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Tri Borough Director of Law
Tasnim Shawkat

City of Westminster

Please contact: Hayley Davies
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Our Ref: LS/L/HD/30096249
Your Ref:

Date: 15 July 2015

Alexander Economou
34 Alexandra Mansions
333 King's Road
London
SW3 5ET

Dear Mr Economou,

Re: Claim No: CO/2664/2015 - R (de Freitas) v HM Coroner for West London

We are instructed to represent HM Coroner for West London, Mr Chinyere Inyama ("the Coroner").

We are sending you copies of these documents for information, as we have suggested that you should be entitled to participate in the proceedings as interested parties for reasons given in the Submission.

Yours sincerely

H. Davi

Hayley Davies
Legal – Contentious
for and on behalf of the Director of Law

Judicial Review
Acknowledgment of Service

In the High Court of Justice Administrative Court	
Claim No.	CO/2664/15
Claimant(s) *(including ref.)*	David de Freitas
Defendant(s)	HM Coroner for West London
Interested Parties	(1) Crown Prosecution Service (2) West London Mental Health NHS Trust

Name and address of person to be served

name
HM Coroner for West London

address
C/O Hayley Davies
Legal Services Department, Westminster City Council
Westminster City Hall
64 Victoria Street
London SW1E 6QP

SECTION A

Tick the appropriate box

1. I intend to contest all of the claim	☐	complete sections B, C, D and F
2. I intend to contest part of the claim	☐	complete sections B, C, D and F
3. I do not intend to contest the claim	☐	complete section F
4. The defendant (interested party) is a court or tribunal and **intends** to make a submission.	☑	complete sections B, C and F
5. The defendant (interested party) is a court or tribunal and **does not intend** to make a submission.	☐	complete sections B and F
6. The applicant has indicated that this is a claim to which the Aarhus Convention applies.	☐	complete sections E and F

Note: If the application seeks to judicially review the decision of a court or tribunal, the court or tribunal need only provide the Administrative Court with as much evidence as it can about the decision to help the Administrative Court perform its judicial function.

SECTION B

Insert the name and address of any person you consider should be added as an interested party.

name
Dr Alexandra Ryan

address
Ashville Surgery
Swan House
Parson's Green Lane
Fulham
London SW6 4HS

Telephone no.
020 7371 7171

Fax no.
020 7371 0101

E-mail address

name
Alexander Economou

address
34 Alexandra Mansions
333 King's Road
London SW3 5ET

Telephone no.

Fax no.

E-mail address

SECTION C

Summary of grounds for contesting the claim. If you are contesting only part of the claim, set out which part before you give your grounds for contesting it. If you are a court or tribunal filing a submission, please indicate that this is the case.

The Defendant is a judicial officer and is filing a submission (as attached).

SECTION D

Give details of any directions you will be asking the court to make, or tick the box to indicate that a separate application notice is attached.

The Defendant does not ask the Court to make any directions. His response to the Claimant's applications is set out in the attached Submission.

If you are seeking a direction that this matter be heard at an Administrative Court venue other than that at which this claim was issued, you should complete, lodge and serve on all other parties Form N464 with this acknowledgment of service.

SECTION E

Response to the claimant's contention that the claim is an Aarhus claim

Do you deny that the claim is an Aarhus Convention claim? ☐ Yes ☐ No

If Yes, please set out your grounds for denial in the box below.

SECTION F

*delete as appropriate

*~~(I believe)~~(The defendant believes) that the facts stated in this form are true.

*I am duly authorised by the defendant to sign this statement.

(if signing on behalf of firm or company, court or tribunal)

Position or office held: Principal Solicitor

(To be signed by you or by your solicitor or litigation friend)

Signed:

Date: 15 July 2015

Give an address to which notices about this case can be sent to you

name: Hayley Davies

address:
Legal Services Department
Westminster City Council
Westminster City Hall
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Telephone no.: 020 7641 5984

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If you have instructed counsel, please give their name address and contact details below.

name: Jonathan Hough QC

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4 New Square
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London WC2A 3 RJ

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E-mail address: j.hough@4newsquare.com

Completed forms, together with a copy, should be lodged with the Administrative Court Office (court address, over the page), at which this claim was issued within 21 days of service of the claim upon you, and further copies should be served on the Claimant(s), any other Defendant(s) and any interested parties within 7 days of lodgement with the Court.

Administrative Court addresses

- Administrative Court in **London**

  Administrative Court Office, Room C315, Royal Courts of Justice, Strand, London, WC2A 2LL.

- Administrative Court in **Birmingham**

  Administrative Court Office, Birmingham Civil Justice Centre, Priory Courts, 33 Bull Street, Birmingham B4 6DS.

- Administrative Court in **Wales**

  Administrative Court Office, Cardiff Civil Justice Centre, 2 Park Street, Cardiff, CF10 1ET.

- Administrative Court in **Leeds**

  Administrative Court Office, Leeds Combined Court Centre, 1 Oxford Row, Leeds, LS1 3BG.

- Administrative Court in **Manchester**

  Administrative Court Office, Manchester Civil Justice Centre, 1 Bridge Street West, Manchester, M3 3FX.

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

CO/2664/15

BETWEEN:

THE QUEEN
(On the Application of DAVID DE FREITAS)

Claimant

-and-

HM CORONER FOR WEST LONDON

Defendant

(1) THE CROWN PROSECUTION SERVICE
(2) WEST LONDON MENTAL HEALTH NHS TRUST
(3) DR ALEXANDRA RYAN
(4) ALEXANDER ECONOMOU

Interested Parties

SUBMISSION OF HM CORONER

Introduction

1. These proceedings concern an inquest into the death of Eleanor de Freitas ("Ms de Freitas"), who died on 4 April 2014 at the age of 23. She took her own life by hanging. The Defendant Senior Coroner ("the Coroner") conducted a coronial investigation into her death, culminating in an inquest hearing on 17 March 2015. The Claimant is the father of Ms de Freitas.

2. At the time of her death, Ms de Freitas was about to stand trial on a charge of perverting the course of justice, based on an allegedly false allegation of rape which she had made against a young man, Alexander Economou, in December 2012 / January 2013. That prosecution had been initially been brought on a private basis by Mr Economou, but had

been taken over and pursued by the Crown Prosecution Service ("CPS"). The Claimant is aggrieved about the fact that the prosecution was pursued and he complains about procedural failings by prosecutors.

3. The Coroner conducted an inquest which focussed upon the events of Ms de Freitas's death, but which also considered her mental health background and the events and circumstances which may have influenced her decision to take her own life. However, he declined to engage in an extensive investigation into the conduct of the prosecution – whether or not it should have been taken over by the CPS and pursued; whether or not prosecutors had complied with procedural requirements concerning disclosure; etc. He considered that such an exercise would take the inquest far from its proper territory and would even have required consideration of the original allegation of rape in December 2012 / January 2013. The central question in these proceedings is whether that decision as to the scope of the inquest was lawful.

