Leigh Day

VERY URGENT

HM Acting Senior Coroner Pears

The Court House
Woburn Street
Ampthill
Bedfordshire MK45 2HX

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Email: mvarney@leighday.co.uk
Your Ref:
Our Ref: MVA/TPS/00142064/2
Date: 4 May 2018

First by email via the Coroner's Officer

Letter Before Action

Dear Sirs

In proposed action: R (on the application of Andrew and Amanda McCulloch) v HM Acting Senior Coroner for Bedfordshire and Luton

We write this letter in accordance with the Pre-Action Protocol for Judicial Review.

The Proposed Defendant

HM Acting Senior Coroner for Bedfordshire and Luton, Ian Pears ("the Coroner")

The Proposed Claimants

Mr and Mrs McCulloch
112 Dennett's Road
New Cross
London
SE14 5LW

Interested Parties to any Action

We consider that the following would be interested parties in the proposed judicial review on account of their status as Interested Persons in the Inquest and have provided them with a copy of this letter:

- Mr Fokt (via DAC Beachcrofts)
- Milton Park (via BLM)
- Dr Olutwatyo (via Radcliffes Le Brasseur)
- The "AMHP tri-party alliance" (via Hempsons)
  - East London NHS Foundation Trust
  - Central Bedfordshire Council
  - Bedford Borough Council

Please notify us if you consider there to be additional Interested Persons or if you disagree with our assessment of the likely status of the above parties.

Reference details

MVA/00142064

Please advise us of your reference details.

The details of the Claimants' legal advisers

Merry Varney
Leigh Day
25 St John's Lane
London
EC1M 4LB

Reference details above.

The issue

FACTUAL BACKGROUND

Colette McCulloch

The Coroner will be familiar with the circumstances of Colette's death and the concerns of her family as to the care she was provided.

Colette died on 28th July 2016 from multiple injuries, having been hit by a lorry as she was walking along the A1, about half a mile from Milton Park Therapeutic Campus, in the early hours of the morning. She had a long history of mental health

illness, and in the months before her death her care provider (Trascare) had made it clear they could not meet her needs; there had been multiple referrals for a mental health assessment which had been rejected (by the local AMHP service, who never met Colette); and there was evidence of increasing and escalating risky behaviour.

Conduct of the inquest

Within a month of her death, on 22nd August 2016, Colette's father, Mr Andrew McCulloch, sent an email to the Coroner's officer setting out a number of *'initial concerns'* relating to Colette's death. That was followed by a further email from the family on 5th September 2016 with a chronology of key events. An email of 4th November 2016 requested that the Coroner list a pre-inquest review. At around that time conduct of the inquest was passed from the then Senior Coroner (Mr Osborne), to his replacement, the Acting Senior Coroner, Mr Pears. On 4th November 2016 the family received some records from Milton Park, which they had requested directly. On 23rd November 2016 the family were provided with a Serious Incident Review by Milton Park and two statements, one from a doctor at Milton Park, and another from a GP.

A pre-inquest review was held on 8th December 2016. At the time the family did not even consider instructing a solicitor as they understood it was not necessary in a Coroner's Court, as they had read in the information booklet, *Guide to Coroner Services*. At the outset of the hearing the Coroner stated words to the effect of "there must be no shouting" (which was plainly directed at the family) and told Mr and Mrs McCulloch that only one of them could speak and for three minutes only. For clarity, neither Mr nor Mrs McCulloch had acted in a way to suggest that they would start shouting. This was their first time in a coronial court and they found the Coroner's abrupt beginning to the hearing to be distressing, aggressive and rude.

At that hearing, the Coroner was dismissive of an attempt by Mr McCulloch to persuade him that there were broader issues to investigate than the road traffic collision. Mr McCulloch sought, in particular, to persuade the Coroner that he should consider how Colette came to be on the road given their view that but for failings in their daughter's care she would not have been placing herself and others at such high risk. The Coroner's response was to state *"we don't need to investigate how the lorry got there."* The Coroner indicated that Colette's death was a road traffic accident, and that was to be the scope of the inquest, with no witnesses being called. The inquest was listed for one day on 14th March 2017.

The family, concerned as to the conduct of the 8th December 2016 hearing and worried about the approach that was likely to be taken at the upcoming inquest,

thereafter instructed Leigh Day solicitors, and the same was communicated to the Coroner's office on 29th December 2016.

By email of 24th January 2017 Leigh Day provided the Coroner with a list of documents held by the family, and provided copies of the same, save those already held by the Coroner.

