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2008 No. 106668/01

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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QUEEN'S BENCH DIVISION (JUDICIAL REVIEW)

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Siberry's Application (2) [2008] NIQB 147

AN APPLICATION FOR JUDICIAL REVIEW
BY HAZEL SIBERRY (2)

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HEADNOTE

Coroner's inquest – Senior Coroner for Northern Ireland – Prisoner Ombudsman for Northern Ireland – Coroners Act (NI) 1959 – Coroners (Practice and Procedure) Rules (NI) 1963 – Human Rights Act 1998 – Article 2 of the Convention – ***Wednesbury*** *principle – fairness to directly affected interested parties – Senior Coroner's discretion – rules of evidence – opinion evidence – expertise of Prisoner Ombudsman – judicial review remedies – discretion.*

McCLOSKEY J

I INTRODUCTION

[1] By this application for judicial review, Hazel Siberry (hereinafter "*the Applicant*"), a general medical practitioner by profession, challenges a decision of the Senior Coroner for Northern Ireland (hereinafter "*the Senior Coroner*") relating to the forthcoming inquest hearings concerning the death of Ronald William Davey ("*the deceased*") who, then aged twenty-four years, suffered his demise on 7th October 2005 when an inmate of Her Majesty's Prison Magilligan. The other protagonist in this matter is the Prisoner Ombudsman for Northern Ireland ("*the Prisoner Ombudsman*"), on whose behalf submissions were made at the initial hearing when the court granted leave to apply for judicial review. A written submission was subsequently provided and two affidavits were filed.

[2] An invitation by the court to another potentially interested party, the bereaved family of the deceased, also represented at the initial hearing, to provide a written submission and such affidavit evidence as might be considered desirable was declined in the event. It is appropriate to highlight that this stance was taken on the basis that, in the circumstances, the legal representatives of the bereaved family were of the view that they had nothing to add to the written submission on behalf of the Prisoner Ombudsman. Having regard to the trenchant observation of Lord Hoffmann in ***In Re E (a child)*** [2008] UKHL 66 that a third party intervention is "*… of no assistance if it merely repeats points which the Appellant or Respondent has already made*" (paragraph [3]), I consider that this was a proper and responsible course to take. In the event, the arguments on behalf of the Prisoner Ombudsman, perhaps unavoidably, mirrored closely those of the Senior Coroner. I would add, however, that *some* additional ground was covered in the Prisoner Ombudsman's written submission and, further, the affidavit evidence emanating from this source served to ensure that the court was more fully informed about certain aspects of the factual framework.

[3] In brief compass, the evidence establishes that the deceased suffered from epilepsy and was in receipt of medication accordingly. On 23rd June 2005, he was transferred from Her Majesty's Prison Maghaberry to Her Majesty's Prison Magilligan (hereinafter "*Magilligan*"). It appears that his last reported epileptic seizure had occurred in July 2003. The Applicant provided services in Magilligan as a locum general practitioner. In this capacity, she attended the deceased on 24th June 2005. The outcome of this consultation was a reduction in the dosage of one of the two prescribed anti-epileptic medications being taken by the deceased. Further doctor/prisoner consultations followed on 14th July, 21st July and 11th August 2005. On 17th September 2005, the deceased suffered an epileptic seizure, precipitating an examination by one Dr. Thompson, another locum general practitioner, two days later. On 7th October 2005, the deceased was found dead in a bath. It would appear that he drowned after having suffered a further epileptic seizure.

II <u>THE INPUGNED DECISION</u>

[4] One of the consequences of the death was an investigation of its circumstances by the Prisoner Ombudsman and a resulting report, which I shall outline in greater detail presently. The report is dated 23rd October 2007. Its contents form the background to the decision of the Senior Coroner under challenge in these proceedings. The origins of the impugned decision can be traced to a preliminary hearing conducted by the Senior Coroner on 14th May 2008. The value of such hearings is appreciated by interested parties and their legal representatives throughout this jurisdiction. In the present case, the preliminary hearing and its outworkings served to expose a contentious issue of some significance well in advance of the scheduled inquest hearings. In

granting leave to apply for judicial review, I ruled that the determination of this issue in advance of the inquest hearings would be preferable to a legal challenge arising either in the course of the hearings or in their aftermath. The benefit thus secured is that, as regards the matter of controversy, the findings ultimately returned by the jury will be robust and beyond challenge. I acknowledged at the permission stage, and hereby reiterate, that intervention by the High Court in this kind of context will be the exception rather than the rule.

[5] In advance of the preliminary hearing to be conducted on 14th May 2008, the Applicant's legal representatives furnished a written submission to the Senior Coroner. This submission addressed the issue of the evidence to be adduced at the forthcoming inquest hearings and, specifically, the prospect of the Prisoner Ombudsman attesting to the contents of his investigation report. The concluding paragraph of this submission advocated as follows:

> "*Therefore the Coroner is respectfully invited to consider carefully the extent, if any, to which the Ombudsman can give legitimate evidence of facts (as opposed to opinions, conclusions and inferences drawn from the facts as he viewed then). It is submitted that all the relevant facts can be properly explored without excursion into the views expressed by the Ombudsman*".

Simultaneously, a representation to like effect was made on behalf of the aforementioned Dr. Thompson in a letter from his solicitors to the Senior Coroner. They contended that the Prisoner Ombudsman's report, in complete form, should not be placed before the inquest jury. A further representation in writing was made on behalf of the Northern Ireland Prison Service, addressing the same topic, in a letter dated 22nd May 2008 from Ms McCart of the Crown Solicitor's Office, who suggested that the Prisoner Ombudsman "*… should not be a witness at the inquest and in many respects his investigation and report has pre-empted the findings of the inquest jury, may have trespassed on the jurisdiction of the inquest and that no final report from the Prisoner Ombudsman should have issued until after the inquest has been completed*". *Contra*, on behalf of the bereaved family, it was submitted that the Prisoner Ombudsman should be permitted to attest to his investigation and its conclusions, which evidence could be questioned by all interested parties.

[6] Against this background, the impugned decision materialised. It is expressed in a series of letters written by the Senior Coroner. Firstly, by letter dated 20th May 2008 to Dr Thompson's solicitors, he stated:

> "*In relation to the evidence of the Prisoner Ombudsman, my approach would be not to provide each juror with a copy of the entire report. However, the Prisoner Ombudsman would be asked to give evidence based on it*".

Continuing, the Senior Coroner referred to Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 and its provisions relating to reasonable precautions, defects in the existing system of working and any other facts relevant to the circumstances of the death, observing:

> "*I would allow the Prisoner Ombudsman and other witnesses to state their views on each of these and, of course each would be liable to be examined in relation to what they say*".

This letter stimulated a further written submission on behalf of the Applicant. In reply, by letter dated 5th August 2008, the Senior Coroner affirmed his intention to abide by his earlier ruling.

[7] Undeterred, the Applicant's solicitors continued to correspond and, in particular, posed certain questions about the Senior Coroner's proposals regarding, in particular, the evidence to be adduced from the Prisoner Ombudsman at the inquest hearings. The Senior Coroner responded, by letter dated 27th August 2008. Firstly, he confirmed that the Prisoner Ombudsman would be a witness at the inquest hearings. He continued, secondly:

> "*The Ombudsman will be asked to give evidence based on the contents of his report*".

I pause to observe that this pithy sentence encapsulates the key ruling of the Senior Coroner and has generated the controversy giving rise to these proceedings. The letter continues:

> "*That report does contain what may be termed 'opinion evidence' but then the report of any person or body charged with investigating a death would contain evidence that could be classified in that way. For example, I would refer you to reports prepared by the Police Ombudsman, the Health and Safety Executive, the Marine Accident Investigation Branch and the Rail Accident Investigation Branch. Also, as you will be aware, the report of any independent expert tasked by a Coroner to prepare a report into the circumstances of a death will inevitably contain opinions based on the facts*".

The letter continues:

> "*For the purpose of giving evidence at the inquest the Prisoner Ombudsman would be able to refer to any of the contents of his report. The report contains*

> *recommendations. As you are aware neither the Coroner nor a jury is able to make recommendations. That prohibition does not prevent the Prisoner Ombudsman referring to relevant recommendations in the course of giving evidence. All a coroner is empowered to do is to make a report pursuant to the provisions of Rule 23(2) of the 1963 Rules. It may be that I will take the view at the conclusion of the inquest that I should exercise these powers and make a report to the Secretary of State and the Director General of the Prison Service and enclose with it a copy of the report of the Prisoner Ombudsman*".

This letter provided the final stimulus for the initiation of these proceedings.

III STATUTORY FRAMEWORK

[8] The functions and responsibilities of Coroners in Northern Ireland and the conduct of inquests are regulated by the Coroners Act (Northern Ireland) 1959 ("*the 1959 Act*") and the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963 ("*the 1963 Rules*"). A valuable summary of the statutory framework, its historical antecedents and the comparisons between the legislation in Northern Ireland and that in England and Wales is found in the opinion of Lord Bingham in ***Jordan –v- Lord Chancellor*** and ***McCaughey –v- Chief Constable of the Police Service of Northern Ireland*** [2007] 2 AC 226: see paragraphs [5] – [21]. The core provisions of the legislation in this jurisdiction are, in my view, Section 31 of the 1959 Act and Rule 15 of the 1963 Rules. Section 31(1) provides:

> "*Where all members of the jury at an inquest are agreed they shall give, in the form prescribed by rules under Section 36, their verdict setting forth, so far as such particulars have been proved to them, who the deceased person was and how, when and where he came to his death*".

Rule 15 of the 1963 Rules provides:

> "*The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters, namely:*
>
> *(a) who the deceased was;*
>
> *(b) how, when and where the deceased came by his death;*

> *(c) the particulars for the time being required by the Births and Deaths Registration (Northern Ireland) Order 1976 to be registered concerning the death*".

These provisions have received much judicial attention in recent years and I shall summarise the relevant reported cases below.

[9] A prison death belongs to the category of deaths which may give rise to the exercise by the Senior Coroner of his statutory discretion to conduct an inquest, under Section 13 of the 1959 Act. If the coroner determines that an inquest is appropriate, his power to summon witnesses is contained in Section 17, which provides:

> "*(1) Where a coroner proceeds to hold an inquest, whether with or without a jury, he may issue a summons for any witness whom he thinks necessary to attend such inquest at the time and place specified in the summons, for the purpose of giving evidence relative to such dead body …*
>
> *(2) Nothing in this section shall prevent a person who has not been summoned from giving evidence at an inquest*".

By virtue of Section 18(1), a jury is convened in cases where the death under investigation occurred in a prison. The participation of interested parties at inquest hearings is governed by Rule 7(1) of the 1963 Rules:

> "*Without prejudice to any enactment with regard to the examination of witnesses at an inquest, any person who in the opinion of the coroner is a properly interested person shall be entitled to examine any witness at an inquest either in person or by counsel or solicitor, provided that the coroner shall disallow any question which in his opinion is not relevant or is otherwise not a proper question*".

Rule 16 contains the following prohibition:

> "*Neither the coroner nor the jury shall express any opinion on questions of criminal or civil liability or on any matters other than those referred to in the last foregoing Rule*" [Viz. Rule 15].

Rule 22(1) provides:

> "*After hearing the evidence the coroner or, where the inquest is held by a coroner with a jury, the jury, after hearing the summing up of the coroner shall give a verdict in writing, which verdict shall, so far as such particulars*

> *have been proved, be confined to a statement of the matters specified in Rule 15*".

Further regulation of verdicts is contained in Rule 23:

> "*(1) Any verdict given in pursuance of Rule 22 shall be recorded in the form set out in the Third Schedule.*
>
> *(2) A coroner who believes that action should be taken to prevent the occurrence of fatalities similar to that in respect of which the inquest is being held may announce at the inquest that he is reporting the matter to the person or authority who may have power to take such action and report the matter accordingly*".

IV THE SCOPE OF INQUESTS IN NORTHERN IRELAND

[10] As a result of the Human Rights Act 1998 ("*HRA 1998*") and the decision in ***Re Jordan and McCaughey*** [2007] 2 AC 226, two different types of inquest are, in principle, possible in Northern Ireland. The question of which type of inquest (for convenience labelled "type 1" and "type 2") is appropriate is determined (a) by the arbitrary consideration of whether the death predated or post-dated 2nd October 2000, being the operative date for the coming into effect of most of the provisions of HRA 1998 and (b) whether, in the case of deaths postdating 2nd October 2000, a "***Middleton*** adjustment" is required in order to comply with Article 2 of the Convention (c.f. paragraph [12], *infra*).

