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Delivered: 12/12/2025

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

**KING'S BENCH DIVISION
(JUDICIAL REVIEW)**

**IN THE MATTER OF AN APPLICATION BY MARGARET DRAKE
FOR JUDICIAL REVIEW**

**Mr Henry KC with Mr Fitzsimons (instructed by Holmes & Moffit Solicitors) for the
Applicant**

**Mr Scott (instructed by the Coroners Service) for the Respondent
Mr Daly (instructed by the Directorate of Legal Services) for the Belfast Health & Social
Care Trust, Notice Party**

McLAUGHLIN J

Introduction

[1] This is an application for judicial review of a decision by Coroner Toal (hereinafter 'the coroner') dated 2 May 2025, to issue a notice pursuant to section 17A of the Coroners Act (Northern Ireland) 1959 ("the 1959 Act), requiring the applicant to produce to the coroner an expert report by Dr Husain which the applicant had commissioned for the purposes of an inquest into the death of Stephen Moore ("the deceased"). The applicant is the deceased's next of kin and was a properly interested party to the inquest. Having commissioned the report, the applicant informed the coroner that she did not propose to rely upon the evidence of Dr Husain and declined to produce the report. In a series of reasoned written decisions, the coroner decided that the report was relevant to the inquest, issued the notice requiring production of the report to her and later refused to revoke the notice.

[2] Leave to apply for judicial review was initially refused by the High Court but granted by the Court of Appeal on 24 June 2025, following a renewal of that application.

[3] I am very grateful to all counsel for their extremely helpful oral and written submissions.

[4] The application for judicial review was commenced in the course of an inquest which had already heard a significant amount of evidence. The circumstances of the death will be determined by the coroner in due course, following conclusion of all evidence. It is not therefore, appropriate for this court to comment extensively upon the substantive issues under consideration. The following outline of events focuses upon procedural matters and any commentary upon the facts should not be interpreted as a conclusion or finding of fact which is binding upon the coroner. All parties were agreed that it was appropriate to determine the challenge during the course of the inquest, on the basis that it would ultimately reduce the risk of the inquest having to be re-heard if a successful challenge was mounted after the findings were given. The case also raises an issue of principle which is of wider importance, rather than a dispute over the application of established principles. It is therefore an example of the type of exceptional circumstances in which the court will entertain a challenge to procedures at an inquest, prior to its conclusion.

Background

[5] Mr Stephen Moore was born on 23 September 1956. On 17 September 2018, he fell from a ladder. He suffered multiple left-sided rib fractures and a pneumothorax. He was taken to the Royal Victoria Hospital, Belfast, where he was admitted onto a cardiothoracic surgery ward. Mr Moore remained on this ward until he was found dead on 27 September 2018 by a member of the nursing staff. His death was reported to the Coroners Service by PSNI on 28 September 2018. A post mortem was carried out and the pathologist's report contains the following description of the circumstances of his death:

"At around 14.30 hours on 27 September, he was found by a staff nurse in the toilet, hanging by his neck from a shower cord having last been seen approximately an hour before. He had also attempted to cut his wrist. At the time of discovery, he was unresponsive and without a pulse and CPR was started and the arrest team was called. The ward staff lifted and cut him down from the cord. After around 25 minutes of CPR, life was pronounced extinct.

The presumed cause of death was reported as suicide by hanging, traumatic rib fractures and delirium.

Additional information was also received from the police and from this I understand that the deceased was found hanging by the neck from a shower cord with his legs

touching the ground. He was found by a staff nurse who initially identified blood at the scene and a razor with part of it missing.”

[6] The commentary section within the post-mortem report records injuries consistent with a ligature around the neck and self-inflicted injuries to the right forearm. The pathologist also noted the following:

“The injuries sustained during the fall did not appear to have played a direct role in his death. That said, he reportedly suffered a period of delirium following this in hospital which could have arguably altered his state of mind. Equally, the presence of rib injuries and plural effusion could have also decreased his body’s ability to efficiently react to the effects of the ligature compression and bleeding, thus arguably playing an indirect role in his demise.”

[7] The post mortem report records the cause of death as:

- I. Suspension by ligature and incised wounds of right wrist.
- II. Multiple rib fractures following a fall.”

[8] On 27 November 2019, a decision was taken to hold an inquest into the death of Mr Moore and Coroner Toal assumed conduct of the inquest on 16 November 2020.

[9] There are two Properly Interested Persons (“PIPs”) to the inquest: the applicant, as Next of Kin, and the Belfast Health & Social Care Trust (“Trust”).

[10] On 17 November 2022, the Coroners Service instructed Professor Palazidou, Consultant Psychiatrist, to provide an expert report to the coroner. She was instructed to address a number of issues including (in summary):

- (a) whether it is likely that the deceased died by his own hand while the balance of his mind was disturbed;
- (b) whether his former mental health issues, chronic back pain and neck injuries may have contributed to his death; and
- (c) whether agitation and delusional behaviour in hospital may have contributed to his death.

[11] The report from Professor Palazidou was received on 12 February 2023. Following review, she was asked a number of follow up questions by the Coroners Service, which were answered on 19 April 2023 in a supplemental report. Both reports were shared promptly with the PIPs.

[12] In February 2023, the coroner circulated a scope document for the inquest which set out the issues for investigation, namely (in summary):

“(1) Was Mr Moore delirious at any point following his admission to the Royal Victoria Hospital on 17 September 2018;

(2) If so,

(a) What was the cause(s) of the delirium?

(b) Were the staff aware that Mr Moore was delirious?
If not, why not?

(c) What treatment (if any) could have been of benefit to Mr Moore to treat or manage the delirium?

(d) Did Mr Moore receive that treatment? If not, why not?

(3) Was Mr Moore delirious at or around the time of his death?

(4) Did Mr Moore die by his own hand?

(5) If the coroner finds that Mr Moore did die by his own hand, was the balance of his mind disturbed at that time?”

[13] Following disclosure of Professor Palazidou’s report, no substantive changes to the scope of the inquest were proposed by the PIPs.

[14] In late September 2023, the Coroners Service identified hearing dates in late December 2023 in Banbridge. On 6 November 2023, the Trust informed Coroners Service that it intended to instruct its own independent Consultant Psychiatrist (Dr Armstrong) to address issues relevant to the scope of the inquest and which had been addressed by Professor Palazidou. The report from Dr Armstrong was produced by the Trust to the coroner on 11 December 2023 and, thereafter, shared with the next of kin.

[15] On 13 December 2023, the applicant wrote to Coroners Service requesting an adjournment of the inquest to enable the family to instruct their own independent expert evidence. The application was made in correspondence of 13 December 2023, which explained the rationale in the following terms:

“... we were previously aware that Professor Palazidou had been instructed by the coroner and had provided her report. It was provided in order to assist the coroner and the inquest. We were not aware the Trust was obtaining its own expert report. On 12 December 2023, we received a report from Dr Armstrong. He attempts to undermine a number of Professor Palazidou’s conclusions which were of some importance to the NoK.

We find ourselves in a difficult position. On the one hand, the NoK would like the inquest to conclude. However, on the other, they want it to proceed on a fair footing.

The last minute addition to the expert evidence means the NoK is disadvantaged. The equality of arms and natural justice principles are engaged ...”

[16] By correspondence the following day, the coroner allowed the application and adjourned the inquest.

[17] It took some time for the applicants to secure legal aid funding and to identify a suitable expert witness. At a preliminary hearing on 11 December 2024, the coroner was informed that an expert had been identified but that legal aid authority remained outstanding. This position remained unchanged during January 2025 and further preliminary hearings were also adjourned. On 28 January 2025, counsel for the coroner was informed by counsel for the applicant that legal aid authority had been granted. On 2 April 2025, the applicant’s counsel confirmed that the report of Dr Husain had been received.