In view of the carefully expressed and wholly reasonable concerns relating to Colette's death raised by the family, it was a matter of concern that the family received the following by email on 9th February 2017:

> *"I write concerning the inquest touching the death of Colette McCulloch*
>
> *The Acting Senior Coroner, Ian Pears has had sight of the police collision investigation report. He believes this to be a straightforward road traffic collision, where the only required witnesses would be the police officer and driver of the HGV (if they are UK based). Mr Pears has asked for written submissions regarding the scope of the inquest should you not agree with his decision"*

On 21st February 2017 the family provided written submissions drafted by Caoilfhionn Gallagher QC, based on the limited material then available, on the scope of the inquest and whether the investigative duty under Article 2 was engaged. The hearing listed for 14th March 2017 as an inquest was changed to be a pre-inquest review.

By letter of 7th March 2017 the family made a written complaint as to the Coroner's conduct at the pre-inquest review in December 2016. It was noted that the recording of the hearing was missing the opening few minutes. Complaint was made that the Coroner had been rude and caused the family considerable distress. A request was made for the Coroner to recuse himself.

The Coroner's officer responded by stating that, at the Coroner's direction, *"there is to be no further communication by email or telephone prior to this hearing."*

The pre-inquest review took place on 14th March 2017. At the time the only recognised interested persons were the family, Tracscare and the driver of the vehicle involved in the road traffic collision. The Coroner declined a request from the family that he recuse himself given the circumstances and the family's deep distress and concern regarding his conduct at the December hearing, and halted the pre-inquest review to enable additional interested persons to make representations. An inquest was listed for 7th November 2017, to last six days. No

decision was made on the Article 2 question, raised by the family in their submissions of 21st February 2017.

On 17th March 2017 the Coroner circulated a note with 'preliminary views', indicating that the scope of the inquest was to investigate the conduct of AMHP dealing with applications by Milton Park to have Colette sectioned.

On 18th April 2017 a note from the Coroner was provided indicating that he had received *"about 2 boxes of documents"* which *"is taking some time to go through, please be patient."* It was said that the AMHP service indicated three bodies were involved: ELFT, BBC and CBC.

A further note from the Coroner of 9th May 2017 indicated he was *"aware that things are not progressing as fast as may have been hoped"*. The Coroner proposed a timetable in which disclosure was to be completed by 4th July 2017, 'primary submissions' were to be provided by 1st August 2017, and 'Secondary submissions' by 15th August 2017.

The family wrote a letter to the Coroner dated 15th May 2017 expressing concern regarding the lack of progress and inviting him to reconsider the timetable. It was noted that Colette had died almost a year previously, and the family sought an explanation as to *"why the public bodies involved are not being required to act more promptly, in particular in light of the time that has passed..."*.

The Coroner provided a note dated 18th May 2017:

> *I have received yet another letter from the solicitors for the family. This is dated 15th May 2017.*
>
> *I am not proposing to conduct the investigation through correspondence. When the steps envisaged have been completed, I will be able to assess:*
>
> - *The scope of the inquest*
> - *whether Article 2 is engaged*
> - *whether any further disclosure is required*
> - *who should give evidence*
>
> *I am not prepared to second guess at this stage whether there is any substance in the demands being made by the family's*

solicitors. It is completely inappropriate to do so, particularly by correspondence.

This does not mean that the family's solicitors are prevented from raising their concerns about, inter alia, disclosure with the other Interested Parties at this stage.

...

In terms of the timetable, it is generous because it seems to me that the demands for disclosure is so extensive that it allows for any concerns relating to missing disclosure to be resolved. This of course assumes that the family's solicitors are communicating with the other Interested Parties. It seems pointless to me to force a short timetable and then be faced with a further list, which no doubt will then delay submissions.

I have been asked about primary and secondary submissions. At the PIR Miss Gallagher seemed to want to reply to the other Interested Parties' submissions. I was surprised that Miss Gallagher wanted to be able to do this, but nevertheless I don't see any particular reason for not accommodating her request.

Having never had advocates requiring a double set of submissions, the terminology of "primary" and "secondary" is my own. No doubt I will be advised of the correct terminology in due course.

If Miss Gallagher no longer wants to submit secondary submissions, then I'm happy to delete that direction.

In terms of the timings, I regard the directions of a Coroner as having the same footing as that of a (District) Judge in that the substance is the important aspect, the timings, however, can be changed by agreement amongst the Interested Parties. The only aspect that the Interested Parties need to take into account is that on no account is the inquest date to be interfered with. That date is a fixture and will only be adjourned if there are unusual circumstances.

All I ask, as with civil procedures, is that any revised timetable be provided to my officer."

