Neutral Citation Number: [2025] EWHC 781 (Admin)

Case No: CLAIM NO: AC-2024-MAN-000377
(Formerly AC-2022-LON-002865)

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

Royal Courts of Justice
Manchester Civil Justice Centre
1 Bridge Street West
Manchester, M60 9DJ

Date: 03/04/2025

Before :

MR JUSTICE KERR

- -

Between :

THE KING (on the application of MRS VERONICA ROBINSON	**Claimant**
- and -	
HM ASSISTANT CORONER FOR BLACKPOOL & FYLDE	**Defendant**
- and -	
CHIEF CONSTABLE OF LANCASHIRE POLICE	**Interested Party**

Mr Philip Rule KC (instructed by **Hodge Jones and Allen Solicitors Limited**) for the **Claimant**
Mr David Pojur (instructed by **Corporate Legal Services, Blackpool Council**) for the **Defendant**
Ms Rebecca Hirst (instructed by **Chief Constable of Lancashire Police)** for the **Interested Party**

Hearing date: 24 January 2025

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Approved Judgment

This judgment was handed down remotely at 10.00am on 3 April 2025 by circulation to the parties or their representatives by email and by release to the National Archives.

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MR JUSTICE KERR

Mr Justice Kerr :

Introduction

1. This is a judicial review challenge, by permission of Sir Peter Lane, to a jury's inquest verdict of death by misadventure. The claimant is the mother of the deceased, Mr Ronald Robinson. The inquest took place from 20 to 24 June 2022 in Blackpool, before the defendant, HM Assistant Coroner Mr Andrew Cousins (**the coroner**), and a jury. Mr Robinson died on 11 March 2021 at Blackpool Victoria Hospital after being arrested by officers of the interested party (**the police** or **the chief constable**). The coroner has in the usual way adopted a neutral stance. The claim is defended by the chief constable.

2. The record of inquest signed by the jurors stated as follows at paragraphs 2-4:

> "2. Medical cause of death
>
> Acute upper airways obstruction.
>
> 3. How, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death
>
> Mr Robinson died on the 11 March 2021 in Blackpool Victoria Hospital as a result of an incident at Knowle Avenue, Blackpool on 11th March 2021.
>
> 4. Conclusion of the Coroner as to the death
>
> Misadventure."

3. The claimant seeks an order quashing the verdict, an order for a fresh inquest and declaratory relief. There are three grounds of challenge, which I take from the summary in the claimant's skeleton argument. The first is that the coroner was wrong to rule that the inquest was not required to discharge the duty of investigation required by article 2 of the European Convention on Human Rights 1950 (**the ECHR**). The second is that the coroner's summing up was inadequate. The third is that the coroner unlawfully failed to make a "Prevention of Future Deaths" (**PFD**) report.

4. The chief constable submits that the coroner was justified in deciding that an inquest governed by article 2 of the ECHR was not required; that the verdict was lawfully reached; that a fresh inquest should not be ordered; that the decision whether to make a PFD report was for the coroner alone; that it was lawfully open to him to decide not to make a PFD report; and that such a report is ancillary to the inquest verdict and would not, even if mandatory in this case, require a fresh inquest to be held.

The Facts

5. On 11 March 2021, Mr Robinson was driving on Knowle Avenue, Blackpool, when at about 5.35pm he was stopped by two police officers in a police car, PC Reeve and PC Hardacre. Mr Robinson got out of the car and while being subdued by the officers was seen by one of them, PC Hardacre, to place an object in his mouth. Mr Robinson and the two officers went to the ground. PC Hardacre said that Mr Robinson was "swallowing something". The officers were trying to get him to spit out the object. They handcuffed him on the ground, with his hands behind his back.

6. The two officers believed he had swallowed drugs. When Mr Robinson ceased to resist and became lethargic, they suspected the drugs swallowed had taken effect. PC Reeve tried to rouse him with conversation and, as he put it, "a few gentle slaps to the back side of his head". There was no reaction. PC Reeve told Mr Robinson to "spit it out". Both told the coroner they did not suspect an obstructed airway. They said they did not see signs of gagging. They called an ambulance, suspecting a drug overdose.