4. In advance of the inquest hearing, the Claimant's legal representatives argued (a) that the state's procedural obligation under Article 2, ECHR, was engaged in relation to the inquest by reason of the conduct of the prosecution; and (b) that the inquest needed to investigate the conduct of the prosecution in great detail. The Coroner rejected those arguments in a written ruling dated 8 January 2015. The Claimant's representatives then argued that, even on the basis that the Article 2 procedural obligation was not engaged, a detailed investigation of the prosecution was still necessary. The Coroner issued another written ruling dated 9 March 2015 in which he rejected that argument for reasons given in his earlier ruling. The Claimant's counsel raised these arguments again on the morning of the inquest hearing. The Coroner heard and rejected them for reasons which were (it is submitted) in substance the same as those previously given.

5. In the Claim Form and Grounds, the Claimant's principal arguments reiterate those made to the Coroner and rejected in his rulings. The Coroner's position in these proceedings is as follows. He is a judicial officer who made decisions in good faith, in the knowledge that the interests of a number of people and bodies were involved. He remains of the view that his decisions were legally sound and correct. He will participate in these proceedings in order to assist the Court on matters of coronial law and procedure and to explain his relevant decisions. In summary, the views he took on the main issues raised by the Claimant were as follows:

(a) The question whether the procedural obligation under Article 2 was engaged depended on whether the state or its agents had arguably breached substantive obligations under Article 2 in relation to Ms de Freitas's death. The Coroner found that, on the evidence, it could not be said that the CPS had both owed and breached any such substantive duty. On that basis, he concluded that the procedural obligation was not engaged.

(b) As to the issue whether he should undertake the detailed investigation of the prosecution which had been suggested, he considered that this was not justified. It would have involved an extensive collateral inquiry leading far from the facts of Ms de Freitas's death and the usual remit of an inquest. The Coroner did, however, consider in the inquest the mental state of Ms de Freitas in advance of her death and the effect on her mental state of the impending trial.

6. The point is raised in this Submission that the claim has been issued outside the three-month time limit for judicial review claims. The Coroner raises this as a matter of principle for the Court to consider.

7. In his Claim Form, the Claimant makes two applications. The Coroner's response to these is as follows:

(a) The Claimant applies for a stay of proceedings while he pursues an application to the Attorney-General for the inquest to be referred to the Divisional Court under section 13 of the Coroners Act 1988. That section lays down a statutory review procedure under which the Attorney-General (a) may grant his authority for an applicant to pursue a challenge to an inquest or (b) exceptionally, may pursue a challenge himself. Having seen the Claimant's Memorial to the Attorney-General, the Coroner notes that the grounds relied upon are substantially the same as those raised in these proceedings (save that Grounds 2 and 6 in this claim do not feature in the Memorial). The Coroner takes a neutral position on the Claimant's application for a stay. However, he observes that in this case the

statutory review procedure would not appear to provide a better procedural means for the challenge to be pursued than these proceedings.[1]

(b) The Claimant seeks a protective costs order or costs capping order. It is submitted that the usual grounds for such an order are not satisfied, for reasons given in more detail below (para.54). However, in view of the position he is taking, the Coroner does not intend in these proceedings to claim costs against the Claimant. He would therefore be prepared to agree to a prospective order that, as between himself and the Claimant, there be no order as to costs of the proceedings up to and including the judicial review hearing, irrespective of its outcome.

Factual Background

8. Ms de Freitas was born on 26 June 1990, and was brought up in her family home in West London. Although there is some evidence of a family history of depression, it does not appear that she suffered from mental ill-health in childhood. She started an undergraduate course at Durham University in September 2008 and, shortly thereafter, she began experiencing depressive symptoms which included suicidal thoughts. In around March 2009, she withdrew from the course.

9. In August 2009, Ms de Freitas was referred to a consultant psychiatrist, Dr Christopher Bench, who continued to see her up to the time of her death. After initial assessment by him, she was diagnosed as suffering from recurrent depressive disorder. That diagnosis was formally changed to one of bipolar disorder in October 2010. Over the period from late 2009 to her death, Ms de Freitas had reasonably regular consultations with Dr Bench. She also saw her local GP, Dr Ryan, at times. Medical notes over this period record fluctuating symptoms, with references to depression on some occasions (including suicidal ideation at times) and more positive reports at other times. Dr Bench sought to manage Ms de Freitas's symptoms with various forms of medication (including escilatopram, quetiapine, lamotrigine and diazepam). For periods, she was able to sustain

[1] The statutory review procedure affords a means of challenging inquests which is separate from, and an alternative to, judicial review. If the Attorney-General grants authority or pursues the challenge, a claim is brought under CPR Part 8 and it leads to a hearing in the Divisional Court similar to a judicial review. There is no obligation on a claimant to make use of the statutory review procedure before pursuing a judicial review claim. Statutory review may provide a better procedural means of challenge in some cases, notably where the applicant is seeking a new inquest on the ground that material new evidence has come to light since the first inquest (a ground which would justify intervention under the statutory procedure but not under judicial review). However, that is not the situation in this case. See generally *Jervis on Coroners (13th ed.)* at paras. 19-01 to 19-024 and 19-033.

work at the Body Shop chain of stores and to study for financial services examinations, although both her employment and her studying were sometimes disrupted by her symptoms.

10. In February 2012, Ms de Freitas was admitted to hospital under Mental Health Act section, after exhibiting severe symptoms of manic, depressive and disinhibited behaviour. She remained as a voluntary patient after her compulsory admission ended, and left hospital in mid-March 2012.

11. On 23/24 December 2012, Ms de Freitas spent some time with a young man called Alexander Economou, during which they had sex on one or more occasions. She spent Christmas with her family and then, on 31 December 2012, she told her consultant psychiatrist that she had been sexually assaulted on 24 December by a man she knew. She reported the alleged offence to the police on 4 January 2013. The Metropolitan Police investigated the matter and decided against charging Mr Economou. It appears that their decision was influenced by a number of factors, including:

(a) the lack of forensic evidence to corroborate Ms de Freitas's account;

(b) the fact that Ms de Freitas had communicated with Mr Economou by text message after the alleged offence in which she had made no reference to any assault and had expressed herself in friendly terms;

(c) CCTV evidence of Ms de Freitas and Mr Economou shopping together with an apparently normal / friendly demeanour in an Ann Summers shop on the day after the alleged offence;

(d) Mr Economou's previous history of not having committed any offence; and

(e) the fact that Ms de Freitas had a history of a caution for theft.

12. In August / September 2013, Mr Economou commenced a private prosecution of Ms de Freitas, alleging that she had done an act which had a tendency to pervert the course of justice (i.e. making a false allegation of sexual assault). Following the commencement of the private prosecution, the CPS discussed the case with the police. Meanwhile, Dr

Bench saw Ms de Freitas on 9 September 2013 and recorded that she had been displaying disturbed behaviour. In the next two appointments, she exhibited worries about the court proceedings. However, on 14 October and 19 November 2013, Dr Bench noted that she was gradually improving.