The tone is increasingly terse (*"yet another letter"*, and indeed, sarcastic *"No doubt I will be advised of the correct terminology in due course"*). In fact, the family had

only sent two letters and one email since the pre-inquest review on 14th March 2017. They were still awaiting a decision on the Article 2 issue, so critical to the conduct of the inquest.

By letter of 30th May 2017 the family wrote to say that *"The opening comment and the overall tone of your Note compounds their lack of confidence in you to treat them fairly and to fully and fearlessly investigate the death of their beloved daughter".*

By email of 2nd June 2017 the Coroner's office indicated that the Coroner recognised that time was passing, but also that making a decision without the evidence fully available was *"not helpful to anyone"*. The Coroner also noted that *"the request to change coroner remains outstanding, but so too is my decision that this is a decision for the new Senior Coroner when he or she is appointed."*

On 18th September 2017 (six months after the last pre-inquest review) the AMHP service provided submissions which were to the effect that Article 2 was engaged. Accordingly, amongst the interested persons both the family and the AMHP service had made representations to the effect that Article 2 was engaged (the family in February 2017, and the AMHP in September 2017), and no interested person had made any submissions to the contrary.

On 21st September 2017 the family indicated that as the interested persons were in effect agreed as to Article 2 being engaged they would not make further written submissions.

The Coroner then provided a ruling dated 4th October 2017 that, inter alia, Article 2 was not engaged. This was seven and a half months after the family's submissions had been made on 21st February 2017. The Coroner's ruling was pre-occupied with criticising the family's representatives, and persisted in his terse and at times facetious tone, including, for example (this is an indicative rather than an exhaustive list of concerns regarding this ruling):

a) The Coroner referred to Ms Gallagher's submission that deciding the scope of the inquest before the applicability of Article 2 was kafkesque but *"without explaining what she meant or why it would be Kafkaesque (nor indeed why the writings of Kafka are binding)."*
b) The Coroner described it as *"an unfortunate aspect of the family's submissions that there is no factual matrix available"*. Quite what the Coroner meant by a 'factual matrix' was not clear, but the family had provided a detailed chronology over a year previously, and a summary of their concerns, and submissions both orally and in writing, commencing with

their very first communications in the weeks following Colette's death, 14 months prior.

c) The Coroner described having been *"hampered in this investigation by the failure of the family to provide me with their evidence" and " no doubt when the family's advisers realise their error I will be provided with the documents requested."* That criticism was wholly unfounded, as the documents had been provided many months previously.

d) The Coroner expressed *"concern"* at the point that Milton Park had applied for Colette to be sectioned *"but the family then, for whatever reason, deciding not to support the application."* He considered it arguable that this did *"release the state from its obligations."* and stated that *"no attempt was made by Miss Gallagher to explain whether Article 2 is triggered when the sectioning process is brought to an end by a family member."*

The family sent a letter-before-claim dated 16th October 2017 warning of a challenge by way of judicial review relating *inter alia* to the decision that Article 2 was not engaged and procedural unfairness.

By letter of 30th October 2017 the Coroner (via his instructed solicitors) indicated that he now conceded that Article 2 was engaged. It is a matter of serious concern to the family that, although they had been waiting for the Coroner's ruling on the Article 2 issue for a period of many months (February to October 2017, over seven months), he continued to be resistant to accepting this until they sent a pre-action letter. The letter of 30th October 2017, whilst conceding that Article 2 was engaged, stated that the Coroner would contest a judicial review to the effect that the inquest should have a broader scope. Part of the reasoning in relation to scope was that evidence from the family was only *"conjecture"*. That was addressed by further correspondence from the family dated 7th November 2017 who asserted that:

> *...the evidence of Colette's parents is not conjecture, as characterised by the [Coroner]; it is evidence of two people who knew Colette perhaps better than any of those caring for her, and were intimately involved in her day to day life. They spoke frequently, and Colette's parents were in frequent contact with Milton Park. The evidence of Colette's parents as to what was contributing towards Colette's risky behaviour prior to her death is important and valuable evidence. It is based on their detailed knowledge of Colette and her experience at Milton Park. It is more than conjecture, and to be dismissive of it (as the Defendant has been) is unreasonable and disrespectful.*

The Coroner thereafter indicated that he was prepared to look at scope again.

By letter of 24th November 2017 the family wrote:

> *[The family] remain deeply disappointed by your latest letter, both in terms of its content and its tone. ...*
>
> *Given the bereaved family's loss of confidence and trust in [the Coroner], together with the fact that holding a PIR in front of the Coroner who will preside over the final inquest would be by far the most proportionate, cost effective and sensible way to proceed given the nature of the inquest, [the Coroner] is requested to make a decision regarding the request to exercise his [power to transfer] now, rather than as you have suggested as a subsequent PIR.*

By letter of 14th December 2017 the family requested that a PIR be listed promptly.