[11] Inquests into deaths belonging to the period before 2nd October 2000 continue to be governed by the decision of the English Court of Appeal in ***Regina –v- Coroner for North Humbershire and Scunthorpe, ex parte Jamieson*** [1995] QB 1 and its Northern Irish counterpart, ***In Re Ministry of Defence's Application*** [1994] NI 279 ("***Re MOD***"). The former case concerned a death by suicide in custody, while the latter had the familiar matrix of three deaths perpetrated by the shooting of two members of the security forces in controversial circumstances. In both cases, it fell to the respective courts to interpret the meaning of the word "*how*" in the two statutory regimes. In ***Jamieson***, the Court of Appeal held that "*how*" means "*by what means*":

> "*Both in Section 11(5)(b)(ii) of the 1988 Act and in Rule 36(1)(b) of the 1984 Rules,* ***how*** *is to be understood as meaning* ***by what means****. It is noteworthy that the task is not to ascertain how the deceased died, which might raise general and far-reaching issues, but* ***how… the deceased came by his death,*** *a more limited question directed to the*

> *means by which the deceased came by his death*". [p. 24, conclusion (2)]

The Court simultaneously held that while a verdict could properly incorporate a brief, neutral, factual statement it was to be factual in character, expressing no judgment or opinion [p. 24, conclusion (6)]. The Court further highlighted the duty of the Coroner [p. 26, conclusion (14)] –

> "*… to ensure that the relevant facts are fully, fairly and fearlessly investigated. He is bound to recognise the acute public concern rightly aroused where deaths occur in custody. 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*".

In ***Re MOD,*** the Northern Ireland Court of Appeal followed the decision in ***Jamieson***.

[12] In ***Re Jordan and McCaughey***, the House of Lords reconsidered the decision in ***Jamieson***. Lord Bingham observed [paragraph 24]:

> "*Two points may be made on this authority. First, the thrust of the judgment was to discourage verdicts referring to causes indirectly and perhaps remotely contributing to a death, which were at the time routinely sought at inquests to bolster claims in subsequent civil litigation. Secondly, and very shortly after its decision in* ***Jamieson****, the Court of Appeal had occasion to consider the permissible breadth of an inquest investigation in* ***[Dallaglio]****… where it was acknowledged that* ***the inquiry is almost bound to stretch wider than strictly required for the purposes of a verdict. How much wider is pre-eminently a matter for the coroner ...***
>
> [And] *it was observed that the investigation need not be limited to the last link in the chain of causation and that it was for the Coroner to decide, on the facts of a given case, at what point the chain of causation became too remote to form a proper part of his investigation*".

[Emphasis added]

The words in bold emphasize the discretion possessed by the presiding coroner and, simultaneously, are suggestive of a level of superintendence by the High Court, where challenges materialise, lying closer to the lower, rather than upper, extreme of the notional scale of intensity.

[13] In ***Re Jordan and McCaughey***, one of the arguments canvassed on behalf of the Appellants was that the decisions in ***Jamieson*** and ***Re MOD*** had been over-ruled by the decision of the House in ***Regina (Middleton) –v- West Somerset Coroner*** [2004] 2 AC 182 (discussed in paragraph 32, *infra*). This argument was rejected. Lord Bingham, giving the majority judgment, recited the third and fourth of the questions raised for consideration by the House and their Lordships' answers thereto:

> "*(3) Were the decisions in **Re Jamieson** and **Re Ministry of Defence's Application** implicitly overruled by **Middleton**? … [**NO**]*
>
> *(4) Alternatively, should the decisions in **Re Jamieson** and **Re Ministry of Defence's Application** be expressly overruled now? … [**NO**]*".

In paragraph [35], Lord Bingham explained the rationale for the negative answer to question 3:

> "***Jamieson** was approved by the House in **Middleton**. It continues to apply to inquests into deaths occurring before 2nd October 2000 and to inquests into deaths occurring after that date save where re-interpretation of the relevant legislation and rules in accordance with the ruling of the House in **Middleton** is called for to avoid violation of a party's Convention right to an investigation meeting the requirements of Article 2 of the Convention. The decision of the House in **Middleton** did not overrule the decision in **Re Ministry of Defence's Application**.*"

Lord Bingham then explained the negative answer to question 4 as follows:

> "***Jamieson** should not be overruled. Nor, to the extent that it is authoritative, should **Re Ministry of Defence's Application, but the judgments in that case should be read subject to what is said below.***"

[Emphasis added].

[14] I have highlighted the final part of the above quotation as it appears to signify an intention to provide some adjustment or exposition or reinterpretation of the ***Jamieson/MOD*** standard. The ensuing paragraphs [36-

41] are of some importance and must be examined in a little detail. In paragraph [37] Lord Bingham makes the following general pronouncement:

> "*The purpose of an inquest is to investigate fully and explore publicly the facts pertaining to a death occurring in suspicious, unnatural or violent circumstances, or where the deceased was in the custody of the State, with the help of a jury in some of the most serious classes of case. The Coroner must decide how widely the inquiry should range to elicit the facts pertinent to the circumstances of the death and responsibility for it. This may be a very difficult decision and the inquiry may (as pointed out above) range more widely than the verdict or findings*".

His Lordship then addresses the topic of verdict/findings. In paragraph [38], he expresses the following conclusion:

> "*I agree with the Northern Irish Courts … that a jury in Northern Ireland may not return a verdict of unlawful or lawful killing*."

Continuing, he states in paragraph [39]:

> "*I also agree with the Northern Irish Courts … that nothing in the 1959 Act or the 1963 Rules prevents a jury finding facts directly relevant to the cause of death which may point very strongly towards a conclusion that criminal liability exists or does not exist*".

Next, see paragraph [40]:

> "*There can be no objection to a very brief verdict, elaborated by more detailed factual findings*".

Finally, paragraph [41]:

> "*In the forthcoming, but lamentably delayed, inquest* ***the jury may not return a verdict of lawful or unlawful killing but make relevant factual findings pertinent to the killing of Pearse Jordan***".

[Emphasis added]

[15] In summary, the decisions in ***Re Jamieson*** and ***Re MOD*** have now been affirmed by the House of Lords. The central theme of those earlier decisions is that the statutory word "*how*" is to be interpreted as "*by what means*" rather than "*in what broad circumstances*". They are now to be

considered in conjunction with paragraphs [38-41] of the Opinion of Lord Bingham in ***Re Jordan and McCaughey***. For convenience, I shall describe the ***Jamieson/MOD*** kind of inquest as a "type 1" inquest.

[16] The second *genre* of inquest ("type 2") is of the species arising out of the decision of the House of Lords in ***Regina (Middleton) –v- West Somerset Coroner*** [2004] 2 AC 182. In short, the ***Middleton*** doctrine governs inquests into deaths postdating 2nd October 2000, where Article 2 of the Convention is engaged. This dichotomy arises on account of the non-retrospective effect of HRA 1998, as explained in ***In Re McKerr*** [2004] 1 WLR 807 and in ***Re Jordan and McCaughey*** and ***R (Hurst) v London Northern District Coroner*** [2007] 2 AC 189 (which were heard at the same time). The decision in ***Middleton***, when it is applicable, effects an adjustment to the interpretation of the word "*how*". The effect of this adjustment is to extend the meaning from ***by what means*** to ***by what means and in what circumstances***.

[17] The dichotomy identified in the paragraphs immediately above flows from the decision in ***Re Jordan and McCaughey***. It is important to recall the context. In that case, the Appellants sought to persuade the House of Lords that ***Jamieson/MOD*** had been implicitly over-ruled by ***Middleton***. Their alternative contention was that the House should take the opportunity expressly to over-rule ***Jamieson/MOD***. *Their purpose in advancing these contentions was to establish a single category of inquests, governed uniformly by the wider* ***Middleton*** *standard.* The House rejected their arguments: see paragraph [34] of the judgment. If the arguments had succeeded, the consequence would be the existence of only one species of inquest, viz. the "type 2" model. The rejection of the arguments must mean, logically and in principle, the preservation of the two distinct types of inquest. In some cases, the crucial question which arises is whether there are any material differences between these two types of inquest and, if so, what those differences are. I would add that having regard to the arguments presented by the parties, this question does not fall to be determined in the present case.

[18] There is one particular matter which the judgment in ***Re Jordan and McCaughey*** does not address directly. One of the arguments canvassed on behalf of the Respondents was that a Coroner's jury in Northern Ireland is strictly confined to making purely factual findings and is precluded from expressing evaluative judgments or opinions. However, by implication, the House has affirmed the correctness of this contention, in two ways. Firstly, the judgment confirms the interpretation of the Northern Ireland legislation advocated on behalf of the Respondents: see paragraph [38]. Secondly, in affirming the decision in ***Jamieson***, the House did not dissent from or modify the proposition in that case that the verdict of a Coroner's jury should incorporate "*a brief, neutral, factual statement*" and, further:

> "… *such verdict must be factual, expressing no judgment or opinion, and it is not the jury's function to prepare detailed factual statements*". ([1995] QB 1 at p. 24, conclusion (6), per Sir Thomas Bingham MR).

Re Jordan and McCaughey was, of course concerned with a "type 1" inquest. The inquest arising for consideration in the present case is of the "type 2" variety. I shall give further consideration below to how this may impact on the present inquest and the impugned determination.

[19] Any reflection on the leading authorities in this sphere would be incomplete without some consideration of the decision of the House of Lords in ***Regina –v- Secretary of State for the Home Department, ex parte Amin*** [2003] UKHL 51, which arose out of the murder of a prisoner by his cellmate. The central question addressed was whether the consequential investigative steps take by the relevant authorities were sufficient to comply with Article 2 of the Convention. The cellmate was prosecuted for and convicted of murder. Having opened and formally adjourned an inquest in advance of the criminal trial, the Coroner declined to resume the process. The spotlight fell on an internal Prison Service inquiry, followed by a further inquiry by the Commission for Racial Equality. Representations were made on behalf of the bereaved family to the responsible Minister of State that an independent public inquiry should be conducted. The Minister declined. Hooper J ruled that this refusal was in breach of Article 2 of the Convention and declared that there should be an independent public investigation in which the family would be legally represented, provided with all relevant materials and entitled to cross-examine the principal witnesses. While the Court of Appeal reversed this order, the House of Lords restored it.

[20] The importance of a public and independent investigation into any prison death featured prominently in the House's reasoning. Lord Bingham distilled from the Strasbourg jurisdiction a series of propositions. Drawing from the decision in ***Jordan –v- United Kingdom*** [2001] 37 EHRR 52 (paragraph 107), he formulated his sixth proposition thus:

> "*The investigation must be effective in the sense that … 'it is capable of leading to a determination of whether the force used in such cases was or was not justified in the circumstances … and to the identification and punishment of those responsible …*
>
> *This is not an obligation of result, but of means*'".

Lord Bingham continued:

> "*[30] A profound respect for the sanctity of human life underpins the common law as it underpins the jurisprudence of Articles 1 and 2 of the Convention …*
>
> *The State owes a particular duty to those involuntarily in its custody …*
>
> ***Reasonable care must be taken to safeguard their lives and persons against the risk of avoidable harm ...***
>
> *[31] The State's duty to investigate is secondary to the duties not to take life unlawfully and to protect life .*
>
> *The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others*".

In paragraph [33], Lord Bingham observed that "*… a properly conducted inquest can discharge the State's investigative obligation, as established by* ***McCann***".

The final passage in Lord Bingham's opinion worthy of note, in the context of the present proceedings, is contained in paragraph [39]:

> "*It will be very important for the investigator to take a firm grip on the inquiry so as to concentrate the evidence and focus the cross-examination on issues justifying further exploration. Reliance should be placed on written statements and submissions so far as may properly be done at a hearing required to be held in public. All those professionally engaged, for any party, should bear in mind their professional duty to ensure that the investigation of this tragic and unnecessary death is conducted in a focussed and disciplined way*".

