content of Mr Hopkinson's interview. The way he expressed his reservations was as follows:

> "Yes, it is a difficulty with the interview and the circumstances in which the interview took place. Essentially my client was being interviewed under caution at Lincoln Police Station back on 10th September and that is very clear from the beginning of the interview not only if he was under caution but also the matter that the Police were considering at the time and that I would regard as being prejudicial and therefore should be edited out. Obviously the other point is that there may well be hearsay in the interview which again perhaps ought to come out and it will really be a question of whether the matter ought to perhaps be stood down to enable me to try and edit the interview in consultation with my learned friends and also DC Bradley or whether you wish to remove the prejudicial items at the beginning of the interview?"

60. In our opinion, from the way in which he put the matter to the coroner, it is clear that Mr Walker did not object in principle to the note of Mr Hopkinson's police interview being admitted into evidence, provided it had been suitably edited so as to remove any purely prejudicial and (possibly) hearsay material. As it seems to us, Mr Walker's reservations were perfectly understandable and the course he suggested was an entirely sensible way of dealing with the matter. Unfortunately, the coroner treated his submission as a general objection to the admissibility of the notes of interview and, in due course, he made the following ruling:

> "Mr Walker has objected to the notes of interview of Mr Hopkinson being put in evidence and I assume Miss Goodrich faces the same position as regard to Dr Sen, so in those circumstances I am bound by Rule 37 of the Coroners' Rules and I cannot put them in evidence because they are documentary evidence."

So far as material, r.37 is in the following terms:

> "37(1) Subject to the provisions of paragraphs (2) to (4), the coroner may admit at an inquest documentary evidence relevant to the purposes of the inquest from any living person which in his opinion is unlikely to be disputed, unless a person who in the opinion of the coroner is within Rule 20(2) objects to the documentary evidence being admitted . . ."

61. Mr Fitzgerald submitted that, putting on one side the question whether the coroner was right to treat Mr Walker's submissions as a general objection to the notes of interview being admitted into evidence, he was plainly in error in determining the matter on the sole basis that the written notes of the police interviews were documents which fell within r.37. It is true that the

written notes were documents which recorded the police interviews of both witnesses, but the actual questions and answers which were thus noted were not, of course, documents within r.37. Thus, there would have been nothing to prevent the interviewing police officers from giving appropriate evidence as to what was said in the course of each interview. Although that evidence would have been hearsay, it is clear that there is no rule of law which precludes a coroner from admitting hearsay evidence: see *R v Greater Manchester Coroner, ex parte Tal*[1985] 1 QB 67, *[1984] 3 All ER 240* at p.84F of the former report, where Robert Goff LJ said:

> "We do not think that it can be fairly said of the Coroner that he allowed hearsay evidence to be received . . .
>
> . . .
>
> But, even if the Coroner had admitted hearsay evidence, we know of no rule precluding a Coroner from admitting evidence of this kind . . . there is no general prohibition against admission of hearsay evidence, either in the Coroners Act 1887 . . . or in the Rules. Indeed, there is authority that it is clear that a coroner's inquest is not bound by the strict laws of evidence . . ."

62. We doubt whether the coroner was right to treat counsel's reservations about the contents as an objection to the principle of admitting the notes of the police interview into evidence. Had the note of Mr Hopkinson's interview been suitably edited, it seems clear to us that counsel would have agreed to it being read to the jury. Be that as it may, we are satisfied that Mr Fitzgerald is correct in submitting that the coroner was wrong in law to hold, in effect, that r.37 of the 1984 Rules prevented him from admitting evidence of the police interviews into evidence. The interviewing police officers were available and could have given evidence about what was said by each witness during the police interviews in question. By having regard only to the written notes of the interviews, and treating them as documents to which the provisions of r.37 applied, the coroner misdirected himself because he failed to give any general consideration to the admissibility of other evidence as to what was said during those interviews, such as the evidence of the interviewing officers. On behalf of the coroner, Miss Hewitt did not seek to submit otherwise.

63. For all these reasons, therefore, there was in our judgment an insufficiency of inquiry by the coroner with regard to the evidence of Dr Sen and Mr Hopkinson in both the respects suggested by Mr Fitzgerald and we accept his submissions to that effect.