[18] By correspondence of 24 April 2025, solicitors for the applicant informed the coroner that she did not intend to rely upon or produce to the coroner the report of Dr Husain. The letter referred to section 17A(4) of the Coroners Act (NI) 1959 (“the 1959 Act”) and it was stated that this position was based upon paras [36] and [37] of the decision of the Court of Appeal in *Re Ketcher and Mitchell* [2020] NICA 31, [2021] NI 306.

[19] On 20 February 2025, the coroner had fixed hearing dates for the inquest on 27-30 May 2025 in Banbridge. She had also produced a schedule of witnesses required to give oral evidence, the dates of their evidence and those whose evidence was agreed under Rule 17. Witnesses were scheduled on Tuesday 27 May 2025 and

Wednesday 28 May 2025 with Thursday 29 May 2025 set aside for the expert evidence.

[20] On 2 May 2025, the coroner issued a notice to the applicant pursuant to section 17A of the 1959 Act requiring the applicant to “produce to the coroner, the report of Dr Husain obtained by you and in your custody and control, which is relevant to the inquest into the death of Stephen Moore.” The report was to be disclosed by 8 May 2025. The notice was supported by detailed written reasons issued on the same date.

[21] In response, the applicant made a written application to the coroner pursuant to section 17A(2)(b) of the 1959 Act to revoke the notice of 2 May 2025. The grounds for the application were again focused upon the decision in *Re Ketcher and Mitchell*.

[22] In a further written ruling of 12 May 2025, the coroner refused to revoke the section 17A notice.

[23] Pre-action correspondence was sent by the applicant on 14 May 2025, to which the coroner responded on 15 May 2025. The application for judicial review was filed on 22 May 2025. Leave was refused by McAlinden J on 23 May 2025 and the inquest opened, as scheduled, on 27 May 2025. Oral evidence was heard on both 27 and 28 May 2025 but adjourned by the coroner following an indication by the applicant that the application for leave would be renewed before the Court of Appeal. The inquest therefore remains part heard pending the outcome of these proceedings.

Statutory framework

[24] Section 49(2) and Schedule 11 to the Coroners and Justice Act 2009 (“the 2009 Act”) (an Act of Parliament) came into force on 29 February 2016, [S.R.2016/23]. The new provisions repealed section 17 of the 1959 Act and inserted new sections 17A, 17B and 17C into the 1959 Act, which empower the coroner to issue notices requiring, *inter alia*, the attendance of witnesses, the production of documents or the preparation of a witness statement. Prior to the amendments, section 17 of the 1959 Act empowered a coroner to issue a summons for the attendance of a witness at an inquest. However, the coroner did not have a power to compel the production of documents, save for those received from police pursuant to its duty under section 8 of the 1959 Act. It requires police to provide the coroner with “such information ... in writing” as police are able to obtain concerning the death. In order to secure production of relevant documents, the coroner was required to seek the assistance of the High Court pursuant to Order 38, rule 17 of the Rules of the Supreme Court (NI) 1980.

[25] The 2009 Act also introduced equivalent (but not identical) powers for England & Wales, which empowered coroners to require evidence to be given or documents to be produced to the coroner (section 32, Schedule 5, Para 1, 2009 Act).

The England & Wales provisions have been in force since 25 July 2013 (S.I.2013/1869). Accordingly, the same Act of Parliament introduced equivalent amendments in both Northern Ireland and England & Wales, which were commenced at different times. As recorded in the Explanatory Notes for section 49 of the 2009 Act, the purpose of the amendments for Northern Ireland was to “bring Northern Ireland into line with the reformed system in England & Wales.”

[26] Section 17A of the 1959 Act provides in relevant part as follows:

“17A(1) A coroner who proceeds to hold an inquest may by notice require a person to attend at a time and place stated in the notice and –

- (a) to give evidence at the inquest,
- (b) to produce any documents in the custody or under the control of the person which relate to a matter that is relevant to the inquest, or
- (c) to produce for inspection, examination or testing any other thing in the custody or under the control of the person which relates to a matter that is relevant to the inquest.

(2) A coroner who is making any investigation to determine whether or not an inquest is necessary, or who proceeds to hold an inquest, may by notice require a person, within such period as the coroner thinks reasonable –

- (a) to provide evidence to the coroner, about any matters specified in the notice, in the form of a written statement,
- (b) to produce any documents in the custody or under the control of the person which relate to a matter that is relevant to the investigation or inquest, or
- (c) to produce for inspection, examination or testing any other thing in the custody or under the control of the person which relates to a matter that is relevant to the investigation or inquest.

...

- (4) A claim by a person that –

- (a) he is unable to comply with a notice under this section, or
- (b) it is not reasonable in all the circumstances to require him to comply with such a notice,

is to be determined by the coroner, who may revoke or vary the notice on that ground.

(5) In deciding whether to revoke or vary a notice on the ground mentioned in subsection (4)(b), the coroner shall consider the public interest in the information in question being obtained for the purposes of the inquest, having regard to the likely importance of the information.

...

(8) Nothing in this section shall prevent a person who has not been given a notice under subsection (1) or (2) from giving or producing any evidence, document or other thing."

[27] Section 17A(6) provides a coroner with a power to fine any person who fails to comply with a notice under section 17A(1) or (2). This power is without prejudice to any other power available to coroners to compel the person to appear, to provide evidence, to produce any document or other thing, or to punish that person for contempt of court (section 17B of the 1959 Act).

[28] Section 17B also provides in material part, as follows:

"17B(2) A person may not be required to give or produce any evidence or document under section 17A if –

- (a) he could not be required to do so in civil proceedings in a court in Northern Ireland, or
- (b) the requirement would be incompatible with a community obligation.

(3) The rules of law under which evidence or documents are permitted or required to be withheld on grounds of public interest immunity apply in relation to an inquest as they apply in relation to civil proceedings in a court in Northern Ireland."

[29] The application of these provisions is analysed in more detail below.

***Re Ketcher and Mitchell* [2020] NICA 31, [2021] NI 306**

[30] Ketcher and Mitchell were soldiers found dead, hanged, in their barracks. An inquest took place into the deaths. The coroner commissioned a psychiatric report into each of the deceased. Both families were dissatisfied with the report and commissioned their own psychiatric report. The inquest was adjourned to allow preparation of the report and other matters. The families later refused to produce the report to the coroner who issued a notice pursuant to section 17A, compelling production. The families challenged the notice, contending that it was covered by litigation privilege. They also argued that an inquest constituted “civil proceedings”, for the purposes of section 17B(2) and that disclosure could not be ordered.

[31] The judicial review was dismissed at first instance. On appeal, the Court of Appeal analysed the common law authorities on litigation privilege and concluded that it was bound by the decision of the House of Lords in *Three Rivers District Council v Governor and Company of the Bank of England (No.5)* [2005] 1 AC 610, in which it was held that litigation privilege only applied if the proceedings were adversarial, rather than investigative or inquisitorial. Accordingly, the Court of Appeal considered that the assertion of litigation privilege must fail and the appeal was dismissed. The Court of Appeal also made clear that if it had not been bound by authority, it would have preferred the approach to litigation privilege explained by Lord Nicholls in *Re L* [1996] 2 All ER 78 which may have enabled litigation privilege to extend to the report in that case (at [32]). The Court of Appeal explained that, in practice, many inquests - particularly those governed by article 2 ECHR - were conducted in adversarial manner. The Court of Appeal stated:

“[30] ... In most Article 2 inquests involving an allegation of state responsibility for the death, the representatives of the family of the deceased are trying to achieve an opposing outcome to that of the state body. That is why Article 2 requires that both of those parties be involved in the proceedings advancing their respective cases ...”