13. On 5 December 2013, the CPS decided to take over and to pursue the prosecution of Ms de Freitas. Before that decision was made, the solicitors for Ms de Freitas had commissioned a report from Dr Tim Rogers, an independent consultant forensic psychiatrist, which expressed the following relevant conclusions:

(a) that Ms de Freitas would have been able to form the necessary intent to commit the offence and would have been aware that her allegation would lead to Mr Economou being investigated;

(b) that, at the time of the assessment, Ms de Freitas would have been fit to plead to the indictment, understand evidence, give instructions, follow proceedings and challenge a juror; and

(c) that her illness was such that her fitness could change, and a trial would be an extremely stressful event for her.

14. Dr Bench saw Ms de Freitas again on 10 December 2013, after she had heard that the prosecution would be pursued by the CPS (rather than discontinued). She told him that her mental health had been "pretty good". He recorded that she had engaged very well in interview, and that she had only "very mild residual symptoms". She was hoping for a phased return to work. The next appointment was on 9 January 2014, when Dr Bench noted that she had "some mild depressive symptoms but otherwise presented very well." He saw her again on 11 February 2014, when he recorded that the court proceedings remained a significant stressor but that she was "essentially unchanged" since the last appointment, showing only mild symptoms.

15. Dr Bench's final appointment with Ms de Freitas was on 27 March 2014. In his letter following that appointment, he noted that she was managing a part-time job and study for financial qualifications; that she was in a supportive relationship; and that she had "some

mild depressive symptoms in particular diminished motivation, interest and poor concentration."

16. The trial of Ms de Freitas was due to start on Monday 7 April 2014. It is understood that her legal team had either considered or pursued an abuse of process argument, but the trial remained fixed. It is also understood that there were some issues of late or incomplete disclosure in the run-up to the trial. During the week before the trial was due to start, the prosecution served late on the defence a recording of Ms de Freitas's Achieving Best Evidence interview in which she had made her rape allegation. Ms de Freitas was due to meet her lawyers on the afternoon of 4 April 2014.

17. In the early afternoon of Friday 4 April 2014, Ms de Freitas's mother returned to the family home and found that Ms de Freitas had hanged herself from the banister of a staircase, using a dog leash as a ligature. The emergency services were summoned and CPR was attempted, but without success. Ms de Freitas was declared dead at 2.45pm. A number of suicide notes were found, addressed to family and friends. In the note to her parents, she made reference to having battled with her bipolar condition, having made reckless decisions and having brought shame upon her family. She added:

> "It has been a terrible decision to have to make and I am so sorry for the mess that I will leave behind. I know how selfish it is, but I really feel that there is no way out. If I were to lose the case, I know that I would have brought huge shame to the family. It is entirely my fault for what has happened, and there were many other events that made me make this decision."

18. Following her death, the West London Mental Health NHS Trust ("the Trust") carried out a review of her care. This concluded that there had been no advance indication of Ms de Freitas's suicidal intention. The report made no criticism of the care she had received, notably from Dr Bench.

19. Dr Bench himself prepared a report for the Coroner dated 10 October 2014 in which he concluded that Ms de Freitas had engaged well with treatment; that she had generally adhered to a crisis plan when she became unwell; that she had in his view been fit to attend court at the time of his last consultation with her (on 27 March 2014); and that to his knowledge she had demonstrated no apparent suicidal ideation in the period leading up to her death. He pointed out that a counselling service which she had been using in the period before her death had scored her suicidal ideation at zero. It should also be noted that Ms de Freitas's parents were similarly shocked by their daughter's suicide.

The Coronial Investigation and the Inquest Proceedings

20. Since Ms de Freitas's death was sudden and unnatural, it was reported to the Coroner and he commenced an investigation. He initially scheduled the inquest for 16 October 2014. On 19 September 2014, the Claimant wrote a long letter to the Coroner in which he asked for the inquest to be postponed in order that the Coroner could fully investigate the conduct of the CPS prosecution (including the decision to pursue it and the compliance of the CPS with Court orders during the trial). The Coroner rejected that request, although he did subsequently re-schedule the inquest date for 7 November 2014.

21. On 28 October 2014, the Claimant's solicitors wrote to the Coroner to confirm that they had been instructed and to make representations. In that letter, they argued that the procedural obligation under Article 2, ECHR, was engaged by virtue of the role of the CPS in relation to the death of Ms de Freitas. They also argued that the role of the CPS and its conduct of the prosecution should be explored within the inquest. The Coroner replied by letter of 30 October 2014, saying that that letter could be read as his ruling. He said that he was not persuaded that the procedural obligation under Article 2 was engaged and that he considered that he could conduct a sufficient inquiry by calling the witnesses he intended to call (i.e. without detailed investigation of the prosecution). However, he left it open to the Claimant's representatives to renew their submissions at the hearing on 7 November.

22. On 6 November 2014, the day before the scheduled date of the inquest hearing, the Director of Public Prosecutions ("DPP") announced that she would be looking into the case of Ms de Freitas. On 7 November 2014, counsel for the Claimant filed written submissions with the Coroner's office, arguing for an adjournment pending the DPP's review and pending the supply to the family of Dr Bench's report. Appended to the submissions was a long document arguing that the procedural obligation under Article 2, ECHR, was engaged by reference to the conduct of the CPS. The Coroner acceded to the request to adjourn the inquest and ensured the disclosure of Dr Bench's report and other medical materials to all interested persons.

23. The DPP undertook the promised review, in the course of which she met the Claimant and his solicitors. On 3 December 2014, she wrote to the Coroner to notify him of her conclusions. She expressed the view that it had been correct to take over and pursue the prosecution, since both stages of the Full Code Test had been satisfied. As regards the

evidential stage, there were some 10 pieces of evidence which supported the prosecution case either (a) in that they contradicted Ms de Freitas's account of the assault or (b) in that they amounted to apologies by her for making the allegations. As regards the public interest stage, prosecutors had reviewed a very full assessment of her fitness to stand trial, which had suggested that she was fit. The DPP made a public statement to the same effect on 9 December 2014.

24. After receipt of the DPP's letter, the Coroner notified all interested persons that they should file written submissions on any remaining issues of procedure. After he had granted an extension of time, the deadline was set for 29 December 2014. Counsel for the family filed a 22-page submissions document, supplemented by an eight-page annexe providing comments on the DPP's letter. In those submissions, it was again argued that the procedural obligation under Article 2, ECHR, was engaged. Submissions were also made asking for extensive disclosure of CPS documents relating to the prosecution (including the full prosecution file, police file and procedural documents). Solicitors for the Trust wrote a short letter opposing these arguments.