F. Mr Wass and Mr Sanderson

64. Mr Fitzgerald's next complaint was that there was a further insufficiency of inquiry by the coroner in relation to the evidence which might have been given by two further witnesses who could have given evidence about Mr Hay's condition during the last three hours of his life. Although the coroner had read statements taken from these witnesses and had accepted that they could give relevant evidence, he declined to adjourn the inquest to enable these two witnesses to attend. This issue arose in the following way.

65. In the autumn of 1996 Mrs Hay's solicitors interviewed two other prisoners who had been in the hospital wing on the night of 7th-8 July. By the time the inquest took place one of them had been released from prison (although his home address was known) and the other had been moved to Wormwood Scrubs. Witness statements were drawn up for each of them, on the basis of what they had said, but these had not been signed by either of them. The solicitors did not send copies of these two statements to the coroner, so that he saw them for the first time on the morning the inquest began, although their names (which cannot have meant anything to him) had been mentioned in a letter he

received from those solicitors the previous day.

66. The first of these prospective witnesses was Mr Damien Sanderson. His draft witness statement shows that he was in a cell whose door was only about ten steps away from the cell in which Mr Hay was placed. He explained why it was very easy to hear noises from other people's cells. On this particular morning he heard some noises at about 4am. They sounded like very heavy breathing noises, as if somebody had just finished some heavy exercise. The person who was making the noises was also shouting about pains in his chest, Mr Sanderson could clearly hear him in great distress.

67. He then heard this person talking to the night officers and complaining loudly about his chest pains. He was still breathing very heavily. He heard the prison officers trying to reassure him, and he also heard one of them walk away. Shortly afterwards he heard the person discussing with a prison officer the type of pain-killing tablets he was about to be given. He was still breathing heavily at that time. Mr Sanderson then drifted off to sleep. No one from the police or prison services had ever asked him if he had any useful evidence to give about what he had heard that night.

68. The other prospective witness was Mr Nigel Wass. Some time after 2am he heard some noises and saw two prison officers bringing Mr Hay into the wing and putting him in the cell next to his. He had to be supported by the officers, and he was breathing very heavily, panting and complaining of chest pains. Mr Wass was also listening to the manner in which Mr Hay was asking questions about the tablets he was being given. He said they did not seem to make any difference because he kept breathing very heavily and he was still in a lot of distress. Mr Wass must have dozed off then.

69. The particular relevance of the evidence of these two potential witnesses lay in the way they both laid stress on the heaviness of Mr Hay's breathing when he was on the hospital wing. This turned out to be of importance in the light of Professor Marks's evidence on the first afternoon when he explained that he had attached importance in his written report to Mr Warner's evidence that Mr Hay had been gasping for breath. In an earlier question the coroner had reminded the professor that Mr Hopkinson had not confirmed that Mr Hay was gasping for breath. When Mr Glasson asked him how significant a sign this was, Professor Marks replied:

> "Well I thought quite important as you know in writing my report. It would be said that this was just a layman observing this phenomenon, it was not reported by those who should have or might have noticed it. I think it is very important particularly in somebody who we know has got diabetes who has had blood/sugars of 20 not long before. I must admit that if I found the result of 11, I would scratch my head and think, 'Oh dear, what is going on?' It does not hang together nicely."

70. Mr Glasson also included the evidence that he was gasping for air in a compendious question he put to Professor Keen about Mr Hay's signs and symptoms at 2.30am. Professor Keen replied:

> "Well as you describe them you describe diabetic ketoacidosis of course. The thing that really is difficult to reconcile with that is a blood glucose of 11.5."

71. He added that he was still troubled about the diarrhoea which just did not fit the picture. He then explained that the fact that diarrhoea had been present for some hours up till 1am meant that there was some process going on which might have triggered the ultimate evolution of ketoacidosis, but he found it very difficult to reconcile a slightly raised blood glucose with the sort of severe air hunger counsel was suggesting.

72. At the start of the two-day hearing Mr Glasson invited the coroner to consider whether the statements

of Mr Wass and Mr Sanderson were relevant to his inquiry. He drew his attention to the way they spoke of panting and laboured breathing. From the outset the coroner showed himself unwilling to contemplate an adjournment, but he undertook to consider these statements, copies of which were then handed to him. At the end of the first morning the coroner invited Mr Glasson to show copies of these statements to the representatives of the other parties. He said that they could be put in evidence if nobody objected, but if there was an objection, that was the end of it, since he was not prepared to consider a further adjournment for the sake of putting those statements in.