[32] In *Ketcher*, the applicant challenged the section 17A notice without first making an application under section 17A(4)(b) requesting the coroner to revoke or vary the notice. The Court of Appeal observed that, upon hearing such an application, a coroner is required by section 17A(5) to consider the public interest, having regard to the likely importance of that information. The Court of Appeal then made the following obiter comments:

“[37] First, this was a case in which the coroner already had the report of Prof Fazel. He was clearly satisfied with that report as a basis upon which to proceed with the

inquest. He had no basis for considering that the report held by the appellants would add anything to what Professor Fazel was contributing. It is difficult to say how the likely importance of the outstanding report was other than modest. Secondly, there was no other example of this point being taken in coronial proceedings. That is not surprising. In almost all cases, any expert report would have been obtained by the solicitors representing the properly interested persons and in most cases would have been for the dominant purpose of the civil claim. In truth, the circumstances in which this requirement to produce the report arose was almost fortuitous. Thirdly, in the vast majority of cases there would have been no power to require the production of such an expert report. It is difficult to see, therefore, why the public interest of the coroner in obtaining the report in this case was particularly strong since the interest of the family in preparing their case would normally outweigh it. Fourthly, as part of the public interest calculation, the coroner had to take into account the public interest in encouraging properly interested persons in inquests to carry out appropriate investigations in the preparation of their cases. Compulsory disclosure of such reports as a matter of course would be likely to discourage such investigations. In those circumstances it appeared to us that the balance was highly likely to favour the view that a requirement to disclose the report was not reasonable.”

Decisions of Coroner Toal - 2 May 2025 and 12 May 2025

[33] Coroner Toal issued two detailed written rulings. These were prepared in a short timeframe, with commendable clarity and detailed reasoning.

[34] The first ruling dated 2 May 2025 was issued at the same time as the section 17A(2) notice and explained the reasons for her decision. She noted the background to the inquest, the procedural history and the position adopted by the next of kin. She noted that the report of Dr Husain had been obtained solely for the purposes of the inquest and did not attract litigation privilege. She noted the view of the Trust that the report should be disclosed to her in the first instance, followed by review for potential relevance and thereafter disclosure to the PIPs, if the disclosure threshold was met. She satisfied herself that the requirements of section 17A(2)(b) were met in this case and that her discretion to order production was available. Those requirements were that she was holding an inquest, that the document was under the control of the applicant and that it related to a matter which is relevant to the inquest. She stated that disclosure in an inquest followed a two-stage process. First, the material was produced to the coroner. Following a review by the coroner, some

or all of the material may be disclosed to the PIPs. She confirmed that, at that stage, a further public interest balancing exercise would be undertaken. This would involve consideration of the relevance of the document to the issues under investigation by the inquest, balanced against the damage which might be done to any competing public interests if disclosure took place. She confirmed that this was an “inherently fact specific” balancing exercise which would be conducted in the light of the facts of any particular case.

[35] The coroner expressly considered the decision in *Re Ketcher and Mitchell*. She rejected a submission by the applicant that she should follow the obiter indication that the interests of a family in commissioning its own expert report should prevail. She also rejected a contrary submission by the Trust that she should order disclosure because the court had rejected the challenge to the disclosed notice in *Ketcher*. The coroner stated:

“23. ... Each coroner must approach each inquest individually. It does not follow that a decision by one coroner to require disclosure should automatically be applied in another inquest. Every inquest is different. Accordingly, when a coroner is deciding whether to invoke the power in section 17A(2)(b) in any given inquest, a coroner must focus on the specific circumstances of that inquest.”

[36] Following an analysis of the facts of this case, the coroner distinguished it from *Ketcher*. She concluded:

“26. I would welcome further expert evidence on each of those topics, as that evidence will assist me in my consideration of the central issues. It was for this reason, along with fairness to the next of kin, that I was content to adjourn the original inquest to allow the next of kin to seek their own report.

27. I, therefore, consider that Dr Husain’s report is potentially relevant and potentially of probative value ... and that access to that report would further the public interest in a coroner having access to material that allows them to fully, fairly and fearlessly investigate the facts.

...

30. The position in *Ketcher & Mitchell* is fundamentally different compared to the present inquest. I consider that Dr Husain’s report may well add to my understanding of the issues given the current state of the evidence. That was not the view taken in *Ketcher & Mitchell*. The benefit that Dr Husain’s report may bring to the inquest is

weightier than it was in *Ketcher & Mitchell*. The balancing exercise is, therefore, fundamentally different ...”

[37] The coroner also emphasised that the concern expressed by the Court of the Appeal in *Ketcher* (at [37]) was that coroners might order disclosure of experts’ reports commissioned by a next of kin “as a matter of course”. The coroner considered this case to be different insofar as she had conducted her own analysis of the existing expert reports of Professor Palazidou and Dr Armstrong and identified the areas in which this report might assist in resolving areas on which their opinions differed. She therefore considered her decision to be principled and based upon the facts of this particular inquest, rather than one based upon a mechanistic or generalised application of the public interest analysis set out in *Ketcher*. She concluded:

“35. I cannot fully determine the relevance of Dr Husain’s report to the inquest without reading it. Presently, I consider it is highly likely to be more than modest and could potentially be significant. It is only when I know the content that I have understood the precise degree to which the inquest will be assisted by Dr Husain’s report.

36. I bear in mind that the public interest in non-disclosure differs depending on whether it is disclosure to the coroner or to the PIPs. The public interest in non-disclosure to the PIPs is weightier than non-disclosure to a coroner. This is because of the statutory role that a coroner plays, the fact that a coroner, as a judicial figure, acts as the guardian of the public interest in an inquest they are hearing; and because a coroner can make no use of the information to the detriment of a PIP in any further proceedings after an inquest has concluded.”

[38] The applicant responded to the notice by making an application for revocation pursuant to section 17A(4)(b). In a written submission, it was contended by the applicant that the guidance of the Court of Appeal in *Ketcher* was “persuasive and it is respectfully binding.” The applicant also relied upon the issues which had been identified by the coroner for investigation. The applicant contended that all of these issues could be properly addressed by the existing experts or should properly be considered questions of fact for the health care workers who treated the deceased.

[39] In her second ruling of 12 May 2025, the coroner refused the application to revoke the notice. She considered there was nothing in the applicant’s submission which had changed her mind. She also explained in more detail the assistance which she considered that an additional expert could provide. She stated:

“11. I also take a different view from the next of kin on whether the role that expert evidence can play when considering the question of whether delirium as a concept, and the causes of delirium, were well understood by the health care workers who engaged with Mr Moore. The evidence of Trust staff involved in Mr Moore’s care is inherently subjective. Experts provide more objective evidence. Not infrequently, an expert’s opinion can show that a clinician believes they have a good understanding of a concept but that their understanding is not entirely accurate. Expert evidence, therefore, plays an important role in my assessment of that question.”

[40] The coroner reiterated her analysis of the decision in *Ketcher & Mitchell*. She rejected the applicant’s submission that there should be a different balancing exercise between the relevant public interests and concluded:

“14. I reinforce that my original decision was for disclosure of Dr Husain’s report to me so that I could assess the impact that it will have on the evidence received to date. Once I have assessed it, I will conduct a further balancing exercise where I will consider the competing public interests about whether to disclose the report to the PIPs.”