On 9th January 2018 the Coroner sent out a further Note to the interested persons. He stated he was *"fairly confident that I have not yet been provided with all the evidence that the parties have access to"*, and ordered it to be disclosed by 25th January 2018, and that once the missing evidence had been read he would fix a pre-inquest review.

He also stated (paragraph 6) that

> *"the family's view on scope remains a mystery to me. On this point I am referred to pages and pages of submissions. I am looking for one sentence on what scope should be, not submissions supporting their position. It seems to me that if the other parties are similarly unclear as to what the family's position is, that it is unfair to have simultaneous exchange of submissions."*

He observed: *"No doubt the family will send me guidance on what is preferred."*

On 24th January 2018 the family sent a short note expressing, as requested, their view as to scope stated in a sentence.

On 21st February 2018 the Coroner listed a pre-inquest review for 24th May 2018 with a time estimate of 1.5 hours. This was due to be the first substantive pre-inquest review following the belated ruling of October 2017 on Article 2, and it was also due to consider the outstanding question of whether the Coroner would recuse himself or agree to have another Coroner take over the matter. By correspondence of 28th February 2018 the family expressed concern about the

time that was being taken to progress the inquest, and suggested that 1.5 hours was an insufficient time estimate given the number and nature of the issues to be dealt with. The letter further set out some suggested steps to progress the investigation pending the pre-inquest review some 3 months away, so that more time was not lost. The context of this letter was that by that time, February 2018, it was some 19 months since Colette's death and the family was deeply frustrated and distressed by the delays in the investigative process and the lack of any meaningful progress, and they were concerned to ensure that some belated progress be made over the 3 months leading up to the new listing.

However, rather than this communication resulting in any progress, it had quite the opposite effect. On 17th April 2018 the pre-inquest review was re-listed for 15th June 2018 with a time estimate of two hours. The email informing the interested persons stated:

> *"I write concerning the inquest of Colette McCulloch.*
>
> *Having read the letter of Leigh Day dated the 28th February 2018, the Coroner has moved the PIR to the 15th June at 2pm. It should be noted that this will now have a time estimate of 2 hours, but has the advantage that it is guaranteed to start on time."*

Within a couple of hours of the email being sent, two interested persons expressed concerns at this relisting and fixing of a fresh date without notice or discussion: Hempsons, on behalf of the AMHP service providers indicated they were concerned about their Counsel's availability and BLM on behalf of Tracscare had confirmed their Counsel was not available for the re-listed hearing. Similarly, the family had difficulties with the new date and so on 18th April 2018 they wrote to the Coroner to explain that they could not attend the re-listed hearing and asked for the initial hearing date to be maintained.

The following day, the Coroner's Officer sent an email stating

> *"Mr Pears is adamant that the pre-Inquest hearing cannot proceed on the 24th May 2018 as he is now unavailable."*

Dates of availability were requested for June, July and August. Before the family had had a chance to reply the Coroner issued a Note dated 24th April 2018. A full copy of the Note is attached. The Coroner referred to the family's lack of availability as an "outcry of protest", but made no mention of the responses of the other interested persons or their availability difficulties. He went to comment:

"Having re-read the letter from Leigh Day, I don't understand the purpose of it if it was not making submissions about the time estimate. If it is a letter that I am supposed to just ignore, which the subsequent correspondence would lead me to believe, why write the letter to me in the first place?"

The Coroner proposed to have, as an alternative to an oral hearing, a pre-inquest review conducted in writing. The family consider, supported by one other interested person to date, that a written PIR is not appropriate and hence face the prospect of waiting 2 months after the second year anniversary of their daughter's death for a PIR to be listed. They are also still awaiting a decision regarding whether or not this Coroner intends to conduct the final inquest. [It is understood from the Coroner that this delay is said to be due to no new Senior Coroner for the area having yet been appointed.]

Summary of Grounds of Judicial Review

There are two proposed grounds of judicial review, namely (a) breach of Article 2, and (b) recusal on grounds of bias. Both are addressed in some detail below as the family hope that the Coroner will engage with the issues now and take the action sought, rather than them having to proceed with distressing, expensive and lengthy judicial review proceedings. They seek a full, fair and fearless inquest into their daughter's death, which gives them answers and also prompts institutional learning where required. They are entitled to this, under both Article 2 of the European Convention on Human Rights (ECHR) and the statutory framework, and it is a matter of deep regret and concern to them that they are now placed in this position. They very much hope that litigation can be avoided and that the steps which they set out below can be taken swiftly.