7. PC Reeve decided at 5.39pm that this was a medical emergency. He guided Mr Robinson's head to the pavement floor and placed him in the recovery position and removed the handcuffs. No pulse was felt. A pulse oxometer and then a defibrillator was attached to Mr Robinson. The officers attempted CPR[1] chest compressions and PC Hardacre administered oxygen. A "rebreathing mask", or oropharyngeal airway, was attempted.

8. The ambulance was despatched at 5.47pm. While it was en route, the officers reported to the crew that the patient had gone into cardiac arrest. The ambulance arrived at 5.53pm. One of the officers told Craig Eaton, a paramedic, that the patient had "swallowed something". Mr Eaton did not tell his colleague this. He thought there was no obstruction because he thought a check on the airway had been done as the police had inserted an airway. The audio (with video) evidence records the officer saying:

> "So basically mate, his cars pinged up stolen, we've gone to stop him and he's messing with something. So, as we've got there and gone to grip him, he's fucking swallowed something. So as we've tried to prevent him from doing that, I don't know whether what he's taken has blocked something or whatever, but he's gone into an unresponsiveness. So, we've took cuffs off, monitored him and he's fucking gone downhill. We've got defib on, oxygen on, done compressions since but unresponsive at the moment mate".

9. Mr Robinson was then lifted onto a trolley and Mr Eaton continued chest compressions. When Mr Robinson was in the ambulance, at about 6.02pm the other paramedic, Gemma Royle, saw the blockage. They used a laryngoscope and with forceps removed the package from Mr Robinson's throat. CPR and Advance Life Support continued in the ambulance but, unfortunately, without success. Mr Robinson was pronounced dead at Blackpool Victoria Hospital at 6.36pm.

10. The coroner held four pre-inquest review hearings. At the last of them, he noted that in addition to the events of 11 March 2021, he proposed to focus on:

> "… the training received, and the procedures followed by the police officers and NWAS [North West Ambulance Service] personnel that attended Mr. Robinson, and whether any act or omissions of any police officers or any ambulance personnel caused or materially contributed on Mr. Robinson's death. So, absent anything else, I propose to keep that as the scope, and in terms of Article 2, we're going to wait until we've heard the evidence, because if there were some issues around training, particularly in relation to the police, that may have an impact on it."

11. Mr Robinson suffered some injuries such as abrasions while he was being restrained. It was not suggested at the inquest these played a part in causing death. A pathologist, Dr Alison Armour, gave evidence. There was no dispute that it was obstruction of Mr Robinson's airway by the package that made him unable to breathe, leading to cardiac arrest. If Ms Royle had been told Mr Robinson had "swallowed something", the pathologist was unsure whether Ms Royle would have tried to remove the package at

[1] Cardio Pulmonary Resuscitation.

the roadside rather than in the ambulance, i.e. several minutes earlier. The pathologist could not say whether Mr Robinson's chance of survival would have been affected.

12. Expert evidence about the conduct of the police officers was provided to the coroner by the chief constable. Matthew Dunn, a consultant paramedic with the NWAS, provided a clinical overview of the emergency response. He commented that "there was a delay in starting CPR I think CPR could have been commenced sooner … once it was commenced once the defib was on, it was guided by the equipment there". He was critical about a failure of information sharing by the paramedics; but "the prognosis for out of hospital cardiac arrest is unfortunately very poor".

13. Dr Mark Forrest provided medical evidence about the response of the police officers. He explained that he is the medical director of the Anaesthesia, Trauma and Critical Care (**ATACC**) Group, which provides professional training and clinical governance to Lancashire Constabulary; and medical director of Cheshire Fire & Rescue Service, Hampshire Fire and Rescue Service and, through the ATACC Group, oversees a team of consultants that provide clinical governance for up to 50,000 UK police officers.

14. Dr Forrest thought there was a "missed opportunity to administer blows to the back" at the roadside. He commented on the officers' first aid training and said they faced a very challenging situation. The package was blocking Mr Robinson's airway entirely and required a trained paramedic using a laryngoscope to see the package and forceps (called Magill forceps) to remove it.