Submissions of the parties

[41] The applicant made two broad challenges to the coroner’s decision. First, it was contended that the coroner erred by considering that disclosure would follow a two-stage process. The applicant argued that once the report was produced to the coroner, she would be bound to apply a test of “potential relevance” when deciding onward disclosure. It was contended that the bar for disclosure was so low that the disclosure of the report to the PIPs was “inevitable.” The applicant therefore contended that it was unrealistic and entirely artificial to consider that the outcome of any public interest balancing exercise carried out after production of the report would be any different. The applicant highlighted the absence of any statutory procedure governing the process for disclosure of documents by a coroner to the PIPs (as distinct from production to a coroner). The applicant also pointed to section 17B(3) which preserves the application of public interest immunity principles which may permit or require documents to be withheld from disclosure. The applicant acknowledged that these common law principles could be applied by the coroner when deciding whether to make disclosure to PIPs but contended that a coroner could only limit disclosure where the relevant public interest was of a type which had already been recognised by the courts in previous cases. It argued that no

decided case had endorsed the withholding or redacting of documents by a coroner by reason of a countervailing public interest of facilitating families to prepare for an inquest by commissioning expert reports. Insofar as this form of countervailing public interest had been recognised in *Ketcher*, the applicant argued that this only applied at the stage of production of materials to a coroner and not the later stage of disclosure to PIPs by a coroner. Hence, the applicant argued that the coroner had been wrong to believe that she could re-visit the public interest balancing exercise once she had read the report.

[42] The applicant's second ground of challenge arose out of the reasoning given by the coroner for distinguishing this case from *Ketcher*. The applicant acknowledged that the Court of Appeal's comments in para [37] of *Ketcher* were obiter but contended that they were of highly persuasive value which should have provided a "strong steer" to the coroner and that the facts of this case were not materially distinguishable from *Ketcher*. The applicant relied on *Slack v Leeds Industrial Co-operative Society* [1922] Ch 431, at 451 in support of the proposition that some obiter dicta are of greater precedential value than others. It was argued that if the dicta in question expressed a reasoned conclusion by a higher court on an issue of principle, after full argument, the conclusion should carry particular weight and should be followed by an inferior tribunal. The gist of the applicant's submission was that the Court of Appeal in *Ketcher* had given a "strong steer" to coroners as to how they should balance the public interest in disclosure of a relevant document to an inquest against the public interest in facilitating a family to prepare for an inquest. The applicant argued that there were three aspects of the facts of *Ketcher* which, if repeated in a later case, should result in a coroner declining to order disclosure of the expert report or revoking/varying the notice, namely:

- (i) the coroner already had one or more expert reports on an issue within scope;
- (ii) the coroner was willing to proceed with the inquest on the basis of that evidence; and
- (iii) a PIP has an expert report which was commissioned for the purposes of the inquest but is unwilling to share it.

[43] The applicant also presented an analysis of the reports from Professor Palazidou and Dr Armstrong and submitted that the difference between the two opinions was extremely limited.

[44] On behalf of the coroner, reliance was placed upon the general principles governing the conduct of inquests which permit a coroner to determine procedure, with a view to answering the statutory questions, ensuring a full and fair inquiry into the circumstances of the death and doing so in a manner which is fair to all parties. The coroner highlighted existing authorities which supported a two-stage approach to disclosure and it was contended that a coroner was permitted to consider countervailing public interests at the stage of disclosure by the coroner to

PIPs. It was submitted that if the coroner could not follow this process when considering production and/or disclosure of an expert report commissioned by a family, the result would be that these documents would, in effect, enjoy a unique protection from disclosure which was not justified by any statutory provision or existing common law principles. Such an outcome may also risk undermining the effectiveness of an investigation by enabling PIPs to unduly influence the scope of an inquest or the course of the investigations followed by the coroner.

Role of the coroner

[45] As set out above, the Trust elected to adopt a neutral role in the judicial review proceedings, with the result that the coroner was required to defend the challenge through her own counsel. This raised the issue of the proper role of a coroner in a judicial review of their decision.

[46] In the recent case of *R (Maguire) v HM Senior Coroner for Blackpool* [2023] UKSC 20; [2023] 3 WLR 103, the Supreme Court discussed the role of a coroner in a challenge to an inquest decision or verdict. In that case, the PIPs chose not to participate at Supreme Court level and coroner's counsel was the only party to make submissions for the respondent. In the event, the Supreme Court did not receive the full assistance it had hoped for in relation to certain aspects of the facts. The Supreme Court emphasised that the role of the coroner is to remain neutral in a challenge to its decision and to act as an *amicus curiae* to the court. It observed that the role of the coroner is to "assist to ensure that the court is given the full factual picture, including if necessary by drawing the court's attention to matters not emphasised or omitted by a claimant, as well as alerting it to relevant law and authorities." (At [117])

[47] In Northern Ireland, where the decision of a judicial officer or a statutory tribunal is subject to judicial review challenge, the role of the judge/tribunal in responding to the challenge is more limited and must be discharged with care. In *Re Darley* [1997] NI 384, the Court of Appeal held that in a challenge to a decision of the Industrial Tribunal, the opposing party to the proceedings would normally be the contradictor, rather than the tribunal/judge. There are two broad policy reasons for this approach. First, the judge is an independent office holder and not a party to the underlying litigation. It is not generally consistent with that role for the judge to engage in litigation in an adversarial capacity with one of the parties who appeared before it. Second, relatedly, depending upon the outcome of the judicial review, it may be necessary for the judge/tribunal to resume conduct of the proceedings (especially if the challenge arose out of an interlocutory matter). Accordingly, the manner in which the proceedings are defended could affect perceptions about the impartiality of the judge in future conduct of proceedings. The result is that the role of a judge/tribunal in judicial review proceedings is normally limited to ensuring that the court has a full knowledge of all relevant facts relating to the underlying proceedings and also understands both the decision under challenge and the supporting reasons. If a reasoned written decision was given, further explanation is

unlikely to be appropriate or necessary. If the decision under challenge was not recorded in writing, it may be necessary for the judge/tribunal to explain the decision either in correspondence or on affidavit. Where this is necessary, it is essential to avoid any inappropriate amplification or revision of the reasons. Any such supplementary evidence will be treated with care by the court (see eg *JR45* [2011] NIQB 17 at [18]-[20]).

[48] In *Re Jordan* [2016] NI 107, the Court of Appeal reviewed these principles in the context of an inquest (at [14]-[22]). It agreed that the coroner should provide evidence of what happened during the inquest and, if appropriate, appear in court in an amicus role. However, it also recognised that since the proceedings were inquisitorial rather than adversarial, there may frequently not be another party who could act as contradictor. Any PIPs will have their own interests to promote and/or protect. They may be unwilling to appear in the judicial review proceedings or may not be in a position to do so in a wholly independent manner. The Court of Appeal considered that it was ultimately a matter for a coroner to determine whether and to what extent he/she may wish to become involved in an adversarial capacity, bearing in mind the nature of the issue, the stage of proceedings and the possible implications for a perception of bias, if the coroner resumed the inquest. The court emphasised the importance of a coroner having access to the court, not only to explain the reasons for its own decision, but to make submissions on any contrary arguments. The Court of Appeal considered this to be an important aspect of judicial review of a coroner's decision, particularly, where no other party participated. It considered that if the consequence of a coroner's participation gave rise to a future perception of bias, the appropriate remedy may be for a court to direct the inquest should proceed before a different coroner. In my view, I see no inconsistency between the long-established position in Northern Ireland, as explained in *Re Jordan*, and the recent comments by the Supreme Court in *Maguire*. The general principle and starting point will always be that the coroner's role is discharged by ensuring that all relevant facts are placed before the court, together with the reasons for the decision and drawing the court's attention to any relevant authorities or applicable legal principles. A coroner may discharge this function by instructing representatives to appear at the hearing, even where other PIPs are also represented. However, the nature of coronial proceedings is such that there may be occasions in which it is necessary for the coroner to ensure that the court is made aware of all relevant matters and principles or to counter a submission considered to be erroneous which might mislead the court, even if this may have an adversarial appearance and in an extreme case, it may even come at the cost of a coroner's inability to resume conduct of the inquest. All of these matters will be assessed by a coroner when deciding how its role as a respondent should be discharged. In the vast majority of cases, it is likely to be capable of being performed without any risk to the coroner's future impartiality.