A correct appreciation of the context within which this passage is to be considered is essential: previous investigations, which had given rise to certain factual findings, had "*fully explored*" certain issues, with the result that the further public investigation flowing from the House's Order was not to revisit the same territory. That said, the final observation in this passage properly applies to all forms of legal proceedings, including inquests (whether "Type 1" or "Type 2").

[21] Most recently, the requirements of Article 2 with regard to prisoners have been considered again by the House of Lords in ***Regina (JL) –v- Secretary of State for Justice*** [2008] UKHL 68, where the factual matrix was shaped by the attempted suicide of a prisoner, to be contrasted with a death in custody. Throughout the opinions of the Appellate Committee members, one finds due emphasis on the need to investigate, and expose, both operational failures and systemic failures, while recognising that the line separating the two may not always be obvious. See, for example, per Lord Phillips of Worth, paragraphs [30], [40] and per Lord Walker of Gestingthorpe, paragraphs [87] – [88]. The requirement that compliance with Article 2 demands, *inter alia*, an *effective* investigation also features in the opinions of the Committee. I refer particularly to the opinion of Lord Rodger, paragraph [38], where his Lordship, citing the decision of the Grand Chamber in ***Ramsahai –v- The Netherlands*** [Application No. 52391/99, 15th May 2007] highlights that *efficacy* requires an investigation "*… capable of leading to the identification and punishment of those responsible* [for the death] …" and, secondly, "*… it may generally be regarded as necessary for the persons responsible for it and carrying it out to be independent from those implicated in the events*". I highlight this passage, given that efficacy is the most salient of the Article 2 requirements featuring in the context of the current proceedings.

[22] There are two additional features of the decision in ***JL*** worth noting in the present context. The first is the emphasis on prison deaths as a freestanding category of importance within the realm of Article 2: see per Lord Rodger, paragraph [54], per Lord Walker, paragraphs [86] – [87] and per Lord Brown paragraph [98]. The second relates to the role of the Prisoner Ombudsman in respect of deaths in prison. As noted by Lord Phillips (in paragraph [18]):

> "*Where a death occurs in prison Section 8(3) of the Coroners Act 1988 requires the Coroner to conduct an inquest with a jury. It is also the practice of the Prisons and Probation Ombudsman for England and Wales to carry out an investigation into the death.* ***The Coroner will consider his report in order to assist him to decide whether there are issues in relation to the conduct of the prison authorities that he will wish to be covered by the jury's verdict in accordance with the procedure laid down ... in [Middleton]*** *…*".

[Emphasis added].

Continuing, Lord Phillips observes that it is common ground that "*… this regime satisfies the obligations imposed by Article 2 where a suicide takes place in prison*": paragraph [19]. The contribution which the Prisoner Ombudsman can make to the discharge by the State of its investigative duty under Article

2 is clear from the opinion of Lord Walker: see paragraph [95]. These various passages, in my view, reaffirm the proposition, now firmly embedded, that in those cases where Article 2 of the Convention requires the investigation of a death in accordance with the now recognisably familiar standards, the Coroner's inquest will normally provide the mechanism for compliance: see per Lord Bingham in ***Amin***, paragraph [33]. As a general rule, no further investigative mechanisms are required.

V THE PRISONER OMBUDSMAN FOR NORTHERN IRELAND

[23] The first incumbent of the post of Prisoner Ombudsman for Northern Ireland was Brian Coulter, appointed on 1st May 2005. Pauline McCabe has held the office since 1st September 2008. The appointments were made by the Secretary of State and it is suggested that his power to do so resides in the general power of appointment enshrined in section 2(2) of the Prison Act (Northern Ireland) 1953. In the affidavit evidence, it is averred that the Prisoner Ombudsman is independent of the Northern Ireland Prison Service and reports to the Secretary of State. The stimulus for the creation of the post was a recommendation contained in the Steele Report which reviewed staff and prisoner safety in Maghaberry Prison in 2003. According to the evidence, the Prisoner Ombudsman is supported by a small team of investigators and administrative staff.

[24] The remit of the Prisoner Ombudsman is couched, firstly, in the following terms:

> "*The Ombudsman … is an independent point of appeal for prisoners, ex prisoners (as appropriate) and young offenders who have failed to obtain satisfaction from the internal complaints system …*
>
> *The Ombudsman can consider the merits of matters complained of, as well as the procedures involved. He/she is able to investigate all decisions relating to individual prisoners taken by Northern Ireland Prison Service staff and decisions involving the clinical judgment of health care staff …*
>
> *The Ombudsman's final report may uphold a complaint in whole, in part, or may reject it …*
>
> *Notwithstanding the outcome of the complaint, a recommendation may be made to the Director General* [of the Northern Ireland Prison Service] *or the Secretary of State …*

> *The Ombudsman must be notified of action taken as a result of his/her recommendations.*"

This is an extract from the materials appended to the Ombudsman's affidavits.

[25] The Prisoner Ombudsman is also charged with the freestanding duty of investing deaths in prison custody. The expressed aims of such investigation are to:

> "*****Establish the circumstances and events surrounding the circumstances and events surrounding the death, especially as regards management of the individual, but including relevant outside factors.
>
> **Examine whether any changes on operational methods, policy and practice or management arrangements would help prevent a recurrence.*
>
> **In conjunction with the NHS, where appropriate, examine relevant health issues and assess clinical care.*
>
> *****Provide explanations and insight for the bereaved relatives.
>
> **Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under Article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified and any lessons from the death are learned.*"

Under the banner "Clinical Issues", the Prisoner Ombudsman's terms of reference continue:

> "*The Ombudsman will be responsible for investigating clinical issues relevant to the death where the health care services are commissioned by the Prison Service. The Ombudsman will obtain clinical advice as necessary and may make efforts to involve the local Health Care Trust in the investigation, if appropriate.*"

As regards any Ombudsman's report concerning a death in custody, the terms of reference provide:

> "*The Ombudsman will produce a written report of each investigation which, following consultation with the Coroner where appropriate, the Ombudsman will send to the Prison Service, the family of the deceased and any other persons identified by the Coroner as properly interested persons. The report may include recommendations to the Prison Service and the responses to those recommendations …*
>
> *Taking into account any views of the recipients of the proposed published report regarding publication, and the legal position on data protection and privacy laws, the Ombudsman will publish the report on the Ombudsman's website …*
>
> *The Prison Service will provide the Ombudsman with a response indicating the steps to be taken by the Service within set time frames to deal with the Ombudsman's recommendations …*
>
> *The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Secretary of State for Northern Ireland. The Ombudsman may also publish material from published reports in other reports. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Secretary of State for Northern Ireland.*"

The power to investigate deaths was conferred on the Prisoner Ombudsman by an extension of his initial terms of reference, effected on 1st September 2005. It is the exercise of this power which generated the report stimulating the matters of controversy to be determined by this court.

[26] The affidavit evidence asserts with some emphasis that the Prisoner Ombudsman enjoys particular expertise in the administration of prisons and the investigation of prison deaths. The Ombudsman's office has, since its establishment, considered almost 1,000 complaints, 14 of which relate to deaths in custody. As a result, some 300 recommendations, 96 concerning deaths in custody, have been made by the Ombudsman to the Prison Service. Addressing the North South Criminology Conference in June 2008, Mr. Coulter stated:

> "*It is crucial at the outset that I should preface my remarks by making clear that I speak not as an academic, lawyer or a criminologist but as an operational Ombudsman. Furthermore my views are those of a specialist Ombudsman concerned solely with prisons and prisoners.*

> *Such expertise as I have is the product of my work in the narrow operational field of the Northern Ireland Prison Service with its three prisons and around 1500 persons in its custody at any one time. Added to this are the insights I have gained as a mature student in human rights law at the transitional Justice Institute, the University of Ulster, and my experience in regulatory activity in the Health and Social Services.*"

I have taken account of, but need not rehearse extensively here, the experience and credentials of Mr. Coulter, as set out in the evidence and as developed by reference to, *inter alia*, the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, Articles 3 and 35 and Schedule 1 in particular.

[27] The affidavit sworn by the current Prisoner Ombudsman, Ms McCabe, contains the following material averments:

> "*For the avoidance of doubt, neither my staff nor I are (nor do we claim to be) expert <u>medical</u> witnesses. I believe that this may be the kernel of the Applicant's complaint in this application. Where deaths in custody involve health care management, the Ombudsman will often employ the services of independent medical experts (as occurred in this case with the reports provided by Dr. Cooper and Dr. Lloyd-Jones) to carry out a clinical review of the health care provided by the Prison Service during the prisoner's time in custody. I understand that the Senior Coroner intends to call each of these professionals to give evidence at the inquest*".

I shall consider further the significance and implications of these averments presently. Ms McCabe's affidavit then highlights the following distinction:

> "*However, the Ombudsman is well placed to make findings and recommendations in relation to prison health care and, in particular, good practice and service failures, the need for robust clinical governance for prison health care, issues around the need for improved recording of health care and the sharing of clinical records, the communication between health professionals and the prison authorities …*
>
> *In short, the issues arising from a death in custody such as the present case do not end with an examination of the propriety of the clinical judgment of a practitioner such as Dr. Siberry (in which the Prisoner Ombudsman is not an expert) but extend to wider considerations about the*

> *arrangements for and administration of health care in prison in general (in which the Prisoner Ombudsman can properly be said to be an expert)*".

I shall address below the implications of the distinction acknowledged by the Prisoner Ombudsman in these averments.

VI THE PRISONER OMBUDSMAN'S REPORT

[28] The controversy which has arisen in the present case surrounds the "Report by the Prisoner Ombudsman into the Circumstances Surrounding the Death of Ronald William Davey in Magilligan Prison on 7th October 2005", dated 23rd October 2007 (hereinafter "*the Ombudsman's Report*"). This comprehensive document consists of 164 pages, 455 paragraphs, 18 annexes and 20 recommendations. Any attempt to summarise adequately this report would almost certainly be doomed to failure. The outline which follows is designed to provide a backdrop to the arguments of the parties and my conclusions. In compiling this outline, I have considered the report in full.

[29] The report confirms that the Prisoner Ombudsman, in conducting his investigation into the death, was assisted by (and, presumably, reliant upon) medically qualified persons with regard to clinical and health care issues. Paragraph 6 of the Report states:

> *"[6] As an integral part of my investigation I commissioned a clinical review of Ronnie's healthcare needs and medical treatment whilst he was in custody both in England and Northern Ireland. I also obtained expert clinical opinions on the management of Ronnie's epilepsy in custody, including risk management and medication. I employed two experts to provide separate and independent opinions, a Consultant Neurologist with expertise in the management of epilepsy and a General Medical Practitioner with forensic experience. I considered any other information that was relevant to the care of Ronnie in Magilligan Prison or to the circumstances surrounding his death."*

Paragraph 7 continues:

> *"[7] The clinical review and expert clinical opinions formed an integral part of my investigative report and I drew from them in framing my overall findings, conclusions and recommendations. I have made 20 recommendations as a result of my investigation. Of these recommendations, nine are for action to be taken by NIPS,*

> *ten for joint action by both NIPS and its new Health and Social Service Trust partners and one specific recommendation is addressed to the Department of Health and Social Services and Public Safety (Recommendation 12).*"

Mr. Coulter continues, in paragraph 12:

> *"[12] I will identify in my report some good practice at Magilligan Prison, including a detailed, speedy and caring response to Ronnie's death. However I will also identify failings in areas relevant to the circumstances and events surrounding Ronnie's death, including deficiencies in the level of duty of care which I would expect towards a person in the custody of the Northern Ireland Prison Service."*

The report further records that finalisation of the text was carried out following the distribution of a draft report to interested parties (including the Applicant's representatives) and consideration of representations submitted in response.

[30] Much of the Ombudsman's report is devoted to issues, with associated views and recommendations, of no concern to or impact upon the Applicant and, hence, remote from the framework of this litigation. Accordingly, except insofar as necessary, I shall not dwell on such matters. I shall, rather, highlight in particular those passages which can be properly linked to the Applicant's challenge in these proceedings.