BREACH OF ARTICLE 2

Legal framework

There is a heavy obligation on Coroners to conduct inquests promptly. The core statutory duty placed upon Coroners by the Coroners and Justice Act 2009 (CJA 2009) is a duty to investigate "as soon as practicable" (section 1(1)). Rule 8 of The Coroners (Inquests) Rules 2013 states that *"A coroner must complete an inquest within six months of the date on which the coroner is made aware of the death, or as soon as is reasonably practicable after that date."* Pursuant to Regulation 26(1) of The Coroners (Investigations) Regulations 2013 where an investigation has not been completed within a year of the date that the death was reported, the Coroner must notify the Chief Coroner of that fact as soon as is reasonably practicable from the date that the investigation becomes a year old and explain why the

investigation has not been completed or discontinued. The Coroner must again notify the Chief Coroner when that investigation is completed.

Further, the Chief Coroner in turn has a statutory duty to report to the Lord Chancellor on investigations lasting more than 12 months beginning with the day on which the coroner was made aware that the person's body was within the coroner area (section 16, Coroners and Justice Act 2009). The Chief Coroner is required, under section 18 of the same Act, to write an annual report for the Lord Chancellor in which he must include the number of cases in which the investigations are lasting over 12 months.

The statutory scheme makes clear that there is a presumption of promptness in investigation, and a duty on Coroners to act with due expedition, with the process being overseen by the Chief Coroner and reported to the Lord Chancellor where the investigation exceeds 12 months.

That obligation of expedition is consistent with the investigative duty arising under Article 2 of schedule 1 to the Human Rights Act 1998 (the right to life), one component of which is that the investigation into the death is conducted promptly: see, for example, amongst many authorities on the point, *Jordan v UK* (2003) 37 EHRR 2.

The duty is both to commence the investigation promptly, and to proceed with reasonable expedition, and *"this is required quite apart from any question of whether the delay actually impacted on the effectiveness of the investigation"*: *McCaughey* (2014) 58 EHRR 13 at [130].

One purpose of the requirement of promptness is to ensure the effectiveness of the investigation. In *Al-Skeini v UK* (2011) 53 EHRR 589 at [167], promptness was described as *"essential in maintaining public confidence in … adherence to the rule of law"*. In *Edwards v UK* (2002) 35 EHRR the Strasbourg court emphasised the importance of promptness given that the passage of time "*will inevitably erode the amount and quality of the evidence available*", while "*the appearance of a lack of diligence*" will both "*cast doubt on the good faith of the investigative efforts*" ([86]).

The courts have also recognised the impact of a dilatory investigation can have on the victims and families of those directly concerned. Thus, in *Edwards* the court described that an investigation lacking promptness will "*drag out the ordeal*" (86]). At first instance in *Hugh Jordan* [2014] NIQB 71, Stephens J observed that

> *"The investigation into the death of a close relative impacts on the next of kin at a fundamental level of human dignity. It is obvious that if unlawful*

delays occur in an investigation into the death of a close relative that this will cause feelings of frustration, distress and anxiety to the next of kin. The primary facts lead on the balance of probabilities to the inference of feelings of frustration, distress and anxiety."

Another reason for promptness is that part of the function of the coronial process is to provide an opportunity for the learning of lessons in order to avoid the occurrence of future deaths. There is a compelling public interest in identifying any systemic failings giving risk to a risk of future deaths at the earliest possible stage. That was recognised in *Silih v Slovenia (2009)* 49 EHRR 37:

> *"195 A requirement of promptness and reasonable expedition is implicit in this context. Even where there may be obstacles or difficulties which prevent progress in an investigation in a particular situation, a prompt response by the authorities is vital in maintaining public confidence in their adherence to the rule of law and in preventing any appearance of collusion in or tolerance of unlawful acts. The same applies to art.2 cases concerning medical negligence. The State's obligation under art.2 of the Convention will not be satisfied if the protection afforded by domestic law exists only in theory: above all, it must also operate effectively in practice and that requires a prompt examination of the case without unnecessary delays.*
>
> *196 Lastly, apart from the concern for the respect of the rights inherent in art.2 of the Convention in each individual case, more general considerations also call for a prompt examination of cases concerning death in a hospital setting.* ***Knowledge of the facts and of possible errors committed in the course of medical care are essential to enable the institutions concerned and medical staff to remedy the potential deficiencies and prevent similar errors. The prompt examination of such cases is therefore important for the safety of users of all health services." [emphasis added]***

Application to this case

As the second anniversary of Colette's death approaches, the Coroner is in the process of making arrangements for a pre-inquest review to consider a number of basic questions which are central to the inquest process: (a) who is to hear the inquest, (b) the scope of the inquest, (c) who is to be identified as an interested party, (d) the witnesses that are to be called, (e) whether the inquest is to be heard

by a jury. Two years on there is still no listing for a final inquest, and nor can there be as fundamental questions about the inquest still remain to be determined.