25. On 8 January 2015, the Coroner issued a written ruling which covered both scope of inquiry and the engagement of the procedural obligation under Article 2, ECHR. He ruled that the procedural obligation was not engaged, because he did not consider "that the death of Eleanor de Freitas was caused by any arguable breach of any of the substantive obligations of Article 2." In the ruling, he also explained that it was inappropriate for the inquest to investigate the conduct of the prosecution. A more detailed account of that ruling is set out below (para. 35).

26. After the Coroner had issued that ruling, counsel for the Claimant filed further submissions dated 3 March 2015 in which she addressed the scope of the inquest. She argued that the inquest should further explore the prosecution of Ms de Freitas even though the inquest was going to be conducted as one in which the procedural obligation under Article 2, ECHR, was not engaged. Further arguments were made regarding investigation of the role of the Trust.

27. The Coroner produced another written ruling on 9 March 2015 in which he addressed the latest set of submissions. In relation to the CPS, he repeated his previous view that it was

inappropriate for the inquest to investigate the conduct of the prosecution. See para. 36 below for further details.

28. The inquest took place on 17 March 2015. At the start of the day, leading counsel for the Claimant sought to re-argue the Article 2 issue. After hearing brief submissions, the Coroner gave a short oral ruling in which he confirmed his earlier decisions. The Claimant's Grounds document (at para. 63) includes a quotation from that ruling. The Coroner cannot at present confirm that it is entirely accurate, since a transcript of the inquest hearing is yet to be obtained.

29. After the ruling, the Coroner proceeded to call the following witnesses: Mr de Freitas; Dr Ryan; PC Kibbey (officer on the scene); and Dr Bench. He also admitted the reports of a pathologist and a toxicologist in written form. At the end of the inquest, the Coroner recorded the following relevant determinations in the Record of Inquest:

(a) The medical cause of death, in section 2 of the record, was: "1a. hanging".

(b) The following findings were made in section 3 concerning how, when and where the deceased person came by her death: "The deceased was found at her home suspended by a ligature from the staircase bannister. She was declared life extinct at the scene and the police confirmed there were no suspicious circumstances."

(c) The "conclusion of the coroner as to the death" in section 4 was: "The deceased took her own life. An impending court hearing was clearly a significant stressor in her life at the time."

The Grounds document contains a quotation from the Coroner's summing-up (see para. 65). It cannot be confirmed whether or not this is accurate until a transcript has been obtained.

Legal Principles

Inquest Proceedings

30. Sections 5 and 10 of the Coroners and Justice Act 2009 ("CJA") make provision respectively for the matters to be ascertained by a coronial investigation and the determinations to be made at an inquest. Those sections provide as follows:

> "**5 Matters to be ascertained**
>
> (1) The purpose of an investigation under this Part into a person's death is to ascertain –
>
> (a) who the deceased was;
>
> (b) how, when and where the deceased came by his or her death;
>
> (c) the particulars (if any) required by the 1953 Act to be registered concerning the death.
>
> (2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.
>
> (3) Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than –
>
> (a) the questions mentioned in subsection (1)(a) and (b) (read with subsection (2) where applicable);
>
> (b) the particulars mentioned in subsection (1)(c).
>
> This is subject to paragraph 7 of Schedule 5 [concerning the distinct jurisdiction of a Coroner to make reports for the purpose of preventing future deaths].
>
> ...
>
> **10 Determinations and findings to be made**
>
> (1) After hearing the evidence at an inquest into a death, the senior coroner (if there is no jury) or the jury (if there is one) must –
>
> (a) make a determination as to the questions mentioned in section 5(1)(a) and (b) (read with subsection (2) where applicable);

(b) if particulars are required by the 1953 Act to be registered concerning the death, make a finding as to those particulars.

(2) A determination under subsection (1)(a) may not be framed in such a way as to appear to determine any question of –

(a) criminal liability on the part of a named person, or

(b) civil liability."

31. The Coroners (Inquests) Rules 2013 ("the Rules") prescribe the form in which the coroner or jury's conclusions should be recorded. Rule 34 requires that a specific form, which is scheduled to the Rules, be used as the record of the inquest.

32. The following legal principles governing inquest proceedings are relevant to this claim:

(a) An inquest is a statutory inquiry the purpose of which is to supply answers to four factual questions set out in sections 5 and 10: who the deceased was; and when, where and how he/she came by his/her death. The coroner or jury may not express a conclusion on any other matter (subject to the requirement to provide formal particulars for death registration, and subject to the Coroner's power to write a report after the inquest (discussed in paras. 49-51 below)): section 5(3). No conclusion may be made which appears to determine any issue of criminal liability of a named person, or any issue of civil liability at all: section 10(2).

(b) Before the incorporation into English law of the ECHR by the Human Rights Act 1998, the question "how" a deceased person came by his/her death was always to be as meaning "by what means" the person came to die. That question is limited to the immediate physical means of death. It may be answered either by the coroner / jury choosing between well-known short form verdicts (such as "accidental death" or "suicide") or by them returning a brief narrative account. See *R v North Humberside Coroner, Ex Parte Jamieson* [1995] QB 1 at 24A and 24F-G. The question is still to be read in this way in any inquest in which the procedural obligation under Article 2 is not engaged. Such inquests are known as "Jamieson inquests". See *R (Hurst) v HM Coroner for Northern District of London* [2007] 2 AC 189 at paras. 48-52.

(c) Article 2 of the ECHR (the right to life) entails a procedural obligation on member states to establish an independent investigation into a death occurring in certain circumstances. Such an investigation must satisfy certain standards, including a Convention standard of "effectiveness". In *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182, the House of Lords decided that, where this obligation was engaged and the inquest was the primary means of its discharge, the statutory provisions should be read down in such a way that the question "how" the deceased came by his/her death is read as meaning "by what means and in what circumstances" he/she came to die. Interpreted in this broader form, the question could encompass underlying and contributory causes of death. This interpretation has now been given statutory force by section 5(2) of the CJA (quoted above). Inquests in which this approach is taken are known as "Middleton inquests".

(d) Because an inquest is an inquisitorial proceeding, it is a matter for the coroner to determine how wide the scope of inquiry should be. The leading authority on this subject is *R v Inner West London Coroner, Ex Parte Dallaglio* [1994] 4 All ER 139. At 155b, Simon Brown LJ said:

> "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."

At 164j, Sir Thomas Bingham MR said:

> "It is for the coroner conducting an 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."

(e) A coroner is not required to conduct an investigation which goes beyond the matters of central importance to the cause and circumstances of death, even in a "Middleton inquest". In *R (Allen) v HM Coroner for Inner North London* [2009] EWCA Civ 623, May LJ said that a coroner is "required to do no more than focus the investigation and the inquisition on the central issues in the case" (para. 33) and is "only obliged to investigate those issues which were, or at least appeared arguably to be, central to the cause of death" (para. 40).

(f) Decisions of a coroner as to which witnesses should be called may only be challenged on rationality grounds: *R (Mack) v HM Coroner for Birmingham and Solihull* [2011] EWCA Civ 712 at para. 9.