73. The following morning Mr Glasson told the coroner that counsel for the Home Office and Dr Sen objected to the statements being admitted under r.37, and he renewed his applications for these two witnesses to be summoned, since they could give evidence as to the deceased's state in the immediate hours leading to his death. The coroner said it was fair to say that the inquest had received evidence about the gasping for air from one of the prisoners, so that there was evidence there. After further exchanges he said he would issue a direction that efforts be made to bring two prisoners to court, but if they could not be brought that day, then the inquest would have to do without them.

74. When the evidence was completed shortly after 12 noon, the coroner told Mr Glasson that he had ascertained that one of the witnesses was in Wormwood Scrubs and the other released from custody, so that it was not going to be possible to get them to the court that day. Mr Glasson renewed his application that they should be brought, and asked that the inquest should be adjourned for a few days for this purpose. He said that these witnesses could clearly give relevant evidence as to whether Mr Hay was panting or gasping for air, and that the evidence on this issue was disputed.

75. He added that now he knew for the first time all the witnesses the coroner was intending to call, it seemed to him that the evidence of an officer named Hennigan who took blood from Mr Hay on the Saturday night and Sunday morning might be relevant, in terms of anything Mr Hay told him about his diabetes, as might the evidence of a prison officer called Sharpe who accompanied Mr Hopkinson to Mr Hay's cell.

76. The coroner replied that he felt that the evidence had been fully gone into, and that the extra witnesses Mr Glasson was mentioning would simply be underlining some of the things that had already been said. He felt that they had sufficient evidence to enable the jury to come to a proper conclusion. He was also mindful of the problems of having an adjournment and getting everybody back again. He therefore refused the application, and after hearing some legal submissions from the parties' lawyers, the proceedings were concluded that day with his summing up and the jury's verdict.

77. Mr Fitzgerald submitted that the problems which arose at the inquest were the inevitable consequence of the coroner's unwillingness to send his solicitors a list of the witnesses he intended to call. If Mr Wass and Mr Sanderson were not named on the list, then his solicitors would have spotted this, and arrangements would have been made in good time for them to attend the inquest, since their addresses were known. He argued that the coroner had been wrong to reject the possibility of hearing relevant and important evidence in an inquest concerned with a death in custody on the grounds of administrative inconvenience. He pointed out that the coroner's attitude throughout his exchanges with Mr Glasson had been characterised by an unwillingness to adjourn the inquest until another day in any circumstances.

78. Miss Hewitt submitted that this was a matter for the discretion of the coroner, and we should be slow to overrule him in a matter like this. In our view, however, the coroner failed to pay sufficient attention to the potential importance of the evidence Mr Wass and Mr Sanderson were capable of giving. The experts were clearly puzzled by the low reading of 11.5 taken by Mr Hopkinson. If the jury had accepted the evidence of these two witnesses about the heaviness of Mr Hay's breathing, a matter not mentioned by either of the officers in the hospital wing, then it was on the cards that they might have returned a different verdict. In *R v Southwark Coroner, ex parte Hicks*[1987] 2 All ER 140, [1987] 1 WLR 1624 Croom-Johnson LJ spoke at p.1630D of the latter report of the public importance of having a full investigation of the circumstances of a death in prison. In *Re Rapier (deceased)*[1988] 1 QB 26, [1986] 3 All ER 726 Simon Brown LJ referred at p.39E of the former report to the need for a full and proper inquest in such a case with all material matters placed before the jury. A similar reference to a need for a thorough investigation in a case concerned with a death in custody is to be found in the judgment of Newman J in *R v HM Coroner for Coventry, ex parte O'Reilly* (1996) 35 BMLR 48.

79. It follows that we consider that Mr Fitzgerald's criticisms are well founded. The coroner ought in the circumstances to have adjourned the inquest so that the evidence of Mr Wass and Mr Sanderson could have been made available to the jury on what was a highly relevant issue. Apart from those employed in the prison, only Mr Firman was called to attest to Mr Hay's condition after he had arrived in the prison wing, and he went back to sleep so quickly he was unable to give evidence as full as that which might have been forthcoming from the other two prisoners. The difficulty stemmed directly from the coroner's unwillingness to give advance notice of the names of the witnesses he intended to call. We are not so impressed by the submission that the coroner was at fault for being unwilling to adjourn the inquest in order to see if the other two men mentioned by counsel at the end of the hearing might be able to give relevant evidence, and we would not be willing to interfere on that ground alone, which Mr Fitzgerald did not very seriously press.