The delay thus far has not been born out of complexity or unavoidable delay or the need to gather evidence; it has been born out of inaction. Notably:

1. The Coroner was notified of Colette's death in August 2016. The Coroner was required by the rules to complete the inquest by February 2017, or as soon as practicable thereafter. In the event, no pre-inquest review was listed until 8th December 2016.

2. At the pre-inquest review on 8th December 2016 it was clear that the Coroner did not consider this a matter of any complexity; on the contrary, he was treating this as a straightforward road traffic matter, with the inquest hearing to be listed for a single day. Nevertheless, he failed to list the final inquest within the six month period, and the one day inquest was not even listed until March 2017.

3. The family made submissions on Article 2 ECHR promptly, within weeks of instructing their solicitors, in February 2017. The pre-inquest review at which oral submissions were initially heard as to Article 2 was in March 2017. No decision was made until October 2017, some seven months later, and only 4 weeks in advance of the final inquest hearing then listed for 6th November 2017. This is an extreme and grave delay, in itself lasting in excess of the 6 month period within which investigations should routinely need to be commenced and concluded. It is noted that there was further disclosure to consider, as well as the need to provide further interested persons with opportunity to make submissions, but a period of seven months was wholly unnecessary and disproportionate.

4. Following pre-action correspondence, on 30th October 2017 the Coroner conceded that Article 2 was engaged. At the same time, the Coroner indicated that further consideration would be given to his recusal, and the scope of the inquest. No listing for a further pre-inquest review was provided until 21st February 2018, and the listing was for 24th May 2018, approximately seven months after it becoming evident that a further pre-inquest review was necessary. Again, this delay in itself is in excess of six months. The listed hearing has now come out of the list, and the Coroner has proposed directions for a pre-inquest review to be conducted in writing only, with decisions to be made over two years after the death, and almost a year after having conceded that Article 2 was engaged and that further consideration would need to be given to the scope of the inquest.

The extent to which the delay in progressing the inquest will impact upon its effectiveness is impossible at this stage to assess. It is inevitable, however, that that by the time of the final inquest (whenever that may be) memories of the witnesses will have faded. If there are lessons to be learnt, there will have been a considerable delay in learning them. What is similarly certain, is the feelings of frustration, distress and anxiety felt by the Claimants as they seek an effective inquest into their daughter's death.

RECUSAL ON GROUNDS OF BIAS

Legal Framework

The approach of a court in considering whether there is a need for recusal on grounds of bias is to (a) ascertain all the circumstances which have a bearing on the suggestion that the judge was biased, and (b) then ask whether those circumstances would lead a fair-minded and informed observer to conclude that there was a real possibility, or a real danger, the two being the same, that the tribunal is biased: see *Porter v Magill* [2002] 2 AC 357, endorsing the approach of Lord Phillips MR in *Re Medicaments and Related Class of Goods (No 2)* [2001] 1 WLR 700.

The principle has, at its core, *"the need for confidence which must be inspired by the courts in a democratic society ... public perception of the possibility of unconscious bias is the key"*: *Lawal v Northern Spirit* [2003] UKHL 35; [2003] ICR 856.

Disqualification or recusal where there is a real possibility of bias is not discretionary; the Judge is automatically disqualified: *AWG Group v Morrison* [2006] 1 WLR 1163 at [6].

An example of a real danger of bias is where *"there was ... animosity between the Judge and any member of the public involved in the case"*: *Locabail UK Limited v Bayfield Properties Ltd* [2000] QB 451 at [25].

In *Howell v Lees Millais* [2007] EWCA Civ 720, Sir Anthony Clarke MR observed that (at [8]):

> *"The mere fact that a judge has decided a case adversely to a party or criticised the conduct of a party or his lawyers will rarely if ever be a ground for recusal. However, a real danger of bias might be thought to arise if there were personal friendship or animosity*

> *between the judge and a member of the public ..." [emphasis added]*

In *R (Butler) v HM Coroner for the Black County District* [2010] EWHC 43 (Admin) the Coroner had acted unlawfully in setting too broad a scope for the inquest. Having declared the Coroner's decision to be unlawful, the Administrative Court considered that the inquest should proceed with a different Coroner, asking itself whether there was *"a real danger that the coroner was unconsciously biased in the sense of there being actual, though unconscious, bias"* ([84]). The court observed that ([85]):