[49] In this case, the conduct of the coroner and legal representatives has been exemplary. This is largely due to the clear and comprehensive written rulings made by the coroner which avoided the need for any argument on anything other than

legal principle. Since the reasoning of the coroner had been explained so clearly, the role of the coroner was limited to assisting the court with the facts, the operation of sections 17A and 17B of the 1959 Act in practice and references to governing principles of coronial law. No objection was taken by the applicant to the manner in which the coroner and her representatives discharged their role and it is important to observe that proceedings were conducted with scrupulous independence.

Consideration

[50] It is important to make a number of general observations about the scope and application of sections 17A and 17B of the 1959 Act:

- (i) Inquests are a statutory process. The jurisdiction of coroners derives from the 1959 Act. While many of the practices and procedures governing the conduct of inquests have developed through case law, the process is ultimately a statutory one. Sections 17A and 17B therefore establish the exclusive procedures to be followed by coroners when deciding an issue of production. Within their scope of application those provisions take precedence over contrary common law principle.
- (ii) Section 17A(1) and section 17A(2) overlap very considerably. The former applies once a decision to hold an inquest has been taken, whereas the latter applies both where the decision has been taken, and where it remains under consideration. Under both provisions, the powers to require production of documents or production of an item for inspection, examination or testing are identical. The primary difference between the two provisions is the availability of the power to require a statement of evidence. Pursuant to section 17A(2), the coroner may require a written statement of evidence both when the decision to hold an inquest is under consideration and after it has been taken. Pursuant to section 17A(1) a person can only be required to give evidence in person, once a decision to hold an inquest has been taken. For present purposes, the power to require production of documents applies equally to an inquest and to an investigation by a coroner, prior to deciding whether to hold an inquest.
- (iii) Both section 17A and section 17B apply to the production of documents to the coroner and not to the dissemination or disclosure of documents to other PIPs. This is expressly clear from the fact that identical language is used to define the power of production when an inquest is still under consideration and when the inquest is underway. In the former case, the question of onward disclosure to PIPs does not arise since there is no inquest and no PIPs. Consequently, any question of onward disclosure of documents by a coroner to PIPs falls outside the scope of sections 17A and 17B and should be resolved by other principles of coronial law or (if applicable) statute.

- (iv) Sections 17A and 17B apply to the production by any person of “any documents.” Despite the fact that both this case and *Ketcher* concern the production of an expert report commissioned by a next of kin, the provisions are of general application. With the exception of production by police under section 8 of the 1959 Act, they apply to all inquests and govern production of all documents by all persons, whether public or private. They are therefore a vital mechanism by which a coroner is able to gather relevant evidence and hence to ensure the effectiveness of an inquest. For example, in article 2 ECHR inquests these provisions enable the coroner to secure access to documents which may shed light on issues of central importance, whether they may be inculpatory or exculpatory of those potentially implicated in the death. The importance of the powers is illustrated by considering the issue through the limited lens of expert reports. There are a large range of potentially relevant expert reports which might be in the custody of persons other than the police and hence liable to be produced. These could include a second autopsy report, ballistics reports, forensic reports, medical reports or engineering reports. All of these could be highly relevant to the inquest, whether they are inculpatory or exculpatory of state authorities. It is therefore of equal importance that a coroner has the capacity to seek production of relevant reports or documents from a private individual as a public authority. In this case, it is also the mechanism by which the coroner could have secured access to hospital/medical records of the deceased or have secured access to the report of Dr Armstrong if the Trust had declined a production request.
- (v) In an article 2 inquest, the inability of an investigative procedure to compel production of relevant material or to obtain the testimony of important witnesses may undermine the effectiveness of the entire investigation and hence impede the ability of the state to discharge its article 2 investigative obligations by means of an inquest (eg *Re Finucane* [2019] UKSC 7, at [118]-[119]; [130] & [134]).
- (vi) The availability of powers to compel the attendance of witnesses; the production of documents and/or inspection of real evidence does not preclude disclosure to a coroner on a voluntary basis, on foot of a request (section 17A(8), 1959 Act).
- (vii) Where an application is made for the revocation or variation of a production notice, the coroner has a duty under section 17A(5) to consider any countervailing public interests. Accordingly, the identification and balancing of any countervailing public interests is a mandatory requirement at the revocation stage. By contrast, when deciding whether to issue a notice in the first instance, section 17A is silent as to the role of any countervailing public interests. At that stage, the coroner may not be fully informed of either the existence or the extent of any such public interest. The coroner will not have heard the witness or seen the material and will be guided by their own

investigative judgment as to the likely relevance of the evidence or materials. However, if an informal request for production has been declined, the coroner is likely to have been provided with at least some reasons for the refusal and some insight into the existence of countervailing public interests. The potential for countervailing public interests may also be reasonably clear from the circumstances. If the coroner does have information of this nature, it will clearly be a material consideration and can properly be considered by the coroner when deciding whether to issue a production notice. In the event of a revocation application, the coroner will have the benefit of more detailed submissions from the producing party and the existence, nature and strength of the public interest will invariably be explained in greater detail. Accordingly, the mere fact that section 17A(5) refers only to the consideration of countervailing public interests at the revocation stage does not preclude their consideration when deciding whether to issue the notice.

[51] Although not relevant to the issues in this case, it is worth observing that the procedures set out in sections 17A and 17B provide the framework for the process under which national security sensitive materials will be produced to an inquest by bodies other than the police. The existence of such material and the identification of the portions of the material which may be damaging to national security, if disclosed, will normally occur after the coroner has made a request for voluntary disclosure. Further engagement between the agencies and the coroner may continue on a voluntary basis, without the coroner issuing a production notice. If disagreement over disclosure takes place between the producing body and the coroner, the matter can crystallise in one of two ways. If the initial voluntary production to the coroner had been expressed to be without prejudice to the agency's position, any dispute could be brought to a head by the coroner issuing a section 17A production notice for the material already inspected. Thereafter the matter can be resolved through an application to revoke/vary the notice. Alternatively, if an inquest is already underway and if unredacted material can properly be regarded as having already been produced on a voluntary basis to the coroner, any dispute about the extent of redactions can be resolved by an application to restrict disclosure of some or all of the material to the PIPs. This is the process sometimes referred to as a public interest immunity application.

Ground 1: Two stage approach to disclosure and public interest assessment

[52] The applicant contends that the coroner erred in her decision to issue the notice by considering that she could apply a two-stage approach to disclosure with a corresponding two-stage approach to the assessment of any public interests. It is therefore necessary to consider the statutory and other legal principles governing the production and disclosure of materials in an inquest.

[53] As set out above, sections 17A and 17B of the 1959 Act apply only to the production of materials to a coroner and not to onward disclosure to PIPs in the course of an inquest. Where the coroner is considering whether to hold an inquest,

the possibility of disclosure to PIPs simply does not arise, because there is no inquest. If an inquest is later commenced, the coroner will have no alternative but to apply a two stage approach to disclosure to PIPs since the material will already have been secured before the inquest was commenced. The question therefore arises whether production pursuant to sections 17A and 17B should operate any differently when an inquest is already underway.

[54] In my view, there is nothing in the language or background to these provisions to support the applicant's contention that a two-stage approach to disclosure of material produced after commencement of an inquest is either impermissible or otherwise inappropriate. On the contrary, I consider that such an approach is entirely consistent with the longstanding and well-established principles of disclosure in inquests.