G. Summing Up: Accident

80. Mr Fitzgerald's next complaint was that in effect the coroner directed the jury that the only verdict properly open to them was one of death by natural causes. In particular, he had suggested that accidental death was not really the right kind of verdict in these circumstances. In his affidavit the coroner rightly said that he did not suggest that this verdict was only applicable to a road accident. Mr Fitzgerald complained, however, that the coroner did not address in his evidence his client's complaint that the clear implication in his direction was that accident/misadventure was not the appropriate verdict. Nor did he address the complaint that he had failed to direct the jury on the possibility that it may have been an appropriate verdict given that the administration of Fortisip made a substantial contribution to Mr Hay's death. If the Fortisip had not been administered, it would have been open to the jury, if carefully directed, to consider that there was a good chance that Mr Hay would have survived till such time when a doctor would have been present at the wing in the ordinary course of daily duty and been able to take appropriate action to correct his deteriorating condition. The possibility that Mr Hopkinson's reading of 11.5 was incorrectly taken, by accident, was not very fully explored at the inquest, but Professor Marks spoke of erroneous readings, and the combination of an erroneous reading and a well-meaning, but wrong, administration of Fortisip could have led a jury, if

properly directed, to conclude that an accident, or a combination of accidents was a substantial cause of this death.

81. Mr Fitzgerald also complains that the examples given by the coroner failed to embrace the occasions where this verdict is appropriately entered in order to reflect a medical intervention which takes a sudden and unexpected turn for the worse. He submits, correctly, that the verdict may be returned where the death has been caused by some deliberate, but lawful, act which unforeseeably leads to death as well as in situations where death results from an unintended act or an event over which there was no human control.

82. In our judgment, the summing up was defective in this respect. On this evidence, and in particular the evidence of Professor Marks, a verdict of accident was properly available to the jury if they found that the administration of Fortisip unintentionally contributed to Mr Hay's death to any substantial extent, as Professor Marks suggested.

H. Summing Up: Accident (or natural causes) aggravated by neglect

83. Mr Fitzgerald was, in our judgment, on weaker ground when he criticised the coroner's approach to a possible verdict incorporating a finding of neglect. In *R v North Humberside Coroner, ex parte Jamieson*[1995] QB 1 the Court of Appeal resolved a lot of the uncertainties surrounding the availability of this verdict, and it would be prudent to approach with care any pre-1995 judgments in the Divisional Court, to some of which Mr Fitzgerald drew our attention, to the extent that the law has now been stated clearly in *ex parte Jamieson*. Self-neglect is comparatively easy to recognise. As Sir Thomas Bingham MR observed at p.24G:

> "Cases arise, usually involving the old, the infirm and the senile, where the deceased contributes to his or her own death by a gross failure to take adequate nourishment or liquid, or to obtain basic medical attention, or to obtain adequate shelter or housing."

84. "Neglect" is the obverse side of that coin. The relevant carer, or carers, on whom the deceased was dependent (because of youth, age, illness or incarceration), must equally have been guilty of a gross failure to give adequate nourishment or liquid, to give basic medical attention, or to provide adequate shelter or housing.

85. In the present case there was, in our judgment, no evidence fit to go to the jury that Mr Hay's death was caused by natural causes aggravated by neglect (or its exceptionally rare variant, accident aggravated by neglect: for its rareness, see *R v Portsmouth Coroner, ex parte Anderson*[1988] 2 All ER 604, [1987] 1 WLR 1640 per Mann LJ at p.1648A of the latter report). He was taken to the hospital wing as soon as his deteriorating condition was identified. A doctor's advice was sought, and medicines were administered in consequence of that advice. He was observed every 15 minutes: there was no challenge at the inquest to that evidence. Sadly, he died within three hours of admission to the hospital wing, and there was expert evidence to the effect that young diabetics have been known to die with frightening suddenness.