(g) The issue of whether the procedural obligation under Article 2 is engaged is primarily relevant to the conclusions which can be reached at the end of the inquest. It is of little, if any, relevance to the scope of the inquest, since that is a matter for the coroner's judgment. In *R (Sreedharan) v HM Coroner for City of Manchester* [2013] EWCA Civ 181 at para. 18(vii), Hallett LJ said:

> "There is now in practice little difference between the Jamieson and Middleton type inquest as far as inquisitorial scope is concerned. The difference is likely to come only in the verdict and findings."

See also: *R (Smith) v Oxford Assistant Deputy Coroner* [2011] 1 AC 1 at 99 (para. 78), Lord Phillips.

(h) There are some cases in which the procedural obligation under Article 2, ECHR, is automatically engaged by reason of the broad type of circumstances in which death occurred. These include cases of suicide in prison and deliberate killings by state agents. Otherwise, the procedural obligation is only engaged if, on the evidence, state agents or bodies arguably breached substantive obligations under Article 2 in relation to the particular death: *R (Humberstone) v LSC* [2011] 1 WLR 1460; *R (Letts) v Lord Chancellor* [2015] EWHC 402 (Admin).

Substantive Obligations under Article 2, ECHR

33. One of the issues in this case is whether or not the procedural obligation under Article 2, ECHR, was engaged in the inquest, such that the approach adopted in the *Middleton* case should have been taken by the Coroner. It is common ground that the procedural obligation would only be engaged if it were arguable that the state or its agents had both owed and breached substantive obligations in relation to the death of Ms de Freitas.

34. The law governing relevant substantive obligations can be summarised as follows:

(a) Article 2 imposes a negative duty on member states not to deprive a person of his/her life intentionally save in limited circumstances (e.g. lawful defence). It also imposes positive obligations to protect life. These obligations fall into two categories:

(i) There is a "general duty" on the state to "establish a framework of laws, precautions, procedures and means of enforcement which will, to the greatest extent reasonably practicable, protect life."

(ii) In certain circumstances, state bodies and agents owe an "operational duty" to protect the lives of identifiable individuals. Where it applies, this duty requires that reasonable action be taken if the authorities know or ought to know of a "real and immediate risk" to a person's life.

See: *R (AP) v HM Coroner for Worcestershire* [2011] EWHC 1453 (Admin) at paras. 50-56.

(b) The "operational duty" has been held by the Strasbourg Courts to apply in certain categories of case, including for example cases where a threat to life has been reported to the police. In *Rabone v Pennine Care NHS Trust* [2012] 2 AC 72, the Supreme Court gave guidance on the approach to be taken where it was being argued that the duty arose in a new category of case. At paras. 22-25, Lord Dyson cited three indicia which might assist: (i) any assumption of responsibility by the state for the victim; (ii) the vulnerability of the victim; and (iii) whether the risk is ordinary or exceptional. However, he stressed that these were merely factors to be considered and not "a sure guide".

(c) Where the "operational duty" arises, a breach may only be established if the relevant public authorities "knew or ought to have known of a real and immediate risk to the life of an identified individual" and "failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk". See *Osman v UK* (2000) 29 EHRR 245 at para. 116. In the language of this test, (i) the word "real" means that the risk must be "substantial and significant"; and (ii) the word "immediate" has the sense "present and continuing." The test thus sets a threshold which is higher than mere negligence. See *Rabone*, paras. 38-39.

(d) In order to establish a breach of the "operational duty", it is necessary to show (i) that, at a particular time, the state agent knew or should have known of a real and

immediate risk to the life of an identifiable individual; (ii) that, at that time, the state agent failed to take preventive action which it reasonably ought to have taken; and (iii) that the failure to take such action deprived the individual of a substantial chance of survival. See *Van Colle v Chief Constable of Hertfordshire Police* [2009] AC 225 at paras. 29-32 and 138. At para. 32, Lord Bingham stressed the requirement that the state agent must have failed to take reasonable action at a particular time when he/she knew or ought to have known of the relevant "real and immediate risk". He warned against the dangers of hindsight.

The Coroner's Decisions and Reasoning

35. As recorded above, the Coroner's first material ruling was dated 8 January 2015. In that ruling, he expressed the following conclusions:

(a) As to scope of inquiry, he explained (citing para. 33 of the *Allen* judgment – quoted in para. 32(e) above) that his duty was to conduct an investigation and inquest focussed on the issues central to Ms de Freitas's death. He did not consider that a detailed investigation of the prosecution was required for this purpose. Having been pressed with arguments about the wider significance of prosecuting people who had made allegations of rape, he said that it was not the function of an inquest to investigation matters of policy. In that context, he cited the remarks of Lord Phillips in *Smith* (*loc. cit.*) at para. 81 (100G-H). See ruling, para. 3.

(b) As to the alleged breach of substantive obligations under Article 2, his reasoning was as follows:

(i) There was no arguable breach of the "general duty" since that duty was concerned with whether there were adequate systems and procedures at a general level, rather than whether those procedures were operated in such a way as to safeguard particular vulnerable persons. See ruling, para. 5.

(ii) It could not be said that the CPS had both owed and breached the "operational duty". First, the state had not assumed responsibility for Ms de Freitas simply by prosecuting her. See ruling, para. 7. Secondly, although she was vulnerable in general terms (because of her bipolar

disorder and history of depression), it could not be said on the particular facts of the case that there had been any breach of the "operational duty". The report of Mr Rogers indicated that she was fit to stand trial. The assessments of Dr Bench, who saw her regularly right up to the time of her death, did not indicate that she was at any particular risk of suicide or self-harm in the weeks before her death. Indeed, he had characterised her symptoms as mild. See ruling, para. 8. Although Ms de Freitas posed a risk of suicide in general terms, her condition was being properly managed by clinicians. In all the circumstances, the CPS did not come under a relevant duty to prevent her fatal act at the material time. See ruling, para. 9.

The Coroner concluded his ruling (at para. 10) as follows:

> "For all the reasons set out above, I do not consider that the death of Eleanor de Freitas was caused by an arguable breach of any of the substantive obligations of Article 2."

36. As noted above, the Claimant's counsel filed further submissions after that ruling, arguing that the conduct of the prosecution ought to be investigated even on the basis that the the Article 2 procedural obligation was not engaged. In his second material ruling, dated 9 March 2015, the Coroner addressed that argument. He said that his previous ruling had dealt with the question of scope of inquiry (including in relation to the prosecution), and that the further submissions had not changed his mind. He pointed out that a decision to prosecute was one which could be judicially reviewed, but that it was not the function of a coroner to conduct such reviews. See ruling, para. 4.

37. On the morning of the inquest, the Claimant's leading counsel sought to argue once again that the procedural obligation under Article 2, ECHR, was engaged. The Coroner heard the argument and gave a short extempore ruling, which has yet to be transcribed. His recollection is that he reiterated his previous ruling, expressing his decision on the basis that the CPS had not arguably breached substantive duties under Article 2 in relation to the death of Ms de Freitas.