[55] The first task of a coroner, both when deciding whether to hold an inquest and when deciding how an inquest should be conducted, is to gather the relevant evidence (see eg *R v Coroner for Inner London West ex p Dallaglio* [1994] 4 All ER 139, at 162, per Bingham MR; *Re Chief Constable PSNI* [2010] NIQB 66, at [24] per Gillen J; *Re Jordan* [2014] NIQB 11 at [68] per Stephens J) Once an inquest has been established, the duty of the coroner is to investigate the facts "fully, fairly and fearlessly" (*R (Jamieson v Coroner for North Humberside* [1995] QB 1, at 26, per Bingham MR) It is well-established that, in the absence of any express statutory provision or procedure, the coroner has a very broad discretion as to how the inquest should be conducted. This includes determining the scope of the inquest and the relevant procedures. The clearest and most authoritative statement to this effect is that of Lord Bingham in *Jamieson*, where he described the duty of the coroner in the following terms:

"... to ensure that the relevant facts are fully, fairly and fearlessly investigated ... he must ensure that the relevant facts are exposed to public scrutiny, particularly if there is evidence of foul play, abuse or inhumanity. He fails in his duty if his investigation is superficial, slipshod or perfunctory. But the responsibility is his. He must set the bounds of the inquiry. He must rule on the procedure to be followed. His decisions, like those of any other judicial officer must be respected unless and until they are varied or overruled." ([1995] QB 1, at p26)

(See also *Jordan v Lord Chancellor* [2007] 2 AC 226 at 37 and *Re Chief Constable PSNI* [2010] NIQB 66 at [25] per Gillen J)

[56] The principles governing disclosure by a coroner to PIPs in the course of an inquest are also well-established. As demonstrated below, the case law makes entirely clear that these principles govern the disclosure stage and are different to those governing production of documents or materials to a coroner. Since the new

procedures under sections 17A and 17B govern only production to a coroner, the principles which have developed through the caselaw relating to disclosure by a coroner to PIPs remain unchanged.

[57] The well-established test for disclosure of documents by a coroner to PIPs is whether the documents are “potentially relevant.” The primary reason why the test is drawn so broadly is to enable PIPs to make informed submissions to the coroner on the proper scope of the inquest and thereafter to participate in it by making submissions on any further evidence to be gathered or on the questioning of witnesses. The documents will also enable PIPs to make submissions on the conclusions to be reached from the evidence or otherwise to contribute to the investigation process. These principles were explained in this jurisdiction at first instance by Stephens J in *Re Jordan* [2014] NIQB 11, at [68]-[69]. On appeal in *Re Jordan* [2016] NI 116, the Court of Appeal confirmed the principle in the following terms:

“[43] ... The starting point is to identify all potentially relevant information. Such information, suitably redacted if necessary, should be made available to all of the parties concerned in the inquest in order to assist in establishing relevance and thereafter determining scope. Because he did not recognise the relevance or potential relevance of the documents in question the Coroner did not get to the next stage of determining the scope of the inquest which, the parties agreed, remained undefined.”

[58] As appears clear from the above comments, the process of disclosure by the coroner to PIPs may not reflect the full scope of material which was originally produced to the coroner. Redaction may be possible, including where disclosure may be damaging to recognised and important public interests. This has been well established in this jurisdiction for many years. One of the clearest examples is the often-cited decision of Weatherup J in *Re McCaughey* [2004] NIQB 2. The case concerned production of documents to the coroner by PSNI, pursuant to its statutory duty under section 8 of the 1959 Act. The disputed documents included reports by PSNI to the PPS concerning the possible prosecution of certain individuals. PSNI objected to production on account of countervailing public interest considerations, if the documents were thereafter disclosed to PIPs by the coroner. Weatherup J emphasised the distinction between production to the coroner and disclosure to PIPs. He also confirmed the ability of the coroner to consider afresh any countervailing public interest considerations when determining possible disclosure to PIPs. He stated:

“[17] This application is not concerned with the disclosure by the coroner of relevant material in a police report. If the police disclose a police report to a coroner and there are issues of confidentiality or other sensitive

issues or public interest issues arising, the police should of course give notice to the coroner to that effect and the issues can be addressed as the nature of the situation requires.

...

[25] Accordingly, the coroner has decided that the unredacted reports are potentially relevant, indeed he goes further and says that they are relevant. The police are under a duty to disclose them to the coroner on the same basis that applied in relation to the police reports under section 8 of the 1959 Act and Article 2. Public Interest Immunity will be dealt with by the issue of a Public Interest Immunity Certificate. The issue will be dealt with by the coroner. The police oppose disclosure of the unredacted reports to the coroner. ... The coroner's letter makes clear that he will hear the public interest immunity objections to any disclosure by the coroner. His decision will be subject to Judicial Review. These established procedures are in place. As far as disclosure by the police to the coroner is concerned the unredacted reports are potentially relevant and there is a duty to disclose them under section 8 and Article 2."

[59] A similar approach was taken in a different context in the case of *Worcestershire County Council v HM Coroner for Worcestershire* [2013] EWHC 1711, which was cited and relied upon by the coroner in both of her written rulings. The *Worcestershire* case concerned an inquest into the suspected suicide of a minor in care. The death was the subject of an internal Council investigation by a Safeguarding Board which produced a number of reports. The Council was reluctant to produce the reports to the coroner on account of countervailing public interest considerations. It was concerned that wider disclosure by the coroner could have a "chilling effect" upon officials and other individuals in the future who may be unwilling to co-operate with a safeguarding review if they considered that full details of their statements or contributions might become publicly available. The Council considered that this was not in the interests of children and may inhibit its ability to discharge its functions. The case was decided prior to the commencement of Schedule 5 to the 2009 Act which contains the equivalent of sections 17A and 17B, 1959 Act. While recognising that the relevant public interest could be sufficient to restrict disclosure to PIPs, the court expressly recognised the propriety of a two stage approach to production and disclosure, in such a case. The court stated:

"90. However, as with any claim for non-disclosure on the basis of public interest immunity, it is necessary to balance the perceived public benefit it affords, against the public benefit of disclosure, both in relation to the

principle of open justice and the particular requirements of justice in the context in which it is being examined.

...

92. ...

- (vi) What is sought is not disclosure of the [reports] to the public in general or, indeed, anyone else, save and except [the coroner]. Thus, the argument in favour of non-disclosure arising out of the need to encourage openness within the [reports] is likely to be significantly diluted, ... This being in contradistinction to the situation which may arise with the question of disclosure to members of the public ...
- (vii) The question of any further disclosure is a matter for [the coroner] having taken into account any further arguments in favour of non-disclosure and subject to the supervisory jurisdiction of this court; thus, maintaining sufficient safeguards to those properly seeking non-disclosure of these documents."

[60] Similarly, in *Inner West London Coroner v Channel Four* [2008] 1 WLR 945, the court was requested to make an order for production of materials gathered by Channel Four while acting in a journalism capacity. It objected to production on article 10 ECHR grounds and the chilling effect which it may have upon the effective conduct of its journalistic activities. The case arose prior to commencement of the 2009 Act procedures for production and the objection to production was considered by the High Court on an application by the coroner for assistance. In making the order, the court stated:

"27. It is important to remember also how restricted will be the disclosure in this case. The effect of my order will be to reveal the documents concerned to the coroner only, in the first instance. He will examine and filter the material paying proper regard to the competing considerations which I have had to take into account. He is obviously fully aware of the policy underlying Article 10 of the European Convention and the sensitivity of journalistic materials. He will only reveal such information as he obtains if it is necessary and proportionate to do so. That will be a similar exercise to the one I am performing, but different, since he will be

addressing those factors with a view to wider dissemination of the material (e.g. to the interested parties and/or to the jury)."