[31] Paragraphs [75] – [120] of the Ombudsman's report are arranged under the heading "Medical Management of Epilepsy". Within these passages, the Ombudsman records a finding that on 24th June 2005, the Applicant reduced one of the deceased prisoner's epileptic medications viz. Lamictal, from 200 mg to 100 mg twice daily. The Ombudsman set himself the task of establishing whether this played any part in the probable seizure precipitating the prisoner's death through drowning. To this end, the report indicates, the Ombudsman commissioned a report from Dr. Paul Cooper, an independent consultant neurologist with a special interest in epilepsy. The Ombudsman's report appends Dr. Cooper's report and quotes extensively from it, in paragraphs [78] and [79]. The Ombudsman's report further indicates that he commissioned Dr. Lloyd-Jones, a "*forensic general practitioner*", to "*provide a peer clinical review on the management of* [the prisoner's] *epilepsy*". This report is also appended. The Ombudsman makes clear that he takes both reports into account. In paragraph 86, his report states:

> *"[86] It is clear from my investigation that the clinical care afforded to Ronnie Davey fell short of good practice for*

> *the management of epilepsy. The prescribing Doctor [Dr Siberry] who was making an important input to his clinical care on behalf of her partner Dr Nutt, who holds the contract for providing medical care to the Prison Service, was in effect acting on behalf of the Prison Service. That is to say she was delivering this important aspect of the duty of care owed to Ronnie Davey by that Service."*

This paragraph is self-evidently critical of the Applicant and is of concern to her in consequence.

[32] The Applicant has similar concerns about paragraph [89]:

> *"[89] In Ronnie Davey's case, I accept the Consultant Neurologist's [Dr Cooper] view that following the reduction in his medication by the prescribing Doctor [Dr Siberry] his epilepsy was no longer 'stable' but 'active'. This suggests to me that good practice requirements should have led to reinstatement of the medication which had been withdrawn [by Dr Siberry] or referral to a Neurologist or both. The fact is that, much as I believe Dr Siberry should have been proactively involved in Ronnie's follow up epileptic treatment post her consultation on 24 June 2005 in which she reduced his Lamictal medication, due to the Doctors working arrangements, she only saw him again on three further occasions, none of which were for a review of his epilepsy management. One was on 14 July when she diagnosed a fungal rash on his back, the second was on 21 July when she wrote in his record 'renew medication', and the third was on 11 August when she attended when Ronnie was reported to have been involved in a fracas with another prisoner."*

One also finds comments critical of the other locum doctor, Dr. Thompson. In paragraphs [90] – [91]. The report then continues:

> *"[92] One critical finding from the Consultant Neurologist's Medical Report is that the prescribing Doctor [Dr Siberry] who reduced Ronnie's medication, not being fully familiar with the management and treatment of epilepsy, should have sought advice from someone who was. To that end I make the following recommendation.*
>
> *Recommendation 8:*
>
> *[93] I recommend that doctors responsible for the clinical management of prisoners with epilepsy should satisfy*

> *themselves that they are working both within their levels of professional competency and to current standards of good practice. Those who are not familiar with the management and treatment of any chronic medical condition, such as epilepsy, should refer the patient to an external specialist before making any significant change in the medication used for the treatment and control of that condition.*
>
> *[94] Another critical finding from the peer review carried out by Forensic General Practitioner, Dr Lloyd-Jones is "that if Dr H.S (Dr S/berry) had the necessary experience and expertise to make such a reduction then the care was common and acceptable medical practice. However the corollary being that if Dr H.S did not have the necessary experience then the care was below common and acceptable medical practice." Dr Lloyd-Jones also stated in his report that the average general practitioner would not have this expertise and that the average general practitioner would have asked for the opinion of a consultant neurologist. Dr Lloyd-Jones report is attached as Annex 7."*

The criticisms in these passages of the standard of care provided by the Applicant to the deceased prisoner require no elaboration.

[33] Further references to the Applicant are found in paragraph [100]:

> *"[100] From the locum Doctor's [Dr Siberry] interview responses it appeared that she was unaware of the increased prevalence of epilepsy in the Magilligan Prison population, however more recent representations state that she was aware that all chronic diseases have a higher rate of incidence in prison populations. These later representations also state she was also fully aware of the prevalence of epilepsy in the patient population registered with the Liffock [Dr Nutt's] Surgery."*

Paragraphs [102] – [109] consider the "Quality Outcomes Framework", introduced on 1st April 2004, which can optionally form part of the new General Medical Services contract. The Framework contains standards for, *inter alia*, the management of epilepsy, prompting the following observations in paragraph [107]:

> *"[107] There was evidence that Ronnie suffered from generalised epileptic seizures without warning. Best practice in the Health Service, monitored through the QOF requires that each General Practice should keep a register of patients with epilepsy and invite them for regular reviews*

> *of the frequency of seizures and their medication. I found no evidence that the General Practitioners providing medical care at Magilligan Prison kept such a register or conducted such regular reviews."*

The report then makes consequential recommendations in paragraphs [108] – [109].

[34] Next the report identifies a lacuna in the management of epilepsy in Northern Ireland, which the author attributes to the absence of any standards published by the Department of Health, Social Services and Public Safety ("*the Department*"), giving rise to a recommendation, in paragraph [113], concerning the adoption of certain clinical guidance on the management of epilepsy and a related recommendation in paragraph [116]:

> *"Recommendation 13:*
>
> *[116] I recommend that the Prison Service and its new Health and Social Services Trust partners explore the avenues for Prison Healthcare Staff to receive further specific training in the management of epilepsy and as a matter of urgency how the Prison Service could secure accessibility to the services of an epilepsy specialist nurse along the lines suggested by the Consultant Neurologist (See Paras 91/92) and within his Medical Report enclosed as Annex 3."*

The report also recommends the development of a self-help group, or clinic, for all prisoners who suffer from epilepsy, in paragraph [120].

[35] The subject matter of paragraphs [129] – [160] of the Ombudsman's Report is "Clinical Governance". Paragraph [135] contains the following recommendation:

> *"Recommendation 16:*
>
> *[135] I recommend that the Prison Service and its new Health and Social Service Trust partners review the current agreements in place for medical practitioners such as Dr Nutt and his locums to ensure specific job descriptions and practice standards are introduced and monitored in line with necessary Clinical Governance arrangements. I extend this recommendation to cover all prison establishments in Northern Ireland, as appropriate."*

[The Applicant is one of the medical practitioners in Dr. Nutt's practice].

A related recommendation is contained in paragraph [140]:

> *"Recommendation 17:*
>
> *[140] I recommend that the Prison Service and its new Health and Social Service Trust partners take immediate steps to finalise a Clinical Governance Framework to include defined practice standards for all medical and healthcare staff who are required to work within the Prison Service. Particular attention should be paid to the use of locum healthcare staff with a view to facilitating continuity of care."*

In paragraphs [141] – [150], there are some references to the medical management of two other prisoners suffering from epilepsy by the Applicant and Dr. Nutt. The author acknowledges, in paragraph [145], that these cases are the subject of separate complaint investigations by his office. The information assembled relating to these other prisoners is deployed, in paragraph [150], as a reason for fortifying the author's recommendation that prison locum practitioners provide their services within a formal "Clinical Governance Framework".

[36] Paragraphs [151] – [160] address the subject of record keeping and prescription cards. While the author comments, in paragraph [153], on "*the inefficiency of the separation of administration records from prescription cards*", instancing a consultation between the Applicant and the deceased prisoner on 14th July 2005 regarding a fungal rash on the prisoner's back, he expressly acknowledges that this is "*not material to* [the prisoner's] *death*". Referring to the two other prisoners, in paragraph [155], he comments that "*… the standard of the prescription charts and administration records was poor*" and in paragraph 156 one finds the criticism that the prescription cards were "*… deficient as an auditable record because when drugs were withdrawn the striking through was not signed or dated*". These shortcomings were the impetus for recommendation No 18, in paragraph [159]:

> *"Recommendation 18:*
>
> *[159] I recommend that the Prison Service in conjunction with its new Health and Social Service Trust partners review the medication recording system in use in prisons in Northern Ireland and improve them to a standard consistent with practice in the Health Service."*

[37] Paragraphs [328] – [395] of the Ombudsman's report are also of concern to the Applicant. They are arranged under the heading "Findings, Conclusions and Recommendations from the Clinical Review". In substance, they repeat the earlier objectionable passages, albeit in somewhat fuller detail

and they also repeat the earlier recommendations. This is a reflection of the structure of the Report, which devotes paragraphs [1] – [178] to the "Summary of Investigation", followed by the "Investigation Report", which occupies paragraphs [179] – [277], followed in turn by the "Summary List of Recommendations", found in paragraphs [278] – [455]. The final passages in the report of concern to the Applicant are contained in paragraphs [427] – [444], under the heading "Clinical Governance", within which one finds the "Overall Conclusion", expressed in the following terms:

> *"[439] In overall conclusion, a major objective for any investigation into a death in custody must be to learn whatever lessons there are which may help to prevent future fatalities.*
>
> *[440] In the light of my findings recorded in this report, supported by the Consultant Neurologist [Dr Cooper] who stated: "It is regrettably well recognised that sub-optimal care is a significant factor in many cases of individuals who die suddenly as a result of their epilepsy, and this does regrettably appear to be the case here". I conclude that the care provided to Ronnie was insufficient to do all that was possible to prevent the seizure which contributed to his sad death by drowning on 7th October 2005. I reach this conclusion for the reasons detailed in the following paragraphs.*
>
> *[441] The Prison Service did not have in place adequate arrangements for the identification and subsequent management of prisoners at risk due to their chronic disease. Risk management must begin with a thorough health risk assessment on arrival at the Prison, in Ronnie's case, Maghaberry Prison. To be effective, that is to trigger individualised risk management, this assessment in Ronnie's case needed to identify the risks associated with his epilepsy, including the triggers which might induce seizures and in what circumstances of daily living he would be at risk whilst having a seizure. The assessment also needed to instigate a Care Plan for Ronnie which was based upon a multidisciplinary approach to his care. The failure to ensure that some front line staff charged with Ronnie's care were aware of his condition and associated risks indicates that a robust risk management system was not in place. A truly multidisciplinary approach to the management of prisoners with epilepsy or other serious chronic conditions which call for risk management is essential. I have addressed this issue with Recommendation 4, under the heading Staff Supervision (See paragraph 55).*

[442] In arriving at this conclusion I attach great significance to the Consultant Neurologist's [Dr Cooper] view that the prescribing Doctor [Dr Siberry] having reduced Ronnie's medication (Lamictal I Lamotrigine) should have re-instated it following two subsequently reported seizures, and then sought a review by a specialist in the clinical management of epilepsy. Since she worked at Magilligan on only one regular day per week, this responsibility must be shared by her colleagues including Dr Thompson, the locum doctor who saw Ronnie two days after the reoccurrence of his seizures. I also conclude that had a more robust risk assessment and risk management system for epilepsy been in place at Magilligan Prison, the risk to Ronnie would have been considerably diminished. It is my view that this failure amounts to substandard clinical care.

[443] I also cannot ignore the likely impact of the illicit Tramadol which was found in Ronnie's bloodstream. Professor Forrest, the forensic toxicologist commissioned by the HM Coroner, Professor Crane, to carry out a second toxicological analysis stated in his report that: "the misuse of Tramadol in an uncontrolled way by a person suffering from epilepsy could certainly precipitate an unexpected fit, even if that person's control of their epilepsy with anti-epileptic drugs was normally acceptable". It is therefore of concern that Ronnie was able to access and misuse this drug in Magilligan prison. I cannot draw any conclusion about whether the drug had been imported into the prison from outside or whether it was obtained through the illicit internal trafficking of medication genuinely prescribed to other prisoners.

[444] It is impossible for me to know whether it was the reduction in Ronnie Davey's prescribed medication (Lamictal) or his ingestion of non prescribed Tramadol which caused him to suffer a suspected seizure on 7 October 2005 resulting in his death by drowning. Nor can I say what the combined effect of these two factors may have been. I can only speculate as to whether the reinstatement of the controlling medication might have reduced the risk arising from Ronnie's use of Tramadol. What I can say is that Ronnie should have known from his personal history of taking baths that he was taking a risk. I am unable to say whether he would have known that ingestion of Tramadol could have put him at risk of seizure. He should certainly

have been aware from his personal experience of the general risk of abusing drugs."