> *... the coroner in this case has, on a number of points, reviewed and changed his position in favour of the claimants, even though he did so in respect of some matters only after these proceedings had been instituted. But the tone of his letter dated 10 June 2009 in response to the solicitors' enquiry and request for disclosure, his assertion that the solicitors did not understand the coronial process, and that he had decided what might be relevant and revealed matters "that are not the subject of an embargo", and "that, with respect, is an end to the matter", together with what he said about evidence being read indicates a surprising approach at the very beginning of his contact with the claimant's solicitors. Thereafter, as is seen from the correspondence I summarised earlier in this judgment, matters escalated on both sides.*
>
> *86 The contents of the correspondence from the coroner's initial response in his letter dated 10 June 2009, his approach to disclosure and failure to disclose or explain the Memorandum of Understanding between the HSE and the National Coroner's Society which he claimed obliged him not to disclose relevant documents to the claimant, and his failure to disclose statements of employee witnesses favourable to the claimants who (see [44]) he had expressed no intention of calling until 27 August 2009 have led me to conclude that it is right that the resumed hearing of the inquest take place before a different coroner or deputy coroner.*

The *Butler* case was characterised by Burnett J in *R (Pounder) v HM Coroner for the North and South Districts of Durham and Darlington* [2010] EWHC 328 (Admin) as a case in which the correspondence from the Coroner had become *"inappropriately combative"* ([35]).

In most cases, the answer as to whether there is a real possibility of bias, one way or the other will be obvious. But if in any case where there is real ground for doubt,

that doubt should be resolved in favour of recusal. Where the hearing has not yet begun, there *"is scope for the sensible application of the precautionary principle. Prudence normally leans on the side of being safe rather than sorry"* : *AWG Group* at [9, 25].

Application to this case

The proposed Claimants submit that considering the following matters, separately and cumulatively, a fair-minded and informed observer would conclude that there is a real possibility that the Acting Senior Coroner is biased against the family:

a) The Coroner has generally been dismissive of concerns raised by the family. Notwithstanding the wholly reasonable and convincingly expressed concerns raised by the family early as Mr McCulloch's email of 22nd August 2016, the Coroner continued until March 2018 to treat the inquest as a 'straightforward road traffic accident'.

b) The concern that the Coroner had little interest in the concerns raised by the family was compounded by his attitude towards the family at the pre-inquest review on 8th December 2016. As above, the Coroner started the hearing by announcing that *"there must be no shouting"* and limited the time the family were allowed to speak to three minutes. The response to wholly reasonable concerns as to the care provided to Colette and the relevance of those concerns to how she came to put herself at risk on a road, met with the comment that there was no need to investigate how the lorry got there. In the circumstances of a bereaved family trying to explain to the Coroner (in calm and reasonable terms) why they are so concerned about the circumstances leading to their daughter's death, the Coroner's conduct was wholly unwarranted, and inevitably leads to the perception that he has little interest or concern for matters raised by the family.

c) The family were entitled to make a complaint by their letter of 7th March 2017 and, moreover, entitled to expect that the Coroner would be able to address it professionally, and without it impacting upon his conduct of the inquest. Instead, the response of the Coroner was to immediately direct that the family was not permitted to communicate with the court prior to the hearing.

d) Thereafter, the Coroner has evidently been aggravated by correspondence from the family, and perceives it to be a nuisance, notwithstanding that the issues raised by that correspondence are reasonable and simply form part of the right of the family to be involved in the inquest process. It was

notable, for example, that on 18th May 2017 the Coroner complained about *"yet another letter"* and *"not proposing to conduct the investigation through correspondence"*, notwithstanding that only two letters and one email had been sent in the preceding two months. Moreover, those communications had done nothing more but seek updates, and raise entirely reasonable concerns as to the progress (or lack thereof) of the inquest. The family finds itself in the invidious position that the very act of raising a reasonable concern in correspondence provokes the ire of the Coroner.

e) The Coroner's tone has been inappropriately combative, adversarial and at times even sardonic. This tone is reserved exclusively for the family. Most recently, when the family wrote on 18th April 2018 to convey the wholly reasonable concern that the re-listed PIR coincided with a date which for medical reasons the family, the Coroner chose to characterise this as *"an outcry of protest."* This was a criticism targeted solely at the family despite the family being one of three Interested Persons which had raised concerns about availability on the unexpected new listing date. The Coroner also queried the purpose of being written letters which he is *"supposed to just ignore."* The family had done nothing more than make the reasonable submission that the pre-inquest review should remain listed for its date on 24th May 2018, albeit with a longer time estimate.