[61] In both the *Worcestershire* and *Channel Four* cases, the court was expressly referred to and relied upon the analysis of Weatherup J in *Re McCaughey*.

[62] It is overwhelmingly clear from the above authorities that it is at the very least open to a coroner to adopt a two-stage approach to disclosure. The first stage involves production of materials to the coroner and the second, in the event of an inquest, involves a broader dissemination to PIPs. Where disclosure by the coroner may cause damage to countervailing public interests of importance, the coroner is fully entitled (if not obliged) to review that disclosure and, if appropriate, to decline to disclose materials or to do so subject to redactions. Such an exercise will take place after the coroner has inspected the material and has determined whether it is potentially relevant. The coroner may also allow an opportunity for further representations from the disclosing person or persons. None of these principles are altered in any way by the new provisions inserted by the 2009 Act governing production. The new statutory procedure under section 17A(5) for revocation/variation will enable the producing body to ensure that a coroner is as well informed as possible about any countervailing public interests before production to the coroner occurs. However, there is nothing in sections 17A or 17B which precludes the subsequent re-consideration of those same issues on an even more informed basis, if production is ordered and if disclosure to PIPs is under consideration by the coroner.

[63] In this case, the coroner has followed precisely the procedures and principles described above. She correctly identified the possibility of a countervailing public interest of the nature described in *Ketcher & Mitchell*. Nevertheless, she considered that the report of Dr Husain may be of assistance in addressing issues within the scope of the inquest and on which there were areas of disagreement between the existing two experts. She had identified this possibility at a much earlier stage and had expressly adjourned the inquest to enable the applicant to commission Dr Husain's report. She decided that the report was potentially relevant to the issues under investigation and wished to assess that for herself. In my view, she was fully entitled to reach that conclusion and she was entirely justified to adopt a two-stage approach in the event she subsequently considered the possibility of disclosure of the report to the PIPs. By inspecting the report, she can determine for herself whether Dr Husain is, in fact, likely to be able to assist in resolving areas of disagreement between the existing experts and, if so, to what extent. Once informed by the content of the report, she will be much better placed to balance the competing public interests in disclosure and any damage which may be caused to the interests of the applicant. There will be a further opportunity for informed submissions from the applicant's representatives, which is an appropriate safeguard. In my view, all of this is entirely in accordance with well-established coronial principles.

[64] For all of the above reasons, I consider that the first ground of challenge must fail. It is far from clear that onward disclosure of the report to PIPs is “inevitable”, as contended by the applicant and I consider that a two-stage approach to production and disclosure was both appropriate and wholly within the procedural discretion of the coroner.

[65] As part of this ground of challenge, the applicant also contended that, if the report is produced to the coroner and she subsequently considers disclosing it to the PIPs, she would be precluded from taking account of the countervailing public interest considerations which were identified in *Ketcher & Mitchell*. The applicant referred to section 17B(3), which expressly preserves the rules of law governing withholding documents on grounds of public interest immunity. The applicant contended that documents could only be withheld by the coroner on grounds of public interest if they fell within one of the recognised categories of public interest which could support such a restriction. It was argued that the countervailing public interest identified in *Ketcher & Mitchell* had only been recognised to apply at the production stage and not at the subsequent disclosure stage and hence could not be relied upon by the coroner. I do not accept these submissions. In my view, they are not justified by either the language or the structure of sections 17A and 17B and they are not consistent with the well-established principles of public interest immunity.

[66] The origin of the modern approach to public interest immunity is the decision of the House of Lords in *Conway v Rimmer* [1968] AC 910; [1968] 2 WLR 988. In that case, it was confirmed that objections to disclosure of materials or documents on the ground that it may be injurious to the public interest could not be based upon the mere fact that the documents belonged to a class of documents, the disclosure of which may be damaging to public interest. Rather, in every case, disclosure decisions required courts to balance the competing public interests which attached to the particular documents in question. The previous practice of “class claims” to immunity from disclosure was ended. In *Conway*, the House of Lords departed from its earlier decision in *Duncan v Cammell Laird* [1942] AC 624. As Lord Reid stated:

“I would therefore propose that the House ought now to decide that courts have and are entitled to exercise a power and duty to hold a balance between the public interest, as expressed by a minister, to withhold certain documents or other evidence, and the public interest in ensuring the proper administration of justice. That does not mean that a court would reject a minister’s view: full weight must be given to it in every case, and if the minister’s reasons are of a character which judicial experience is not competent to weigh, then the minister’s view must prevail ... If the minister’s reasons are such that a judge can properly weigh them, he must, on the other hand, consider what is the probable importance in the case before him of the documents or other evidence

sought to be withheld. If he decides that on balance the documents probably ought to be produced, I think it would generally be best that he should see them before ordering production and if he thinks that the minister's reasons are not clearly expressed, he will have to see the document before ordering production ..." ([1968] 2 WLR 998, at 1015-1016).

[67] In the *Conway* case, the documents consisted of police reports in a civil action between a probationer constable and a superintendent. The countervailing public interest relied upon by police to resist disclosure was a desire for candour and co-operation in police investigations. In the later case of *D v NSPCC* [1978] AC 171, the House of Lords held that a public interest in ensuring candour in child protection investigations may be sufficient to justify the non-disclosure of documents. For present purposes, the importance of the case lies in the fact that the House of Lords confirmed that the categories of public interest which might justify non-disclosure are never closed and that in each case, the relevant interests must be balanced against one another in light of the content of the particular documents and their importance to the relevant proceedings. Lord Hailsham stated:

"... Confidentiality is not a separate head of immunity. There are, however, cases when confidentiality is itself a public interest and one of these is where information is given to an authority charged with the enforcement and administration of the law by the initiation of court proceedings. This is one of those cases, whether the recipient of the information be the police, the local authority or the N.S.P.C.C. Whether there be other cases, and what these may be, must fall to be decided in the future. The categories of public interest are not closed, and must alter from time to time whether by restriction or extension as social conditions and social legislation develop." ([1978] AC 171, at p230),

[68] These principles make entirely clear that a coroner is fully entitled to take account of countervailing public interests of any description when making a disclosure decision. There is nothing in the decided case law to suggest that a particular form of public interest may only be considered at the production stage, but not at the disclosure stage. Nor is there anything in the *Ketcher* decision itself which suggests that the public interest in preparing expert reports for an inquest is only relevant to production but not to disclosure by the coroner. The mere fact that the challenge in *Ketcher* arose out of a production decision does not justify inferring such a significant change to the principles governing disclosure by a coroner. To do so would have the effect of creating a separate class of documents to which special (and more limited) rules of public interest immunity apply. The concept of class claims or of special classes of public interest immunity was swept away by the

House of Lords in *Conway*. Nothing in the language, structure or history of sections 17A or 17B of the 1959 Act alter that position or justify a contrary conclusion. Indeed, in my view, the express preservation of common law public interest immunity principles in section 17B(3) has the opposite effect to that contended for by the applicant. It is an express statutory recognition that the principles continue to apply to other aspects of coronial procedure which fall outside the scope of sections 17A and 17B. Disclosure by a coroner is precisely such a procedure. Accordingly, the pre-existing principles of public interest immunity apply to a disclosure decision by a coroner, who is always entitled (if not obliged) to take account of the possible damage to public interests if disclosure to PIPs is ordered. There is no reason why the type of public interest factors identified in *Ketcher & Mitchell* should be excluded from consideration by a coroner at that stage. Accordingly, this aspect of the first ground of challenge must also fail.