[38] Thus the Prisoner Ombudsman's Report contains two specific criticisms of substance of the standard of care provided by the Applicant to the deceased Prisoner. These are expressed in relatively trenchant terms. The first condemns the Applicant's decision to reduce the prisoner's epilepsy medication and her associated failure to reinstate it following two later seizures. The second is critical of her failure to refer the prisoner for review by a specialist in the clinical management of epilepsy. The report is also critical of other medical practitioners, including Dr. Thompson. Of the twenty recommendations contained in the Report, those of most significance from the perspective of the Applicant and the other medical practitioners concerned are nos. 8, 11, 13, 16 and 18.

[39] The appendices to the Ombudsman's Report include the detailed report of Dr. Cooper, consultant neurologist, which contains the following critique of the actions of the Applicant:

> *"I accept that Dr Siberry is not an epilepsy specialist, she is a General Practitioner, but I have to say that if she takes it upon herself to alter the medication of an individual who has stable epilepsy, then she does assume responsibility for that drug change, and if, as she implies in her statement, she is not that familiar with the treatment of epilepsy, then she should have sought advice from someone who is.*
>
> *Dr Siberry was not aware that epilepsy is more common amongst the prison population. I am not aware of exact incidence figures, but I can understand why this should be. There are several factors, including for instance head injury, which will mean that individuals sentenced to prison are more likely to suffer from epilepsy than the general population. I also don't know what the prison population of Northern Ireland is, and therefore I don't know how many individuals with epilepsy there are in prison in Northern Ireland at any one time. This number is obviously an important factor in making recommendations regarding the appropriate services for patients with epilepsy in Northern Ireland's prisons.*
>
> *It would however be appropriate for any prison medical officer, who is responsible for the management of prisoners with epilepsy to have had suitable additional training, and such training is fairly readily available, at least on the UK mainland. In Northern Ireland it may well be necessary to establish such a course. I could give further advice if*

deemed appropriate, but I am aware that there are excellent epilepsy specialists in Northern Ireland, who could be approached.

SUMMARY

This man's medication was changed by an individual who by her own admission is not experienced in the management of epilepsy, and she changed a drug that she indicated she was not that familiar with. When this resulted in further seizures the action taken was inappropriate by omission, the drug should have been reinstated, this was not done.

Finally it is regrettably well recognised that sub-optimal care is a significant factor in many cases of individuals who die suddenly as a result of their epilepsy, and this does regrettably appear to be the case here."

[40] Also appended to the Ombudsman's Report is a report of Dr. Lloyd-Jones, a well qualified general medical practitioner, whose remit included the following:

"2.0 Remit of my Report

2.01 To consider the standard of medical care given to Mr Ronnie Davey at H.M.P. Magilligan and in particular to consider whether the reduction of his medication namely Lamotrigine on the 24th June 2005 had any bearing on subsequent events. Further, should a person with epilepsy be advised not to bath with particular reference to the level of the duty of care falling to an institution such as a prison."

Dr. Lloyd Jones summarises his views about the standard of care provided by the Applicant in these terms:

"[3.02] In June 2005 at the age of 24 years he was transferred to H.M.P. Magilligan. His epilepsy had been stable for the previous 1-2 years and his anti-epileptic medication was Carbamazepine 300mg twice a day and Lamotrigine 200mg twice a day. On the 24th June he consulted with Dr H.S. who decided to reduce his Lamotrigine medication.

[3.03] It is my opinion that the average general practitioner would not have the necessary expertise to make

this adjustment. If Dr H.S. did have the necessary expertise then his/her standard of care would have bee common and acceptable medical practice. The corollary is also true, that being if he/she did not have the necessary expertise then the standard of medical care would have fallen below common and acceptable medical practice."

To summarise, therefore, both Dr. Cooper and Dr. Lloyd-Jones conclude that the Applicant was guilty of providing sub-optimal care to the deceased.

[41] Among the further materials appended to the Ombudsman's Report is a record of a meeting attended by the Applicant and the Ombudsman's investigators and a detailed exchange between the Applicant's solicitors and the Prisoner Ombudsman following circulation of his draft report for comment by interested parties. In this way, the Applicant took the opportunity to respond in full and robust terms not only to the draft report but also to the reports of Dr. Cooper and Dr. Lloyd-Jones. These representations contain the following passages:

"Prescribed medication

Consultation on 24th June 2005

Dr Siberry saw Mr Davey on 24th June 2005 when he came see her in the Consulting Room at the Prison. Dr Siberry recalls this meeting due to the unusual discussion she had with Mr Davey, when he requested stopping his medication.

At the attendance on 24thJune 2005, Mr Davey informed Dr Siberry that his last fit was two years previously and that he wished to stop his medication due to side effects that he was experiencing, which he attributed to the Lamictal. Dr Siberry informed him that the reason why he was not fitting was due to the fact that he was taking his medication.

From experience, Dr Siberry is aware of the importance of involving patients in discussions about their treatment, as failure to do this often results in non-compliance with their medication. Given Mr Davey's desire to stop his medication, Dr Siberry thought it prudent to discuss the matter with him, suggesting that Tegretol be maintained at the same level and that Lamictal be reduced from 200mg bd to 100mg bd. She informed him that should he start to fit again, however, the previous dosage would be reinstated

> *and thereafter, he would be assessed by a Consultant, in line with the NICE guidelines (quoted at paragraph343).*
>
> *Having retrospectively considered her entry into the notes on 24 June 2005, Dr Siberry accepts that she could have made a fuller note, detailing the discussion that she had with Mr Davey. She does, however, have a clear recollection of the examination given that, the requests of many prisoners, Mr Davey wished to reduce the dose of his medication."*

The significance of this extract is that there will clearly be contentious issues at the inquest hearing belonging to the realm of the clinical care provided by the Applicant to the deceased. It is clear that the views and conclusions of Drs. Cooper and Lloyd-Jones, which have been fully and unreservedly espoused by the Prisoner Ombudsman in his report, will be challenged and debated. It is of no little significance that, to date, there has been no forum or process for an exercise of this kind.

VII THE CASE FOR THE APPLICANT

[42] In the affidavit sworn on behalf of the Applicant by her solicitor, concerns were expressed about paragraphs 86, 89, 92-94 and 100 *only* of the Ombudsman's Report. During the hearing and, in particular, when replying, counsel for the Applicant, Mr. Green, augmented substantially the number of objectionable passages. Mr. McAlinden, representing the Senior Coroner, did not object, properly in my view. In paragraphs [26] – [38] above I have highlighted the various passages under attack.

[43] In the final amended version of the Order 53 Statement, the primary relief sought by the Applicant was formulated in the following terms:

> "*An order of certiorari to quash the ruling of the Senior Coroner … made on 27th August 2008 whereby he ruled that he was going to call the Prisoner Ombudsman … at the inquest … and permit the Prisoner Ombudsman to refer to* ***any*** *part of his report, which includes findings, opinions, conclusions and recommendations, some of which are critical of Dr. Siberry*".

The supporting grounds of challenge were, ultimately, reduced to the following three core propositions:

> "*(a) It would be wrong in principle to adduce evidence of the findings, opinions and recommendations made by the Prisoner Ombudsman …because it will tend to trespass on to the jury's role and risk prejudicing the tribunal of fact.*

> *(b) Accordingly, the Coroner has acted ultra vires in making the ruling of 27th August 2008. He has erred in law and, therefore, acted outside of his jurisdiction and the boundaries of his discretion.*
>
> *(c) If the Coroner did act within his jurisdiction and discretion, then he has exercised his discretion in a manner that is* ***Wednesbury*** *unreasonable*".

Developing these propositions, Mr. Green contended that the Prisoner Ombudsman's Report is plainly judgmental and critical of the Applicant, consistent with its purpose which was to express opinions on failings and lessons to be learned. Mr. Green's fundamental submission was that issues of fact and findings of fact fall within the exclusive domain of the inquest jury, into which no trespass or intrusion is permissible.

[44] While it was accepted on behalf of the Applicant that the Senior Coroner has a discretion regarding the scope of his inquiry, it was submitted that such discretion must be exercised lawfully, fairly and reasonably. It was acknowledged that an inquest is an inquisitorial, rather than adversarial, process in which the rules of evidence do not apply strictly. Mr Green highlighted that in ***Middleton*** (cf. paragraph [15], *supra*), Lord Bingham stated:

> *"**34** Counsel for the Secretary of State rightly suggested that the House should propose no greater revision of the existing regime than is necessary to secure compliance with the Convention, even if it were (contrary to his main submission) to reach the conclusion just expressed. The warning is salutary. There has recently been published "Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review", June 2003 (Cm 5831). Decisions have yet to be made on whether, and how, to give effect to the recommendations. Those decisions, when made, will doubtless take account of policy, administrative and financial considerations which are not the concern of the House sitting judicially. It is correct that the scheme enacted by and under the authority of Parliament should be respected save to the extent that a change of interpretation (authorised by section 3 of the Human Rights Act 1998) is required to honour the international obligations of the United Kingdom expressed in the Convention.*
>
> ***35** Only one change is in our opinion needed: to interpret "how" in section 11(5)(b)(ii) of the Act and rule 36 (1)(b) of*

the Rules in the broader sense previously rejected, namely as meaning not simply "by what means" but "by what means and in what circumstances".

36 *This will not require a change of approach in some cases, where a traditional short form verdict will be quite satisfactory, but it will call for a change of approach in others: paras 30-31 above. In the latter class of case it must be for the coroner, in the exercise of his discretion, to decide how best, in the particular case, to elicit the jury's conclusion on the central issue or issues. This may be done by inviting a form of verdict expanded beyond those suggested in form 22 of Schedule 4 to the Rules. It may be done, and has (even if very rarely) been done, by inviting a narrative form of verdict in which the jury's factual conclusions are briefly summarised. It may be done by inviting the jury's answer to factual questions put by the coroner. If the coroner invites either a narrative verdict or answers to questions, he may find it helpful to direct the jury with reference to some of the matters to which a sheriff will have regard in making his determination under section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976: where and when the death took place; the cause or causes of such death; the defects in the system which contributed to the death; and any other factors which are relevant to the circumstances of the death. It would be open to parties appearing or represented at the inquest to make submissions to the coroner on the means of eliciting the jury's factual conclusions and on any questions to be put, but the choice must be that of the coroner and his decision should not be disturbed by the courts unless strong grounds are shown.*

37 *The prohibition in rule 36(2) of the expression of opinion on matters not comprised within sub-rule (1) must continue to be respected. But it must be read with reference to the broader interpretation of "how" in section 11(5)(b)(ii) and rule 36(1) and does not preclude conclusions of fact as opposed to expressions of opinion. However the jury's factual conclusion is conveyed, rule 42 should not be infringed. Thus there must be no finding of criminal liability on the part of a named person. Nor must the verdict appear to determine any question of civil liability. Acts or omissions may be recorded, but expressions suggestive of civil liability, in particular "neglect" or "carelessness" and related expressions, should be avoided. Self-neglect and neglect should continue to be treated as terms of art. A verdict such as that suggested in para 45 below ("The deceased took his own life, in part because the risk of his doing so was not recognised and*

> *appropriate precautions were not taken to prevent him doing so") embodies a judgmental conclusion of a factual nature, directly relating to the circumstances of the death. It does not identify any individual nor does it address any issue of criminal or civil liability. It does not therefore infringe either rule 36(2) or rule 42."*

It was argued that within these passages one finds some emphasis on discipline and constraints, in the context of inquest hearings.

[45] While acknowledging that the rules of evidence do not apply strictly to inquest hearings (see, for example, Leckey and Greer, ***Coroners Law and Practice in Northern Ireland,*** paragraph 10-02) Mr. Green submitted, nonetheless, that such rules are designed to ensure fairness and to promote forensic efficiency. He contended that the course proposed by the Senior Coroner in the present case constitutes a radical departure from the rules of evidence which is manifestly unfair and unreasonable. The Applicant's submissions reminded the court of the common law principles governing the reception of expert evidence, by reference to the judgment of Lawton J in ***Regina –v- Turner*** [1975] 2 WLR 56, at p. 60 and the statement in ***Jervis on Coroners*** (12th Edition, paragraph 12-115) that at common law the eliciting of expert evidence is generally confined to those possessed of the relevant special expertise. It was further argued that the Senior Coroner's proposals regarding the reception of evidence from Mr. Coulter at the inquest gives rise to the twofold risk of such evidence usurping the function of the jury and exercising inappropriate influence over the jury's findings. The conclusions and findings contained in the Ombudsman's Report were made in a quite different context and will be no substitute for the jury discharging its function independently. Mr Green also emphasized that there will be no need for the Senior Coroner to elicit from Mr. Coulter evidence belonging to the realm of medical expertise. It was further submitted that the course proposed by the Senior Coroner gives rise to risks which may not be properly addressed by the mechanism of appropriate directions and warnings to the inquest jury.