The Coroner has known for a period in excess of a year that the family does not have confidence in him and finds his approach and tone extremely distressing. He has been asked to agree to transfer this matter to a colleague, his Deputy, but has not yet made a decision and has indicated that a decision must await the appointment of a new Senior Coroner for the area. There has been a long delay in appointing a new Senior Coroner and so this matter has remained unresolved, awaiting determination at the long-awaited pre-inquest review which was due to take place in May but has now been cancelled.

The Coroner's combative and sarcastic tone and approach is causing Colette's parents serious distress and has undermined their faith in the Coroner's ability to perform his judicial role. It is impeding their ability to effectively participate in their daughter's inquest, which is at the heart of their rights protected by Article 2.

Details of the action that the defendant is expected to take:

As relief from the Administrative Court the Claimants will seek a mandatory Order requiring the inquest concerning Colette's death to be transferred to a different Coroner.

The Claimants will also seek a declaration of breach of the procedural/investigative duty arising under Article 2 of schedule 1 to the Human Rights Act 1998. The Claimants also reserve the right to seek a payment of damages by way of just satisfaction for breach of Article 2, either as part of the judicial review, or as a matter to be stayed pending the resolution of the inquest (cf the approach in *Hugh Jordan (Delay and Damages)* [2015] NICA 66).

In order to avoid the necessity of issuing judicial review proceedings, the family invites the Coroner:

a) To recuse himself;
b) To indicate to which Coroner he proposes to transfer the inquest;
c) To indicate the timescale within which the 'new' Coroner is likely able to hold a pre-inquest review in order to make the directions necessary to bring this inquest to its conclusion as soon as practically possible.

In the event that the Coroner does not wish to take the steps above, the Coroner is invited to confirm that he will not, as part of the judicial review proceedings, seek any order for costs against the proposed Claimants.

Details of any information sought:

None at this stage.

Details of any documents that are considered relevant and necessary:

A copy of the Coroner's notification to the Chief Coroner pursuant to Regulation 26(1)

Address for reply and service of court documents:

Merry Varney
Leigh Day
25 St John's Lane
London
EC1M 4LB

Proposed reply date:

14 days – Friday 18 May 2018

If we do not receive a satisfactory response within these timescales, we shall issue an application for permission for judicial review on the grounds set out above.

Kindly confirm safe receipt by return.

Yours faithfully

Leigh Day

Leigh Day

CC: All Interested parties listed above

McCULLOCH DECEASED

NOTE 24/04/18

1. I received a letter from Leigh Day dated 28/02/18 which clearly expressed concerns that the PIR which was listed for 24th May 2018 was not going to be of sufficient length. It was listed at 1.5 hours with cases following.

2. I was surprised that Leigh Day felt that 1.5 hours was not sufficient, but felt it was a better use of resources to vacate the PIR and relist with a 2 hour time estimate with no case following.

3. This has resulted in an outcry of protest from Leigh Day.

4. Having re-read the letter from Leigh Day, I don't understand the purpose of it if it was not making submissions about the time estimate. If it is a letter that I am supposed to just ignore, which the subsequent correspondence would lead me to believe, why write the letter to me in the first place?

5. My time has now been re-assigned so the 24th May is no longer available. Leigh Day have asked what I am doing. It seems to me that that question is one I should not answer. My decision to take 24th May off from Coroner duty is one I made following the clear submissions of Leigh Day that 1.5 hours was not sufficient time for the PIR.

6. It is therefore regrettable that the 24th May has been vacated apparently needlessly.

7. I have asked for availability dates from all PIPs and I have agreed to set up an extra date just for this PIR. However, whilst we have capacity to deal with the PIR, there is no date that all the PIPs are available before 31st August.

8. Whilst I am happy for the PIR to be listed after the 4th September it impinges upon the opportunity to have the full inquest being heard in 2018.

9. To resolve the problem, I am prepared, if the PIPs agree, to have a written PIR. That would enable the case to progress now and give a good chance that the inquest could be held before the end of the year.

10. If the PIPs agree to paragraph 9 above then, subject to representations, I would envisage the timetable to be as follows:

    - PIPs to agree to paragraph 9 above by 4th May
    - I will draft an agenda by 18th May.
    - Submissions by 15th June
    - Further submissions [ie upon areas not covered by the original submissions] by 29th June.
    - Rulings sent out by 12th July

11. If paragraph 9 is not acceptable then please provide availability dates to the end of the year by 4th May so my officer can book in the PIR. I'm assuming that 1.5 hours will actually be sufficient.

Ian Pears

Acting Senior Coroner

24/04/18