Ground 2: Failure to follow Re Ketcher & Mitchell [2021] NI 306

[69] The applicant's second ground of challenge was that the coroner erred by failing to follow the "strong steer" given by the Court of Appeal in *Ketcher & Mitchell*, as to how a coroner should balance the competing public interests in gathering relevant evidence and enabling next of kin to commission expert evidence or otherwise prepare their case for the inquest. The applicant contended that this case was materially identical to *Ketcher* insofar as the following three elements were present:

- (i) The coroner already had expert evidence addressing issues within the scope of the inquest;
- (ii) The coroner had been willing to proceed with the inquest on the basis of that evidence; and
- (iii) A PIP has commissioned its own expert evidence but is not willing to share it.

[70] I do not accept this submission and consider that this ground of challenge must also fail, for the following reasons.

[71] First, it is clear that the facts of this case are materially different from those in *Ketcher*. In this case, the coroner was not willing to proceed in the absence of the applicant's expert report. While the inquest was initially scheduled for hearing on the basis of the existing evidence, the coroner expressly adjourned it, at the applicant's request, in order to facilitate obtaining Dr Husain's report. As she stated in her ruling of 2 May 2025:

"25. The key topic in this inquest is the role (if any) played by delirium in Mr Moore's death. Based on the evidence available to me at present, ahead of the hearing,

including the expert reports, I do not consider that I have sufficiently clear picture of the extent to which:

- (a) Mr Moore was suffering from delirium during his admission;
- (b) The cause of that delirium, including the cause of any unexpected increase in delirium shortly before Mr Moore's death;
- (c) The extent to which those causes were treated during his admission;
- (d) Whether alternative courses of action should have been taken; and
- (e) Delirium as a concept, and the causes of delirium, were well understood by the health care workers who engaged with Mr Moore.

26. I would welcome further expert evidence on each of those topics, as that evidence will assist me in my considerations of the central issues. It was for this reason, along with fairness to the next of kin, that I was content to adjourn the original inquest to allow the next of kin to seek their own report."

[72] It is clear from the above, that the coroner welcomed the prospect of additional expert evidence and wished to consider it as part of the inquest, as originally requested by the applicant. Once the applicant informed the coroner that she was not willing to disclose the report, the coroner took the further step of issuing a notice to secure production ahead of the inquest and then refused to the application to revoke it. The coroner took every avenue open to her to secure access to the additional report rather than proceed on the basis of the existing reports. While it is true that the inquest was listed and the hearing had begun, all of this was done by the coroner on the understanding that the report would be made available. It was only after the hearing had been fixed and the running order of witnesses decided that the applicant informed the coroner that she did not intend to rely upon the report. Even after these proceedings were commenced, the coroner had an option not to pursue production and to allow the inquest to conclude. Rather than do so, she took the significant step of adjourning the inquest – part heard – to allow the challenge to proceed and hence keep open the option of seeing the report of Dr Husain. This would then enable her to make future decision on the progress of the inquest such as dissemination to the PIPs and even calling Dr Husain as a witness. For all of these reasons I do not consider that the facts of this case are on all fours with those of *Ketcher*.

[73] Second, even if the above is incorrect and the facts of this case should be regarded as materially similar to *Ketcher*, it does not follow that the coroner was either precluded from seeking production or was obliged to set aside her section 17A(2) notice. It is clear from the Court of Appeal's comments at [37] of *Ketcher*, that a coroner's power to order production of documents is discretionary. Countervailing public interests are a mandatory consideration on an application to revoke a notice and for the reasons explained above are plainly a permissible consideration when determining whether to issue a production notice. As the well-established principles of public interest immunity make clear, discretionary decisions of this nature can *never* be determined based solely upon the category of the countervailing public interest or because the document belongs to a particular class, whose disclosure is always considered to give rise to unacceptable damage to those interests. In every case, the nature and extent of the potential damage to the public interest must be weighed against the public interest in facilitating a "full, fair and fearless" investigation into the circumstances of the death. This balancing exercise must be carried out by reference to the documents in dispute, not by their membership of a class. The applicant realistically accepted that an individual balancing exercise must take place in every case and that *Ketcher* did not lay down any binding principle for all future cases. In my view, once this principle is accepted, the ultimate decision on disclosure must always be a matter for the judgment of the coroner. The precedential value of *Ketcher* is therefore more limited than contended for by the applicant. The decision undoubtedly makes clear that there is a valid public interest in allowing a PIP to commission evidence in preparation for an inquest without fear that they may "as a matter of course" be required to disclose it more widely. *Ketcher* makes clear that this interest should not be discounted and may properly be afforded weight (even substantial weight) in any balancing exercise. However, there is nothing in the decision to suggest that this species of public interest will be decisive in any defined set out circumstances. The result is that the decision in *Ketcher* cannot be regarded as laying down any absolute principle or binding upon any coroner faced with a public interest balancing exercise at the point of production. In my view, there is nothing in sections 17A or 17B which alters this result. On the contrary, I consider that the express preservation of the principles of public interest immunity in section 17B(3) strongly supports this analysis. In addition, if *Ketcher* was to be interpreted as establishing an absolute principle against disclosure or even a "strong steer" against disclosure, the result could be to create, by default, precisely the type of litigation privilege which the Court of Appeal held did not apply to an inquest.

[74] In this case, the coroner has given a fully reasoned analysis as to why she considers, at this stage, the public interest balance favours production. She has given a commitment to further procedural safeguards in the form of reconsidering that balance when considering disclosure to other PIPs. The applicant has not challenged the rationality of her assessment. Her challenge is limited to the contention that the coroner was bound to reach a contrary conclusion, in light of the "strong steer" in *Ketcher*. For the reasons set out above, I do not accept that

submission. In my view, the decision of the coroner was entirely rational and justified by both the available evidence and events in the inquest. It was an entirely appropriate and proportionate means to proceed and for the reasons given above, she was not bound by *Ketcher* to reach an alternative conclusion. On the contrary, she was bound to make her own assessment of how the competing public interests should be balanced. I consider that she has done so in a rational and lawful manner.

[75] Finally, I consider it is also important to consider the possible consequences of reaching a contrary conclusion. In the first instance, it would, in effect, create different rules of disclosure for expert reports commissioned by next of kin, in anticipation of an inquest. Not only would this amount to the creation of a class of documents, which is subject to more restricted disclosure principles, but it is extremely difficult to justify the existence of such a class. It is not clear why reports commissioned by next of kin should be treated differently from expert reports commissioned by other PIPs. For example, in a case such as the present, it is not clear why the principle advocated for would not apply to the Trust which was also a PIP and had commissioned reports in anticipation of the inquest. Similarly, expert reports commissioned for an inquest by other state authorities such as military, security services, government departments, prison authorities etc, might also fall within the scope of such a principle. In an inquest where individuals and/or state authorities might be implicated in a death, such a broad principle could facilitate non-production of material which is either inculpatory or exculpatory of a suspected party. Where the material is under the control of a public authority, such a principle might undermine the effectiveness of the inquest as a whole. In an extreme case, it may even have a materially adverse effect upon any findings or verdict. If exculpatory material could legitimately be withheld by a next of kin, or other party, without the possibility of inspection by the coroner for relevance, it could even lead to the coroner making referrals to the PPS or the initiation of criminal investigations which were unjustified or based upon a mistaken premise. All of these prospects run wholly contrary to the fundamental purposes of an inquest and it could have the potential to undermine the use of inquests as a mechanism for the state to discharge article 2 ECHR investigative obligations.

[76] For all of the above reasons, I do not accept the submission that the coroner was bound to follow a “strong steer” provided by *Ketcher*, and I consider that on the facts of this case, the coroner was wholly justified in reaching the conclusion which she did at the production stage. She has also included appropriate safeguards in the event of future disclosure of the report to PIPs.

[77] For all of these reasons, the application for judicial review must be dismissed.