[46] Mr. Green drew to the attention of the court the decision in ***Regina –v- Her Majesty's Coroner for Inner North London, ex parte Stanley*** [2003] EWHC 1180 Admin, where Silber J stated:

> *"27. While DCI Boxall was giving evidence at the June 2002 inquest, and after he had given details of previous convictions, he was immediately asked by the Coroner if there had been consideration given to prosecuting the officers by the CPS. This question was put by the Coroner without him having given any prior notice of his intention to do so to any of the parties represented at the inquest. Mr Owen again objected on the grounds that this question was*

not relevant but he was told by the Coroner to sit down on two occasions. The Coroner did not allow Mr Owen to address him and he merely stated that he noted Mr Owen's objections.

28. In answer to the Coroner's questions, DCI Boxall then told the jury that a very extensive inquiry had been conducted in which just over 700 statements had been taken. They had then been submitted via the Police Complaints Authority to the CPS, who had considered whether prosecutions could be brought for offences such as murder, attempted murder, inflicting grievous bodily harm with intent and manslaughter by gross neglect. DCI Boxall told the Coroner and the jury that the CPS had concluded that "there was insufficient evidence to justify the institution of criminal proceedings against either officer in relation to any of these offences". He added in reply to a further question that there were no other proceedings pending.

29. Mr Owen contends that this was a serious error on behalf of the Coroner. The officers accept that the Coroner should not have asked about the result of the CPS's enquiries. The acid test for appraising the Coroner's decision to ask this question was whether it was fair bearing in mind the three interlocking aims of the inquest outlined by Lord Woolf CJ in Amin, which I have described. There are four interconnected reasons why I have concluded that the Coroner's questioning about the police enquiries failed to comply with those aims, that it was unfair and that it should not have occurred.

30. First, the jury was bound to have been greatly influenced in its decision-making process by the fact that, as the result of the very substantial enquiries conducted by the police, no prosecution of the officers was to be brought and that this indicated an absence of culpable criminal behaviour on the part of the officers. So this knowledge of the decision of the CPS would or might well have prevented, deterred or influenced the jury in performing its duty, which was to determine its verdict in the light of the evidence before it and not in the light of the view of the CPS.

31. Second, any view of the CPS about a possible prosecution before an inquest is held must be regarded as a provisional view and it should have been described as such at the inquest. Indeed, a verdict of unlawful killing at the

inquest would mean that a prosecution would then be brought. Lord Bingham CJ explained the effect of a jury's verdict of unlawful killing, implicating a person who is clearly identified, who is living and whose whereabouts are known, is that "the ordinary expectation would naturally be that a prosecution would follow" - R v Director of Public Prosecutions ex parte Manning and Melbourne [2001] QB 230, paragraph 33.

32. A similar approach was advocated more recently in R (Rupert and Sheila Sylvester) v Director of Public Prosecutions (unreported, 21st May 2001) by the Divisional Court, when Lord Woolf CJ specifically adjourned a hearing of a judicial review application of a decision by the Director of Public Prosecutions not to prosecute a police officer for causing a death until after the conclusion of the inquest into the deceased's death. He explained that there were a number of reasons for this decision of which one of relevance to the present application was that: "Secondly, it would enable the matter to be reconsidered by the Director of Public Prosecutions after the conclusion of the inquest when he will have had an opportunity to take into account what occurred during the inquest."

33. Indeed, in this case I understand the view expressed by the CPS that there was insufficient evidence to justify the institution of proceedings was provisional would be reconsidered at the conclusion of the inquest. Even if that was not the case, the Coroner must have appreciated that the view of the CPS was only provisional for the reason explained by Lord Bingham in the passage that I have quoted. Thus, a third objection to the course adopted by the Coroner was that he erred by not explaining the provisional nature of the CPS's conclusion to the jury after the evidence about the result of the CPS's enquiries had been adduced in evidence.

34. A fourth valid objection to the course adopted by the Coroner is that even if there were a strong case for considering that the view of the CPS was relevant and was material to the jury's task, this evidence might have had such an effect on the jury that the views and submissions of the parties should first have been obtained by the Coroner in the absence of the jury, and then those submissions should have been considered by the Coroner before reaching a decision on whether to permit it to be adduced.

> *35. By failing to adopt this course, I consider that the Coroner made an error in the sense that potentially prejudicial information was put before the jury and that this would have been likely to have influenced them to exonerate the officers. This is of some importance because the jury could have determined that the death of Mr Stanley could have been the result of criminal offences for which either or both of the officers could be criminally liable."*

It was submitted that ***Ex parte Stanley*** is closely comparable to the present case, emphasis being placed on the issue of the risk of improperly influencing the jury's findings.

[47] Finally, Mr. Green submitted that the court should grant relief on the basis that the Senior Coroner's proposals regarding reception of the Prisoner Ombudsman's evidence are tainted by unfairness and unreasonableness in the ***Wednesbury*** sense. He contended that, in this particular context, unfairness and unreasonableness are interchangeable concepts. The impugned determination, he argued, is unreasonable because it is unfair and vice versa. Fairness, he submitted, is an immutable and fundamental protection which the Applicant must be able to invoke in the prevailing circumstances. He formulated what he termed the "central issue" in these terms: Should the Prisoner Ombudsman be allowed to give opinion evidence in respect of matters upon which the inquest jury can form its own conclusions? He invited the court to supply a negative answer to this question.

VIII THE CASE FOR THE RESPONDENT AND THE PRISONER OMMBUDSMAN

[48] The main affidavit sworn by the Senior Coroner places emphasis on the need for the inquest in this matter to comply with Article 2 of the Convention, in accordance with the ***Middleton*** standard. Other averments reiterate and expand the contents of his earlier letters, set out in paragraph [6] above. The Senior Coroner further avers:

> "*… I am of the opinion that when carrying out an investigation into a death in prison, a coroner is entitled to rely upon the investigations carried out by the Prison Ombudsman, a person with an expertise in matters relating to prison management and good practice …*".

The Senior Coroner is proposing to provide each member of the jury with the "Summary of Investigation" section of the Prisoner Ombudsman's Report viz. paragraphs [1] – [178]. The Senior Coroner characterises these passages "… *an accurate and comprehensive yet manageable summary of the investigations carried*

out by the Prisoner Ombudsman, the findings made by the Prisoner Ombudsman and the recommendations made by him as a result of his findings".

[49] The Senior Coroner's main affidavit also acknowledges the "*clear*" distinction between those proposed witnesses properly described as witnesses of fact (on the one hand) and "*expert witnesses who will give evidence both of fact and expert opinion*" (on the other). He continues:

> "*I regard the Prisoner Ombudsman as being an independent witness with an expertise on issues relating to prison management and good practice who will give evidence both of fact and expert opinion on matters directly bearing on the question of by what means and in what circumstances the deceased met his death*".

The Senior Coroner's affidavit confirms that the witnesses to testify at the inquest include Dr. Cooper and Dr. Lloyd-Jones. In this context, he acknowledges that he, the Senior Coroner, will have to be alert to prevent inappropriate questions being asked of witnesses and, if necessary, to provide suitable advice and directions to the jury, continuing:

> "*The jury will be advised by me in the clearest possible terms and as often as is required that the findings and recommendations of the Prisoner Ombudsman in relation to the clinical care afforded to the deceased* [are] *based on the expert medical evidence obtained by him during his investigations and that they, the members of the jury, have to make up their own minds in relation to the issue of the clinical care afforded to the deceased based on their assessment not only of the evidence of the two medical experts retained by the Prisoner Ombudsman to advise him during his investigations but also on the evidence of the two doctors who treated the deceased in the prison and the evidence of the other medical experts who will be giving evidence at the inquest, whose evidence the Prisoner Ombudsman did not have access to when preparing his report*".

(See paragraph [9] of the affidavit).

[50] The Senior Coroner has already prepared a draft completed Form 22, "Verdict on Inquest", which, firstly, specifies (a) drowning in fresh water and (b) epilepsy/ingestion of Tramadol as the "*cause of death*". There follows a list of eight questions, to be considered and answered by the inquest jury:

> "*1. Where and when did the death of Ronald Davey occur?*

2. What was the cause or causes of his death?

3. Were there any defects in prison procedures in force at HMP Magilligan at the time that caused or contributed to his death? [Yes/No].

4. If 'Yes' what were these?

5. Were there any aspects of the medical care provided to Ronald Davey at the prison which caused or contributed to his death? [Yes/No].

6. If 'yes' what were these?

7. Are there any other facts which are relevant to the circumstances of his death? [Yes/No].

8. If 'yes' what were these?"

In a second affidavit, the Senior Coroner explains that he has deliberately omitted from this list any question relating to reasonable precautions which, in the opinion of the jury were not, but should have been, taken. He further indicates that if he decides, upon completion of the inquest, to exercise his power to make a report under Rule 23(2) of the 1963 Rules, this will be couched in neutral terms, accompanied by "*a full set of inquest papers, including all reports put in evidence at the inquest, to facilitate understanding of the context*".

[51] Mr. McAlinden's submissions on behalf of the Senior Coroner highlighted the opinion of Lord Bingham in ***Regina –v- Secretary of State for the Home Department, ex parte Amin*** [2003] UKHL 51, paragraphs [25] and [30]–[32] in particular, together with Lord Bingham's opinion in ***Middleton*** paragraph [20] and Lord Bingham's later opinion in ***Jordan and McCaughey*** paragraph [37]. The extension of the "*by what means*" standard to "*by what means and in what circumstances*" was duly emphasized.

[52] Mr. McAlinden submitted that Section 15 of the 1959 Act confers a broad submission on the Coroner in the matter of selecting witnesses "*whom he thinks necessary*". He further emphasised the recognition which the decided cases have consistently accorded to the breadth of the presiding coroner's discretion in the conduct of inquest hearings, as exemplified in the statement of Simon Brown LJ in ***Regina –v- Inner West London Coroner, ex parte Dallaglio*** [1994] 4 All ER 139, p. 155:

> "*The inquiry is almost bound to stretch wider than strictly required for the purposes of a verdict. How much wider is pre-eminently a matter for the coroner whose rulings upon*

> *the question will only exceptionally be susceptible to judicial review.*"

To like effect is the following statement in the judgment of Sir Thomas Bingham MR, p. 164:

> "*It is for the Coroner conducting in inquest to decide, on the facts of a given case, at what point the chain of causation becomes too remote to form a proper part of his investigation. That question, potentially a very difficult question, is for him*".

These passages were endorsed by the House of Lords in ***Re Jordan and McCaughey*** (*supra*) at paragraph [24] and were duly acknowledged by this court when granting leave to apply for judicial review.

[53] Mr. McAlinden further submitted that the decision of the Senior Coroner impugned in these proceedings can be challenged only on the ground of ***Wednesbury***" unreasonableness, relying on the decision in ***In Re Bradley's Application*** [1996] NIQB 2 where, in a context formed by the presiding coroner's decision not to summon two particular witnesses to testify, Kerr J stated [p. 9]:

> "*But the acid test for qualification as a witness at an inquest is not simply the relevance of the evidence of the potential witness. As I have already observed, Section 17 of the 1959 Act empowers a coroner to call witnesses whom he thinks <u>necessary</u> …*
>
> *It is not for me to say whether I would have reached the same conclusion. It would only be open to this court to quash the coroner's decision on this ground, if his decision was so perverse as to be insupportable i.e.* ***Wednesbury*** *unreasonable. There is no warrant for so concluding …*".