Grounds 1 and 2

38. These two grounds of review are concerned with the Coroner's decision on scope of inquiry, and they do not depend upon any argument concerning Article 2 (see paras. 101-

106 of the Claimant's Grounds). Ground 1 asserts that, because (as the Coroner found) the prosecution was a significant stressor for Ms de Freitas in the period before her death, it was irrational of the Coroner not to investigate in detail the conduct of that prosecution. Ground 2 puts forward the argument that that the Coroner applied the wrong legal test, asking himself whether the conduct of the prosecution was a central issue rather than whether it was a more than minimal cause of death.

39. The Coroner's response to ground 1 is as follows:

(a) He sought to call evidence to carry out a sufficient and balanced inquiry, properly focussed on the statutory questions. As explained above, he gave extensive disclosure of medical records and evidence, including the report of Dr Bench. By calling Ms de Freitas's GP and the treating psychiatrist, he adduced evidence as to her state of mind and the influences which had been acting upon her mind in the period leading up to her death. To that medical perspective was added the more personal evidence of Mr de Freitas. The Coroner also called evidence of the circumstances in which she was found hanging, the notes found and the physical means of death.

(b) The Coroner considered that his inquiry could and should consider what was influencing Ms de Freitas at the time of her death, including the fact that a trial was hanging over her. In his view, that did not mean that he had to investigate whether the prosecution leading to that trial had been properly conducted. An investigation of that kind would have been an extensive collateral inquiry which would have taken the inquest some distance from the cause and circumstances of Ms de Freitas's death. It would have required the Coroner to consider whether the CPS had acted properly in taking over and pursuing the prosecution. That exercise, in turn, would have necessitated an inquiry into the original rape allegation, because one of the Claimant's central criticisms of the CPS is that there was insufficient evidence that the allegation was false, and indeed that it may have been true (paras. 39-45 of the Claimant's Grounds). As the Coroner explained in his January 2015 ruling (paras. 3-4), it was not his function to act as a court of review of CPS decisions. Neither was it his responsibility to address questions of policy (such as the question whether a rape complainant should be prosecuted over the veracity of his/her allegations). In addition to the passages in

the *Smith* case cited in the Coroner's ruling, see *R (Scholes) v SSHD* [2006] HRLR 44 at para. 70.

(c) When considering the scope of the inquest, the Coroner had to make the difficult decision identified in the *Dallaglio* case: how far back to trace the chain of events leading to the death of the deceased person. In this case, he called evidence as to the influences operating on Ms de Freitas's mind, which included the fact of the impending trial, but decided not to engage in a long and contentious investigation of the rights and wrongs of the prosecution and the original rape allegation. In this regard, his decision may only be challenged if irrational.

(d) The Claimant argues that the Coroner was obliged to investigate the prosecution because the impending trial was a stressor which may have influenced Ms de Freitas's decision to kill herself. However, it cannot be right to say that, in any suicide case, the coroner must investigate in detail any and all events which may have distressed the deceased person and influenced his/her decision. Was it, for example, incumbent on the Coroner in this case to investigate in detail relationship issues within the de Freitas family, since they were recorded as having an effect on Ms de Freitas's mental condition (e.g. in Dr Bench's records of 31 December 2012, 24 September 2013, 14 October 2013 and 27 March 2014)?

40. The Coroner's response to ground 2 is as follows:

(a) In determining the scope of his inquiry, he took the approach of considering what were the central issues in the case relating to the cause of death. As he said, this was in accordance with the approach recommended in the *Allen* case. In this case, central issues were whether Ms de Freitas had made a conscious decision to end her own life and, if so, why she had made that decision. The Coroner did not consider that the question whether the CPS had acted correctly in taking over and pursuing the prosecution was such a central issue.

(b) The Claimant says that the Coroner was obliged to investigate the prosecution in detail because it was a more than minimal cause of death. In support of that proposition, he cites *R v Inner South London Coroner, ex parte Douglas-Williams* [1999] 1 All ER 344. The material part of that authority makes the point that, for

a verdict of unlawful killing based on gross negligence manslaughter to be returned, the jury have to find that the relevant negligence was more than minimally causative of death (see 350e). It is thus a case about the causal threshold to be met before a conclusion can be returned. The authority does not say or mean that any event which may have influenced a person's decision to take his/her own life must be investigated in detail as part of the inquest.

(c) The Coroner did not misunderstand the causal threshold applying to conclusions which a coroner or jury can return. The real question for him was whether and how far he should investigate matters which distressed Ms de Freitas and which may have contributed to her final fatal act. As explained above, that was a question for his judgment.

Grounds 3 to 6

41. These four grounds relate to the Coroner's decision that the procedural obligation under Article 2, ECHR, was not engaged. His material rulings are summarised at paras. 35-37 above.

42. Ground 3 asserts that the Coroner irrationally concluded in his oral ruling on the morning of the inquest that there had been no arguable failure by the CPS in its prosecution (see paras. 107-118 of the Claimant's Grounds). The Claimant says that the prosecution involved a number of errors, including the late service of the ABE interview record before the trial. The Coroner responds as follows:

(a) As he does not have a transcript of his extempore ruling, he is unable to confirm precisely what he said. However, the argument put to him was that there had been arguable breaches by the CPS of the substantive obligations owed under Article 2. His conclusion, consistent with his written rulings, was that there had been no such arguable breach. As he recalls, he was not making a broader finding to the effect that the CPS had committed no procedural error of any kind in the prosecution.

(b) If the note of his ruling recorded in the Claimant's Grounds (para. 63) is accurate, the Coroner said that the question for him was "has there been an arguable breach of Article 2", and he concluded that the answer was that there had not been any.

If, as the note records, he said that his view would have been different had he had evidence of "clear failings" by the CPS, that must be read as a reference to failings which constituted arguable breaches of substantive obligations owed under Article 2. Otherwise, it would not make sense in context.

(c) In any event, the legal issue for the Coroner in deciding whether the procedural obligation was engaged was whether the CPS had arguably breached a substantive duty owed under Article 2. If he could find no such arguable breach, he was obliged to say that the procedural obligation was not engaged: see *Plymouth CC v HM Coroner for Devon* [2005] EWHC 1014 (Admin). It was not relevant to the Coroner's decision in relation to Article 2 whether the CPS had committed some error which did not constitute an arguable breach of Ms de Freitas's Article 2 rights.

43. Ground 4 asserts that the Coroner unlawfully and/or irrationally failed to satisfy himself that a risk assessment had been conducted by the CPS before pursuing the prosecution, having regard to the case of *R (D) v Central Criminal Court* [2004] 1 Cr App R 41 (see paras. 115-118 of the Claimant's Grounds). The Coroner responds as follows:

(a) The case of *D* concerned a defendant in a criminal trial who was a police informer and who said that his life would be at risk if the prosecution proceeded, as his defence would necessarily involve making known his role as an informer to his co-defendants. The Court held that, in that case, the state's obligations under Articles 2 and 3 were engaged by the apparent risk to his life and safety, and that the prosecutor's obligation was not to prosecute unless the risk could be adequately met (paras. 21-22). In that case, the pursuit of the prosecution was held to be lawful.