86. It would, of course, have been better if the coroner had given the jury a more precise direction on the facts and the law, once he had decided to make this verdict available to them, instead of limiting himself to quoting verbatim from the relevant passage in the former Master of the Rolls's judgment in *ex parte Jamieson* and then saying "so we are talking about a very bad example of somebody making a mess of things". We would respectfully support in this context what the Court of

Appeal has recently said in *R v Inner South London Coroner, ex parte Douglas-Williams*[1998] 1 All ER 344 about the need for standard directions to be prepared for the assistance of coroners. We would add that if the Judicial Studies Board, the Coroners' Society, or some other body were to be entrusted with the task of providing the help for coroners which these two cases have shown to be necessary, they would probably need to be provided with additional resources to undertake this important public duty, which would be likely to eliminate a lot of needless difficulties in future. We do not, however, consider that the coroner's failings in this respect would in themselves provide grounds for the intervention of this court.

I. Conclusion

87. For the reasons we have given, we are of the opinion that by reason of irregularity of proceedings and insufficiency of inquiry it is open to us to consider whether it is necessary or desirable in the interests of justice that another inquest should be held. It is now settled that one of the relevant tests we should apply it to consider whether it is *possible* that a new inquest would furnish a different verdict (see *Re Rapier (deceased)*[1988] 1 QB 26). In our judgment that test is satisfied, and in any event there were enough shortcomings in the way this inquest was conducted to make it desirable to order a fresh inquest. These are the reasons why we said at the end of the hearing that we would direct that another inquest be held into Mr Hay's death by the coroner for another district in the administrative area of Lincolnshire.

88. In the circumstances we need say nothing about the alternative claim for judicial review, save to say that there were, in our judgment, sufficient grounds for quashing the inquisition by reason of procedural impropriety if it had been necessary to consider whether certiorari should issue. We are content, however, to limit our order, save as to issues concerned with costs, to the proceedings arising out of the Attorney-General's fiat.

JUDGMENT AS TO COSTS

BROOKE LJ

In this matter Mr Fitzgerald, quite properly, applies for costs in favour of his legally aided client. He has very helpfully submitted to the court a note which draws our attention in particular to two recent authorities which suggest that it would be appropriate to make such an order. The usual practice in these cases is, in my judgment, clearly set out in 11 Edition of Jervis on Coroners published in 1993 at page 348 which reads:

> “Cases where the coroner loses are more difficult. The basic rule, derived from cases involving magistrates' courts and other inferior tribunals, is that if a coroner does not appear at the hearing, and (although he has been found to be in the wrong) he has done nothing calling for strong disapproval, then the court will not make an order for costs against him.”

Three cases from the 1980s are cited in support of that proposition. On the other hand, if the coroner has done something calling for strong disapproval, then the court may make a costs order against him. Two cases are cited in relation to that proposition. If the court is minded to make such an order, then the court should give the absent coroner the opportunity to attend to make representations. These principles apply to a situation in which the Coroner does not appear at the hearing. The learned editor goes on:

> “If the coroner does appear at the hearing, and loses, then the court has a discretion whether to order the coroner to pay the successful applicant's costs, even though he acted reasonably. But such an order has only rarely been made.”

Then there is a reference to a case in 1983:

> “Usually no order is made unless the Coroner's behaviour

called for strong disapproval."

There are seven cases dating from 1974 to 1993 supporting that proposition. One additional factor said to militate against making a costs order applies where the applicant is legally aided, and therefore it would only be the public paying the public.

In my judgment, this passage from Jervis sets out correctly what the practice of the judges in the Divisional Court has been for many years in a case of this type where an application for costs is made against a Coroner.

In *R v West Yorkshire Coroner, ex parte Smith (No 2)*[1985] 1 QB 1096, 149 JP 97 Webster J said this:

> "Mr Simon Brown [who appeared for the coroner] made these submissions as to the practice of this court in relation to the making of order for costs in cases where an application for judicial review is made against a public judicial body. He submitted that it is singularly unusual for any order for costs to be made against such a body in the absence of any misconduct on its part, even if that body appears at the proceedings to resist the application. Where the body does not appear to resist the application . . . then in Mr Simon Brown's experience, he had never known of an order for costs being made against the judicial body in question in the absence of misconduct. I must say that understanding of the practice accords with my own."

In my judgment, that passage clearly and correctly sets out the long established practice in this court.

Mr Fitzgerald has drawn our attention to two cases decided during the last four years where this court has exercised its discretion to make orders for costs against a Coroner. The first was *R v HM Coroner for Kent, ex parte Johnstone*(1995) 158 JP 1115 [1995] 6 Med LR 116. In that case it is quite clear that the Divisional Court was troubled because the successful applicant had had to finance his representation and was not in receipt of legal aid, and McCowan LJ applied the principle that where the Coroner appears and fights the case, and loses, then he may be liable to pay costs. This is clear from his short judgment at page 127.