[54] Mr. McAlinden's submissions also highlighted the inquisitorial character of inquests and the inapplicability of the strict rules of evidence. He submitted that opinion evidence could be elicited from a non-expert witness, provided that there were sufficient attendant safeguards. He pointed out that the Prisoner Ombudsman's investigation explored territory well beyond the narrow ground occupied by issues of clinical care, emphasizing also the prison context within which such issues must be considered by the inquest jury. He submitted that the decision in ***Ex parte Stanley*** is not authority for the proposition that non-expert opinion evidence can never be admitted at the hearing of an inquest with a jury. He further developed an argument to the effect that the decision in ***Stanley*** should be treated with caution, not least because the court's attention had not been drawn to the earlier decision in

Field –v- HM Coroner [1998] EWHC (Admin) 111, where an inquest jury recorded a verdict of death by misadventure. This was challenged by an application for judicial review which sought an order quashing the inquisition and an order requiring a fresh inquest, on the ground that the Coroner had wrongly received evidence about the previous convictions of the deceased. Per Simon Brown LJ:

> "*[4] The contended for irregularity is that the Coroner permitted those representing the police to adduce in evidence certain previous convictions recorded against the deceased, evidence which the Applicant argues was irrelevant and inadmissible and which she submits may unfairly have influenced the jury against reaching a verdict of unlawful killing, the verdict for which the deceased's family was hoping.*"

His Lordship continued:

> "*[31] I can state my conclusions upon the central ground of challenge really quite shortly:*
>
> *1. The decision whether or not this evidence was relevant was for the Coroner. Subject only to* ***Wednesbury****, the question was essentially one of fact and degree for him. Unless only no reasonable coroner could have reached the view that these particular convictions went somehow to a matter at issue, his decision cannot be impugned.*
>
> *2. Not only do I think the Coroner here entitled to have ruled as he did, for my part I think he was right to do so …*
>
> *3. Despite the considerable age of the deceased's convictions it seems to me plain that they were indeed relevant and not too remote.*"

[55] Finally, while Mr. McAlinden's skeleton argument invited the court to dismiss the application on the ground of delay, *pace* the ruling made in granting leave to apply for judicial review, this contention was not developed in oral argument. In this respect, I note from paragraph [11] of the Senior Coroner's main affidavit that the evidence gathering exercise has not yet been completed by him: specifically, he awaits a report from a consultant neurologist with specific expertise and interest in the management and treatment of prisoners suffering from epilepsy. When leave to apply for judicial review was granted, on 16th October 2008, the inquest was scheduled to commence on 27th October 2008. It is now clear that the inquest could not have started on that date. Furthermore, the adjournment of the inquest was effected voluntarily by the Senior Coroner, without the need for any interim

relief order from this court. I am satisfied that there would be no proper basis for declining to grant relief in this matter on the ground of delay by the Applicant in commencing these proceedings.

[56] I have also given full consideration to the comprehensive written submission of Mr. Scoffield on behalf of the Prisoner Ombudsman. As already observed, this replicates much of the argument advanced on behalf of the Senior Coroner. In addition, Mr. Scoffield drew attention to the recent decision in ***Re Jordan's Application*** [2008] NIQB 140, together with the following passage in ***Inquests – A Practitioner's Guide*** **(**Thomas *et al*, 2nd Edition), paragraph 14.10:

> "*The Coroner tends to rely on witness statements from previous investigations into the particular death, for example internal police reports …*
>
> *The strict rules of evidence do not apply to inquests. Thus, within reason, a Coroner may consider hearsay, newspaper articles and other sources of information that have come to his/her attention …*
>
> *[14.11] Evidence can include information for example from the Independent Police Complaints Commission; the Prison and Probation Ombudsman; internal prison reports; the Crown Prosecution Service; hospital reports; Health and Safety Executive …*".

In the same work, in a section dealing with expert evidence, the authors suggest, at paragraph 18.82:

> "*An independent expert should be called to give opinion evidence on issues relevant to the circumstances of death, provided that evidence falls within their expertise, but should go no further. Medical or forensic experts are common examples. The Prison and Probation Ombudsman who investigated a death in custody might be able to give expert evidence, but only if he or she is independent and suitably qualified*".

Mr. Scoffield's argument also reflected the recognition in the Prisoner Ombudsman's report that while she may not be a medical expert, she can nonetheless be considered expert in other respects. Finally, it was submitted that this court should decline to intervene in circumstances where the full extent of the evidence to be given by the Prisoner Ombudsman at the inquest hearing is not yet ascertained.

IX CONCLUSIONS

[57] At the outset, in the context of the present challenge, I consider that there are two unassailable propositions. The first is that the decision must not be unreasonable in the ***Wednesbury*** sense. The second is that it must not be so unfair as to be ***Wednesbury*** unreasonable. The fairness under scrutiny here is fairness to the Applicant in the conduct of the inquest process. The Applicant is directly affected by this process and her interests qualify for due protection accordingly. It is against this background that I take into account the well settled principles that an inquest is inquisitorial in nature; that it is not bound strictly by the rules of evidence; that the Coroner has a wide discretion in the matter of selection and summoning of witnesses; that the route to the permissible terminus of an inquest can be wider than the terminus itself; and that the Coroner, as the presiding judicial officer, has the function and obligation of ensuring that appropriate advice, instruction and direction are given to the inquest jury. It is also appropriate, though perhaps trite, to observe that the decision under challenge in the present case is amenable to the exercise of the High Court's supervisory jurisdiction through an application for judicial review. I have already acknowledged that intervention for the High Court in a case of this nature is likely to be *comparatively rare*.

[58] The terms of the impugned decision, dated 27th August 2008, make clear that the Senior Coroner is proposing to permit the Prisoner Ombudsman to give evidence to the inquest jury of *all and any of the contents of his report.* As the letter states, this will include matters of opinion, together with the report's recommendations. As appears from paragraphs [24] – [38] above, substantial sections of the report are devoted to medical/clinical issues. Within the relevant paragraphs there are passages unreservedly critical of the Applicant. I refer particularly to paragraphs [86] –[89], [94], [100], [153] – [154], [333] – [334], [341] – [344], [347], [349], [352] – [360], [365] – [366], [388] – [389] and [440] – [442]. In most instances, these passages cannot be clinically segregated from other surrounding paragraphs. Moreover, they are linked with certain of the recommendations littered throughout the report. I refer particularly to recommendations 8-14 inclusive. While, admittedly, some of these are directed to the Department and the Prison Service, they are to be considered, and construed, in the overall context in which they appear.

[59] Against this background, I turn to consider one particular consequence of the impugned decision, which is that Mr. Coulter will be allowed to give evidence of the matters highlighted in the immediately preceding paragraph, to include his own opinions and recommendations. In the written submission and affidavit evidence on behalf of the Prisoner Ombudsman, one finds the concession – utterly unavoidable – that neither the Ombudsman nor his/her staff possesses any medical expertise. I refer particularly to

paragraph [21] of Ms McCabe's affidavit and paragraph [32] of counsel's written submission. The issue which has troubled me most throughout these proceedings is the Senior Coroner's proposal to allow Mr. Coulter to include within his evidence material conventionally reserved to the domain of medical experts and, in this instance, addressed in the reports of medical experts who will be testifying in any event. Given that the twin pillars of the Applicant's case are (a) ***Wednesbury*** unreasonableness and (b) unfairness, this gives rise to two questions:

(a) Is there any rational basis for the Senior Coroner's proposal?

(b) Does the Senior Coroner's proposal create a tangible risk of unfairness to the Applicant?

Wednesbury *Unreasonableness*

[60] A modern statement of the familiar doctrine of ***Wednesbury*** unreasonableness is found in ***De Smith's Judicial Review*** (6th Edition), paragraph 11-003:

> "*The issue under this ground of review is not whether the decision maker strayed outside the terms or authorised purposes of the governing statute (the test of 'illegality'). It is whether the power under which the decision maker acts, a power normally conferring a broad discretion, has been improperly exercised or insufficiently justified. The court therefore engages in the review of* ***the substance*** *of the decision or its* ***justification***".

[The authors' emphasis].

The text continues, at paragraph 11-006:

> "*Various formulations of the test have been devised and applied by the courts over the years, although the most common contemporary formulation asks whether the decision falls 'within the range of reasonable responses open to the decision maker'. Where broad discretionary power has been conferred on the decision maker there is a presumption that the decision is within the range of that discretion and the burden is therefore on the claimant to demonstrate the contrary*".

Having referred to the celebrated formulation devised by Lord Greene MR in the ***Wednesbury*** case, the authors continue, at paragraph 11-018:

> "*That formulation attempts, albeit imperfectly, to convey the point that judges should not lightly interfere with official decisions on this ground. In exercising their powers of review, judges ought not to imagine themselves as being in the position of competent authority when the decision was taken and then test the reasonableness of the decision against the decision they would have taken …*"

Having reflected on the elevated nature of the ***Wednesbury*** threshold and its recent detractors – such as Lord Cooke in ***Regina –v- Secretary of State for the Home Department, ex parte Daly*** [2001] 2 AC 532, at paragraph [32] – the authors reiterate their emphasis on the respective roles of judges and "administrators", while noting that the test "*… is being increasingly rephrased to a decision which is 'within the range of reasonable responses*'": see paragraph 11-024. They also express their preference for the view that *irrationality* is a facet of ***Wednesbury*** unreasonableness, elaborating:

> "*A decision is irrational in the strict sense of that term if it is unreasoned; if it is lacking of sensible logic or comprehensible justification …*
>
> *Less extreme examples of the irrational decision include those in which there is an absence of logical connection between the evidence and the ostensible reasons for the decision, where the reasons display no adequate justification for the decision, or where there is absence of evidence in support of the decision*".

This valuable treatise of the ***Wednesbury*** doctrine also examines the topic of the intensity of review: see paragraphs 11-086/102.

[61] I start from the premise that in the present context, a substantial measure of latitude, or deference, is to be accorded to the Senior Coroner. The breadth of the discretion available to him is positioned towards the upper end of the notional scale. Correspondingly, the intensity of review to be applied in the exercise of this court's supervisory jurisdiction lies towards the lower extremity of the scrutiny scale. That this is the correct approach in principle is clear from the pronouncements of Lord Bingham and Simon Brown LJ set out in paragraphs [11] and [52] above.

[62] Within this framework of legal principle, I consider that the Senior Coroner's letter dated 27th August 2008 invites the following observations:

(a) As both Dr. Cooper and Dr. Lloyd-Jones will be giving evidence to the inquest jury, there is no need to seek to elicit their evidence from any other witness or in any other way: no surrogate is required.

(b) Dr. Cooper and Dr. Lloyd-Jones are qualified medical practitioners, possessing expertise in their particular field of medical practice: Mr. Coulter has no such qualifications or expertise.

(c) Mr. Coulter's report makes explicitly clear his dependence on the two medical experts in relation to medical and clinical governance issues: see in particular paragraphs [7], [333] and [442].

(d) If Mr. Coulter's evidence to the inquest jury trespasses into the territory covered by the two medical experts, he is liable to be questioned by interested parties, giving rise to at least two possible scenarios. The first is that he will be unable to deal with the questions. The second is that he will purport to give evidence which should properly be elicited from the medical experts only. Neither scenario is desirable and neither will facilitate the inquest jury performing its task.

(e) On the first of the scenarios mooted above, the imprimatur of Mr. Coulter could possibly add weight to the evidence of the medical experts, in circumstances where Mr. Coulter's evidence could not be properly tested by questioning. The jury could be improperly influenced in consequence.

(f) Alternatively, if the inability of Mr. Coulter to deal properly with medical issues in his evidence is exposed, this could result in the jury failing to attach sufficient weight to the opinions and conclusions of Dr. Cooper and Dr. Lloyd-Jones and might simply create unnecessary (and avoidable) confusion and/or uncertainty.

(g) A major plank of the Senior Coroner's response to reservations of the above kind appears to reside in the contention that appropriate advice and directions can be given by him to the jury. However, mechanisms of this kind may, or may not, have their intended effect. Moreover, this prompts the questions: If a situation in which warnings and directions to the jury have to be given can properly be avoided, why allow it to materialise? Further, why permit the risk of the jury being improperly influenced or otherwise misled?

(h) If Mr Coulter’s report did not exist, this would not inhibit the jury in the performance of their central functions.

(i) As already observed in paragraph [38] above, those comments, conclusions and recommendations of Mr. Coulter entailing an adverse reflection on the Applicant are based on two medical reports, neither of which has been subjected to any critical scrutiny and both of which will be challenged in this way at the inquest hearings.