(b) The case of *D* thus establishes that there are some cases where a prosecutor comes under an Article 2 obligation in relation to a suspect or defendant. In that case, there were substantial grounds for thinking that the defendant might be at a real and immediate risk of death from his co-defendants. However, it does not follow that this obligation arises in all prosecutions, or even in all prosecutions of vulnerable people. It is presently understood that the *D* case has only been

applied in one other case, which involved a directly analogous situation: *X v Customs and Excise Commissioners* [2005] EWHC 953 (Admin).

(c) The question for the Coroner in this case was whether the CPS had come under a relevant Article 2 duty and had breached that duty. As recorded above, his finding was that the identifiable risk to Ms de Freitas was not such that the pursuit of the prosecution constituted a breach of her Article 2 rights. A psychiatrist (instructed by her own legal team) had assessed her as fit to stand trial in the first place. Treating clinicians who saw her regularly regarded her as displaying only mild depressive symptoms in the period shortly before she died. In other words, she did not foreseeably present such a serious risk that the only lawful option was to discontinue the prosecution. The absence of a documented risk assessment would not mean that the Coroner was obliged to find a breach of Article 2 rights.

44. Ground 5 asserts that the Coroner unlawfully failed to apply established legal principles concerning the engagement of Article 2 in the decision to prosecute (see paras. 119-124 of the Claimant's Grounds).

(a) The Claimant argues that there was a breach of the state's negative obligation under Article 2 (i.e. the duty not to take life). That argument rests on the proposition (taken from the *D* case) that the CPS owed a duty under Article 2 not to prosecute if a risk to life could not be managed. As explained above, the Coroner's decision was that the foreseeable risk to Ms de Freitas from being prosecuted was not of such a kind that it could not be managed. While it is accepted that the prosecution was inevitably stressful and distressing, it requires a much greater step to say that it was a breach of Article 2 rights (equating to an unlawful taking of life) for prosecutors to pursue it at all.

(b) The Claimant argues that there was a breach of a positive "operational duty" to protect life. As explained above, such an obligation would only arise in the context of a prosecution if the defendant was particularly vulnerable and if prosecutors knew or ought to have known of a "real and immediate risk" to his/her life. The obligation would only be breached if, at the time they had that actual or deemed knowledge, prosecutors failed to take reasonable steps and the absence of such steps deprived the defendant of a substantial chance of survival.

As explained above, the Coroner did not consider that the duty had arisen and been breached on the facts of the case.

(i) At the time the CPS took over the prosecution, the expert evidence produced by her own legal team was that Ms de Freitas was fit to be prosecuted.

(ii) At no time after that did any of her treating clinicians say that she was unfit to stand trial or at an immediate risk of suicide (still less at a risk that could not be managed).

(iii) Ms de Freitas was being seen regularly by a psychiatrist who knew her well and who, in his last appointments with her, recorded that she was fit to stand trial and had only minor symptoms.

(iv) It was in any event difficult to see what steps prosecutors should have taken to manage the risk to Ms de Freitas which would have given her a substantial chance of survival, other than the step of discontinuing the prosecution (which is considered above). Even if they had been assessing her condition regularly by reference to her own treating clinicians' notes, they would not have been warned of a serious risk of death.

(c) The Claimant argues that there was an arguable breach of the state's "general duty" under Article 2 to protect life. It is said that the systems and policies of the CPS are not adequate "for the protection of mentally disordered defendants facing prosecution for making rape complaints" (Grounds, para. 119). However, the Grounds fail to identify what flaw, at the level of systems and policies, led to Ms de Freitas's death. The criticisms which are made are directed at individual decisions, rather than underlying procedures.

45. Ground 6 criticises the Coroner for reportedly saying in his oral ruling on the morning of the inquest that the decision to prosecute could not be caught by the word "conduct". It is not clear from the transcript in what context this was said. However, on any view it does not undermine the substantive point made in the ruling, namely that the prosecution had not involved an arguable breach of Article 2 rights.

46. Paras. 125-126 of the Grounds also assert that the Coroner ought to have found the procedural obligation under Article 2 to have been engaged by reason of "the actions of the Second Interested Party [i.e. the Trust]". However, the Grounds fail to identify what breach of Article 2 obligations the Trust arguably committed. Furthermore, it is not clear how these paragraphs fit within any of the grounds of review put forward. To establish a breach of the Article 2 operational duty against clinicians, it is not enough to prove "simple" clinical negligence: *Powell v UK* (2000) 30 EHRR CD 362. No attempt is made by the Claimant to say that any clinician breached the operational duty, as conventionally formulated (i.e. failing to take reasonable action in response to an appreciable real and immediate risk to life and thereby depriving the person of a substantial chance of survival) or otherwise.

Ground 7

47. By this ground, the Claimant raises a separate complaint of procedural unfairness (see paras. 127-128 of the Claimant's Grounds). It is said that the Coroner acted unfairly when he was addressed on the Article 2 issue on the morning of the inquest. In summary, the complaint is that the Coroner heard submissions on the matters covered in his January and March rulings; that he then came to a conclusion on the Article 2 issue on a new ground; and that he did not give the Claimant's counsel a proper opportunity to address him on this "new" basis.

48. The Coroner's response is as follows:

(a) The observations he made at the hearing did not amount to a new basis for his decision. Before his ruling of January 2015, he had received and considered extensive submissions as to the components of the Article 2 duties and the circumstances in which those duties might be breached. In that ruling, at para. 10, he had said –

> "I do not consider that the death of [Ms de Freitas] was caused by an arguable breach of any of the substantive obligations of Article 2."

Assuming that it is an accurate quotation, the passage from the Coroner's oral observations which the Grounds (at para. 63) records is entirely consistent with his previous rulings and does not disclose any new ground for his decision.

(b) The suggestion made in the Grounds is that the Coroner's oral ruling identified a new basis for the decision, namely that the CPS had not committed any "arguable failings". However, as explained above (and assuming that the Coroner said the words quoted), the phrase was used in relation to an argument about breaches of duty under Article 2 and the Coroner's finding was that there was no arguable breach of such duty.

(c) In any event, the complaint of procedural fairness needs to be considered in context. The Coroner had given all interested persons the opportunity to make submissions on the Article 2 and scope issues, and the Claimant's counsel had already made both oral and (voluminous) written submissions on these points. It is not accepted that he unfairly restricted the ability of the Claimant's representatives to address these issues.

Ground 8

49. Ground 8 asserts that, by failing to conduct the suggested detailed investigation into the CPS prosecution, the Coroner "unlawfully deprived himself of the ability to consider whether or not his statutory duty under Sch. 5 para. 7 [to the CJA] to report on the prevention of future deaths was triggered" (see para. 129 of the Claimant's Grounds).