More recently, that decision was followed in *Re Clegg (deceased)*(1997) 161 JP 521. In this case the court (Phillips LJ and Hooper J) received written submissions about costs and did not have the advantage of oral argument. Miss Hewitt has pointed out to us that since the court refused to make an order under s.13 of the Coroners Act 1988, it had no jurisdiction to make the order for costs it made against the Coroner, because it did not have the requisite jurisdiction under s.13(2) of the Coroners Act 1988 because the section did not apply (see s.13(1)) when the court did not order another inquest. Be that as it may, on that occasion the court went much further than its established practice and made an order for costs against a Coroner who merely swore an affidavit and took no part in the proceedings at all. In my judgment, that order, although no doubt made because the court was concerned about its inability to make an order out of public funds in favour of the applicant, did not follow the established practice of the court in any way.

Mr Fitzgerald has shown us the analysis of the position in civil cases before justices contained in the judgment of Rose LJ in *R v Newcastle-under-Lyme Justices, ex parte Massey*[1995] 1 All ER 120, [1994] 1 WLR 1684. In my judgment, the situation there is quite different. The justices are sitting as an adjudicating tribunal with a lis in front of them between a local authority and the citizen. They have the ability to file an affidavit without being at risk as to costs and, in those circumstances, Rose LJ explained that if the justices, having filed their affidavit, then go on to refuse to sign a consent in Crown Office civil proceedings in accordance with the Practice Direction and appear by counsel to resist the making of the order, then they are at risk as to costs in accordance

with the principles set out in that judgment.

In my judgment, that situation is quite different from the situation here when a Coroner is carrying out his important statutory duty to conduct an inquest. In this context the relevant principle appears to be that if a coroner not only files an affidavit but also appears and contests the making of an adverse order in an inter partes adversarial mode, then he or she is at risk as to costs. If, on the other hand, the Coroner, as is fitting for somebody holding judicial office, swears an affidavit to assist the court and then appears in court, more in the role of an amicus rather than as a contesting party, then the court is likely to follow the normal rule set out in Jervis and make no order as to costs provided that it does not express strong disapproval of his or her conduct.

In this case Miss Hewitt and her client nearly followed the example of the Coroner in *ex parte Johnstone* and were at risk as to having an order as to costs made against the Coroner, at any rate as to part of the proceedings.

I have delivered a slightly longer judgment than it is usually necessary to give in a costs matter in order to set out as helpfully as I can to Coroners what the usual practice of the court is. It goes without saying that the court is greatly assisted by Coroners who depose to what took place before them and then appear in court to assist the court in an amicus role. On the present occasion the court was indebted to the Respondent for obtaining the assistance of the Coroners' Society and for providing the court with a very helpful affidavit from the Secretary of the Society which would not have been possible if the Coroner had not been present and represented.

For these reasons, in my judgment, this is not a case in which it would be appropriate to make an order for costs against the Coroner. Mr Fitzgerald is of course entitled to his legal aid taxation.

This line of recent cases shows up, to my mind, the need for Parliament to consider permitting the courts to make an order for costs out of public funds to a successful applicant in a situation like this. The cases we have shown reveal that the courts are very anxious about the position of an applicant who has been put to considerable expense, whether legally aided or not, to obtain an order of this type. In my judgment, it would be wholly appropriate for the courts to be able to make an order to be made out of public funds to a successful applicant in such circumstances.

On the other hand, if the court were to follow a new practice of making an order for costs against the Coroner simply because there is no available public purse for which to make the order, then this could lead to the disadvantage that the court would not get, or would be much less likely to get, the assistance of Coroners in the way that the court has traditionally been very grateful to receive it over the years.

I would add that whether or not the Coroner is receiving an indemnity from his or her local authority in relation to his or her costs of the proceedings and any costs he or she might be ordered to pay in my judgment really takes the matter no further. It is central funds which ought to be the payer rather than the local authority, unless of course the coroner has done something which evokes strong disapproval or takes an adversarial role in the proceedings.

For these reasons, I would not grant Mr Fitzgerald's application for costs against the Coroner.

FORBES J

I agree.

Application allowed.