[63] In the impugned letter, the Senior Coroner seeks to justify his proposal by reference to certain "comparators" viz. reports prepared by agencies such as the Police Ombudsman and the Rail Accident Investigation Branch. His letter does not elaborate. In the absence of elaboration, it seems to me that the comparison asserted by him is far from exact. Furthermore, I must confine myself to the reasonableness and fairness of the Senior Coroner's proposal *in the context of the present case*.

[64] The Senior Coroner also purports to justify his proposals by contending that he is not empowered to make recommendations in the wake of an inquest and he refers to Rule 23(2) of the 1963 Rules, in this context. Both his letter and his second affidavit make clear that if, following the inquest, he determines to exercise his power under Rule 23(2), his report will be couched in neutral terms and he will attach a full set of the inquest papers, including all reports received in evidence. I confess that I do not fully understand this purported rationale. The Prisoner Ombudsman is charged with the obligation of preparing reports of this kind and the audience for which they are destined comprises (*inter alia*) the Secretary of State and the Director General of the Prison Service. The evidence confirms that Mr. Coulter's report has been provided to (*inter alia*) the Director General of the Northern Ireland Prison Service; the Regulations and Quality Improvement Authority; the Chief Medical Officer of the Department of Health, Social Services and Public Safety; the Northern Ireland Human Rights Commission; the Assembly Ombudsman; Her Majesty's Inspectorate of Prisons; and the Chief Inspector of the Criminal Justice System for Northern Ireland. It follows that, in my view, this discrete justification proffered by the Senior Coroner in support of his impugned proposal is unsustainable. I acknowledge, of course, that the Senior Coroner may not have been aware of this level of dissemination. I would add that as the Senior Coroner is already in receipt of Mr. Coulter's report, he will be at liberty to forward it to any agency which does not have it and which the Senior Coroner considers should receive it in the exercise of his power under Rule 23(2) of the 1963 Rules.

[65] I conclude that the Senior Coroner's proposal to permit the evidence of Mr. Coulter to encompass any of the matters addressed in the reports of Dr. Cooper and Dr. Lloyd-Jones (and duly reflected in certain passages of Mr. Coulter's report) is unreasonable in the ***Wednesbury*** sense. Fundamentally, I consider that the justifications for this course proffered by the Senior Coroner do not withstand analysis. While fully respecting the latitude and deference

to be accorded to the Senior Coroner and the breadth of his discretion in the matter, I find no rational justification for the course proposed by him. Further, as appears from paragraph [66], I am satisfied that a finding by the court to this effect will in no way impair the discharge by the Senior Coroner and inquest jury of their functions under Section 31 of the 1959 Act and Rules 15 and 22 – 23 of the 1963 Rules, making due allowance for the ***Middleton*** adjustment.

[66] I have also considered the question of whether any restriction on the ability of the Prisoner Ombudsman to give evidence of medical and clinical matters might impinge on the efficacy of the inquest, from the Article 2 perspective. In this respect, I have given particular consideration to paragraphs [20] and [31] of the opinion of Lord Bingham in ***Amin***; paragraphs [18] and [34] – [37] of His Lordship's opinion in ***Middleton***; and paragraphs [37] – [40] of His Lordship's opinion in ***Jordan and McCaughey***. For reasons essentially the same as those set out in paragraph [62] above, I am satisfied that the Article 2 aims and standards will be in no way compromised if the evidence of Mr. Coulter does not trespass on the domain of the medical experts who will be giving evidence in any event. This will not, in my view, impair the efficacy of the inquest. Indeed, I consider that compliance with Article 2 is likely to be enhanced, rather than compromised, if the inquest hearing proceeds in this manner.

[67] Given the views expressed immediately above, it is unnecessary for me to determine whether the Senior Coroner is correct, as a matter of law, in his contention that Rule 23(2) of the 1963 Rules is couched in terms which disable him from incorporating recommendations when " *… reporting the matter to the person or authority who may have power to take such action …*". I am conscious that in the textbook of which the Senior Coroner is co-author, the view is expressed, tacitly, that Rule 23(2) does not embrace a power to make recommendations, having regard to its statutory antecedents, in particular the amendments to the Rules effected in 1980, whereby the proviso to Rule 16 of the original 1963 Rules was removed [per the Coroners (Practice and Procedure) (Amendment) Rules (NI) 1980]: see Coroners' Law and Practice in Northern Ireland, paragraphs 11-19/20. I would merely observe that there may be scope for some fuller argument in relation to this issue in a future case. Clearly, by virtue of Section 31 of the 1059 Act and Rules 15 and 22-23 of the 1963 Rules, coupled with the Third Schedule Form, an inquest verdict in this jurisdiction cannot incorporate recommendations. However, Rule 23(2) envisages the Coroner taking action separate from and subsequent to the finalisation of the verdict. Moreover, this power is conferred on the Coroner alone: it does not extend to the jury. Whatever is contained in a "report" made under Rule 23(2), it cannot impinge on the verdict, which will remain sacrosanct. These considerations suggest that more detailed argument about the construction of Rule 23(2) might usefully occur in a suitable future case. They also prompt some reflection on the question of

whether the Senior Coroner would be acting in breach of Rule 23(2) (as construed by him) if, following completion of the present inquest, he were to forward the whole of Mr. Coulter's report, which contains twenty recommendations, to the agencies concerned.

Unfairness

[68] The Applicant's second ground of challenge is couched in terms of substantive unfairness, rather than the more familiar complaint of procedural unfairness. It falls to be considered accordingly. The essence of this ground of challenge is that the impugned decision has the potential to impact unfairly on the Applicant. It could result in inappropriate evidence being given by a witness, Mr. Coulter, who could be perceived by the inquest jury as authoritative, persuasive and influential. His imprimatur on evidence relating to medical and clinical matters could result in the jury being improperly influenced, to the detriment of the Applicant. In my opinion, this ground of challenge is made out, for reasons essentially the same as those underpinning my earlier conclusion that the Senior Coroner's proposal is vitiated by ***Wednesbury*** unreasonableness. In short, the Applicant should not be exposed to this avoidable risk of unfairness, absent some compelling imperative. I find that no such justification exists. In the forum of the forthcoming inquest hearings, the Applicant's professional standing and reputation are at stake and, in the language of contemporary jargon, the playing field should be a level one for all concerned. I consider that the Applicant has established unfairness, within the confines of the ***Wednesbury*** principle.

Remedy

[69] It is clear from the affidavit grounding the application and the arguments advanced on behalf of the Applicant to me that the court is *not* invited to hold that Mr. Coulter is an inappropriate witness at the forthcoming inquest hearing and that the whole of his report should be withheld from the jury. Rather, the Applicant's challenge is more nuanced. It does not take issue with substantial portions of Mr. Coulter's report and, effectively, acknowledges that Mr. Coulter may be a competent and proper witness in certain respects. Thus, while the amended Order 53 Statement seeks an Order of Certiorari quashing the entirety of the ruling enshrined in the Senior Coroner's letter dated 27th August 2008, it is clear from the grounding affidavit and the presentation of the Applicant's case at the hearing that this ruling is challenged in certain discrete respects only. I have highlighted above that aspect of the ruling which I consider to be unreasonable and unfair in the ***Wednesbury*** sense. In the exercise of the court's discretion, I consider that an Order of Certiorari quashing the whole of the ruling would be inappropriate. The more appropriate remedy, to

reflect my conclusions, would be a declaration and I propose to adopt this course, subject to any further argument from the parties.

Disposal

[70] **The** declaration will recite that it will be unlawful for the former Prisoner Ombudsman to give evidence at the forthcoming inquest hearings of any of the matters contained in the reports of Dr. Cooper and Dr. Lloyd-Jones and reflected in the corresponding passages and recommendations in the former Prisoner Ombudsman's report. The declaration will be finalised when the parties have prepared a draft for consideration.

[71] Finally, I have considered the parties' submissions on costs. The decision in ***Regina (Davies, No 2) v. HM Deputy Coroner for Birmingham*** [2004] EWCA Civ 207confirms that judicial review applications of this kind are governed by ordinary principles. Given my conclusions, it is appropriate to order that the Applicant recover her costs from the Respondent. Ultimately, there was no dispute about this matter between the parties. In accordance with well settled practice, the intervening party (the Prisoner Ombudsman) will be responsible for its own costs.

Postscript

[72] As a postscript, I would invite the Senior Coroner to voluntarily reconsider the desirability of the inquest jury receiving copies of *any* part of the Prisoner Ombudsman's report and to reconsider what evidence, if any, should properly be given by Mr Coulter at the inquest hearings. In my view, there is a danger that the jury will fail to perform independently its functions and responsibilities under the framework established by Section 31 of the 1959 Act, Rules 15 and 22 – 23 of the 1963 Rules and Article 2 of the Convention if Mr. Coulter's report, with its findings, conclusions and recommendations, should receive undue prominence. This I consider to be a real risk. My second observation is that Mr. Coulter has conducted an investigation quite different from the investigation to be undertaken by the inquest jury. While there will be significant areas common to both investigations, they are not the same and, in particular, the statutory framework which I have just highlighted applies to the inquest jury alone. Thirdly, the evidence assembled by Mr. Coulter and influencing his findings, conclusions and recommendations has not been tested in the manner in which, for example, the evidence of Drs. Cooper and Lloyd-Jones will in all probability be probed and challenged by the legal representatives of the Applicant and Dr. Thompson. Fourthly, I would highlight that the Prisoner Ombudsman's report is something of indisputable value and importance which may be expected to have a substantial impact, irrespective of how it is deployed in the inquest forum. Furthermore, it contributes to compliance by the State with its investigative duty under article 2.

[73] I would further observe that much of the Prisoner Ombudsman's report contains matters of opinion and recommendations. The danger which this generates is that the inquest jury could be distracted from performing its central function, which is to make findings of fact and, insofar as appropriate, to draw inferences from facts found. Lord Bingham's opinions in ***Middleton*** and ***Jordan and McCaughey*** are replete with statements to this effect. In paragraphs [36] –[37] of ***Middleton***, the term "*factual conclusions*" appears four times. The tenor of paragraphs [39] – [40] of Lord Bingham's opinion in ***Re Jordan and McCaughey*** is to the same effect. In short, the function of the jury at the forthcoming inquest will be to make factual conclusions. At most, the verdict may embody "*a judgmental conclusion of a factual nature*": ***Middleton***, paragraph [37]. It seems to me that the unequivocal guidance contained in ***Middleton*** and ***Re Jordan and McCaughey*** requires due reflection and emphasis in light of the controversial issues exposed by the present challenge and given the exhaustive analysis of Mr. Coulter's report which this has generated.

[74] Moreover, fundamentally, the function performed by the Prisoner Ombudsman, duly assisted, was that of *an investigator*. Self-evidently, the Prisoner Ombudsman will have no evidence which he can personally give relating to the circumstances surrounding the death. Most of the evidence possessed by him will have been generated by his investigation and, therefore, belongs to sources other than him. Where such evidence will be given by other witnesses, the propriety of the Prisoner Ombudsman purporting to give the same evidence seems questionable. While it might be different if the evidence in question cannot be adduced in any other way, this contention was not advanced to the court on behalf of either the Senior Coroner or the Prisoner Ombudsman. Further comment on this hypothetical possibility would not be appropriate. Clearly, the Prisoner Ombudsman, arising out of his investigation, which appears diligent and thorough, has formed certain personal views and opinions. Bearing in mind the purposes of the inquest, having regard to the legal framework highlighted above, the Senior Coroner may wish to reflect on the propriety of the Prisoner Ombudsman relaying such views and opinions to the inquest jury.

[75] The further reflection which I have exhorted the Senior Coroner to undertake will, hopefully, contribute to a fair inquest hearing, conducted within appropriate constraints and boundaries and a fair and robust jury verdict. To go any further either in this judgment or in the proposed order of the court is not warranted by the parameters within which this judicial review challenge has unfolded and would probably be inappropriate micro-management on the part of this supervisory court in any event.

[76] For the avoidance of any doubt, my observations in paragraphs [72]-[75] above lie outwith the conclusions expressed earlier and will, therefore, not feature in the final order of the court. Stated succinctly, they are *obiter.*

[77] Finally, I record my gratitude to all counsel for the diligence of their preparations and the quality of their submissions.