50. Para. 7 of Schedule 5 provides (in material part) as follows:

> "(1) Where –
>
> (a) a senior coroner has been conducting an investigation under this Part into a person's death,
>
> (b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and
>
> (c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,
>
> the coroner must report the matter to a person who the coroner believes may have power to take such action."

51. The Coroner's response to this Ground is as follows:

(a) The jurisdiction to make a report under the paragraph quoted above exists where an investigation, conducted in accordance with the Act, has revealed evidence of the kind of systemic risk to life identified in the paragraph.

(b) The fact that a coroner should produce such a report if (in his opinion) the fruits of his investigation indicate that action should be taken does not mean that he should change the entire scope and focus of his investigation in order to be able to produce a report. While the possibility of producing a report is a factor which a coroner can consider when determining the scope of the inquest, the reporting jurisdiction is "ancillary to the inquest, the primary purpose of which is to determine by what means the deceased died…": *R (Butler) v HM Coroner for the Black Country* [2010] EWHC 43 (Admin.) at para. 74.

(c) In the present case, the Coroner took the view, for reasons already given, that an extensive collateral inquiry into the conduct of the prosecution would not be warranted. That decision involved a matter of judgment governed by the approach in the *Dallaglio* case. The decision was not made unlawful by any effect of Schedule 5, para. 7.

Time Limits

52. It is submitted that, in relation to the key decisions challenged, this claim has been brought outside the three-month time limit specified by CPR 54.5(1). This point is raised as a matter of principle for the Court, rather than because the Coroner is making any attempt to prevent the substantive issues being considered.

(a) An application for judicial review should usually be made "as soon as the relevant formal decision is made": *R v Newbury DC, Ex Parte Chieveley Parish Council* [1997] JPL 1137. In the administrative context, the time limit cannot be bypassed by writing a further letter to the decision-maker, receiving a confirmation of the decision and characterising that as a fresh decision: *R v Commissioner for Local Administration, Ex Parte Field* [2000] COD 58.

(b) Insofar as this claim challenges the decision that the Article 2 procedural obligation was not engaged, that is a decision which was made no later than the ruling of 8 January 2015. The Claimant's written submissions dated 3 March

were expressly premised on the basis that that decision had been made. The Claimant's counsel raised the issue again on the morning of the hearing, and the Coroner heard his argument before giving his oral ruling. However, it is understood that counsel did not raise any substantial new argument (still less any new fact) and the Coroner simply repeated his previous views.

(c) The Claimant's response to this point is that the question of whether or not the procedural obligation is engaged is one which a coroner can and should keep under review, so that he can change his mind if the evidence justifies doing so. It is right that such a decision can be kept under review. However, the Claimant's challenge on the Article 2 point in this case is to the effect that the decision of 8 January 2015 was flawed on its own terms.

(d) Insofar as the claim challenges the decision on scope of inquiry, that is also a decision which was made in the ruling of 8 January. By that ruling, the Coroner made the decision that there would not be a detailed investigation of the prosecution. When the Claimant's representatives filed their further submissions on 3 March 2015, the Coroner simply confirmed his previous decision.

(e) In making these observations, the Coroner is not raising a purely technical point. Coroners have been encouraged to hold pre-inquest review hearings and to give rulings on issues such as the engagement of the Article 2 procedural obligation and the scope of inquiry. While such rulings often have to be kept under review in case they are affected by new evidence, it is appropriate for interested persons who are dissatisfied with rulings to challenge them before the inquest hearing itself. Otherwise, any challenge gives rise to an unnecessary risk of multiple inquest hearings.

The Claimant's Applications

53. The Claimant's first procedural application is for a stay of these proceedings pending his application to the Attorney-General under section 13 of the Coroners Act 1988. For the reasons given in para. 7(a) above, the Coroner adopts a neutral stance in relation to that application.

54. The Claimant's second application is for a protective costs order or costs-capping order. The Coroner's responds as follows:

(a) A protective costs order may only be made if five criteria are satisfied: (i) that the issues raised are of general public importance; (ii) that the public interest requires that those issues should be resolved; (iii) that the applicant has no private interest in the outcome of the case; (iv) that, having regard to the financial resources of the applicant and the respondent(s) and to the amount of costs that are likely to be involved, it is fair and just to make the order; and (v) that, if the order is not made the applicant will probably discontinue the proceedings and will be acting reasonably in so doing. See *R (Corner House Research) v Secretary of State for Trade and Industry* [2005] 1 WLR 2600 at para. 74; *R (Goodson) v HM Coroner for Bedfordshire and Luton* [2006] CP Rep 6; *Morgan v Hinton Organics (Wessex) Ltd* [2009] CP Rep 26.

(b) It cannot be said that the applicant has no private interest in the outcome of the case. His apparent objective is to ensure that the prosecution of his daughter is investigated through an inquest. This is a private interest, even if his position generates great human sympathy. This consideration is at least a significant factor militating against a protective costs order: *Goodson* at paras. 24-28; *Morgan* at paras. 35-40.

(c) It is also at least questionable whether this case raises issues of general public importance which must be resolved in the wider public interest. The grounds and the issues they raise are highly specific to the facts of this case. Even if it were held that the Coroner had made some error, it is not easy to see how the decision would affect many other cases.

(d) The Coroner has no knowledge of the Claimant's financial resources and is therefore unable to say whether criteria (iv) and (v) as formulated in *Corner House* might or might not be satisfied.

(e) In all the circumstances, the Coroner does not accept that the case for a protective costs order has been made. However, he is not taking an adversarial stance in these proceedings, and accordingly has no intention of claiming costs against the Claimant. He would therefore be content to agree a prospective order that, as between himself and the Claimant, there be no order as to costs of the proceedings up to and including the judicial review hearing, irrespective of its outcome.

Interested Parties

55. In the Claim Form, the Claimant identifies two interested parties: the CPS and the Trust. The Coroner has proposed two further interested parties, as follows:

(a) Dr Alexandra Ryan: Like the Trust, Ms de Freitas's GP was also designated as an interested person in the inquest proceedings. Her interests are engaged for the same reasons as apply to the Trust, namely (i) that her representatives took a similar stance in the procedural arguments; and (ii) that she would be put to inconvenience and expense if there were a further inquest.

(b) Alexander Economou: The role of Mr Economou is outlined above. He was not designated as an interested person in the inquest for the simple reason that the Coroner decided not to investigate the prosecution. However, the Claimant's arguments that the Coroner should have investigated the prosecution appear to engage the interests of Mr Economou, since such an investigation would inevitably touch upon his behaviour at the time of the alleged assault and/or afterwards, and during the course of the prosecution. It is noteworthy, for instance, that the Claimant's Memorial to the Attorney-General (at paras. 19-23) raises serious criticisms of Mr Economou's conduct both before and after the alleged assault.

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13 July 2015