15. Dr Forrest too thought CPR could have been started earlier but the delay was understandable because of the limited medical expertise of a police officer; and, he said, the delay did not affect the outcome. The enhanced training of police officers does not include removal of large foreign objects with airway instruments, Dr Forrest noted; and specifically does not cover large drug packages obstructing or bursting in a person's upper airway. He recommended that removal of drug packages and subsequent management should be "highlighted nationally to senior officers in each force".

16. A former police officer, Liam Fitzpatrick, provided a report on the use of force in Mr Robinson's case. His opinion was that PCs Hardacre and Reeve "deployed a level of force to a subject that was proportionate, reasonable, and the minimum amount of force necessary to achieve the lawful objective in relation to the stopping of Robinson within a vehicle that has been identified as stolen." He commented that Mr Robinson:

> "made the conscious decision to actively place an item within his mouth with the clear intention of avoiding any consequences for being in possession of controlled drugs. This behaviour is common within individuals who respond 'emotionally' to a set of circumstances and don't 'rationally' assess the potential risk of direct harm to themselves, family or wider society."

17. Mr Robinson's injuries, Mr Fitzpatrick opined, were "consistent with being involved in a physical confrontation during an arrest / detention and the application of force and resistance thereof." The officers were armed with Glock pistols which were within Mr Robinson's reach. They could not have "tasered" him; he was too close to them for that to be a realistic option. The degree of force used was the minimum necessary to achieve the lawful objective of stopping Mr Robinson and was reasonable and proportionate, Mr Fitzpatrick said in his report.

18. In closing submissions, counsel then appearing for members of the deceased's family, Ms Satpal Roth-Sharma, made written and oral submissions inviting the coroner to leave gross negligence manslaughter, or alternatively neglect, to the jury. The duty of the officers, she submitted, was to "keep detained persons safe and to take reasonable steps to prevent the detained person from swallowing a package". The duty was breached, she argued, in various ways.

19. The officers should have handcuffed Mr Robinson or secured his hands before he had time to put the package in his mouth, she submitted; he was travelling in a stolen vehicle. PC Reeve should have carried out a risk assessment, i.e. an assessment of the risk Mr Robinson posed to himself; "a risk assessment was not undertaken of the foreign object placed into Mr Robinson's mouth", she argued. He was taken to the ground in the knowledge that he had a foreign article in his mouth.

20. Medical attention should have been sought urgently and was not. Unnecessary and excessive force was used, Ms Roth-Sharma contended. Mr Robinson's injuries showed that "unreasonable heavy handed force" was used. The adequacy of the officers' actions and response to Mr Robinson's obvious distress should be a matter for the jury to consider. The breaches of duty gave rise to an obvious and reasonably foreseeable serious risk of death. The conduct must be exceptionally bad, she accepted. It was open to the jury to find that it was in this case, she submitted.

21. Oral argument was on the last day of the inquest. Submissions were made on whether article 2 of the ECHR applied. Family members argued, through counsel, that article 2 was engaged on the basis of the actions of the police, not the paramedics. Ms Roth-Sharma had said in written submissions that the police "breached their positive obligation to protect life under Article 2". She relied on knowledge that Mr Robinson had "swallowed a package"; that he was "handled incorrectly"; further harm was "caused by excessive use of force" and "incorrect first aid procedures were applied".

22. For the police, Ms Rebecca Hirst (who also appeared before me) submitted in written and oral argument that the case did not fall within a category that automatically engaged article 2 (killing by state agents, suicides in custody, or unlawful killing in custody). It was for the coroner to make an "evidential assessment" and decide whether there is "a breach or arguable breach of Article 2…."; and the death would have to arise from "that unlawful act".

23. Ms Hirst said in written argument that in any case the coroner "has now heard the evidence in sufficient breadth and depth akin to an Article 2 inquest". But this was not a case where article 2 applied, she contended, because there was not an arguable case of gross negligence manslaughter. The actions of the officers, she said, were lawful. Mr Robinson did a "voluntary act" by placing the package in his mouth. There was then an oral exchange between the coroner and Ms Hirst on aspects of the evidence.

24. The coroner ruled on issues of law, saying that he took account of the totality of the evidence and of the written and oral submissions; and had considered relevant extracts from a text book, *Coroners' Courts: a Guide to Law and Practice*, 3rd edition, by Christopher Dorries OBE; and other legal materials. He did not find there was a case of gross negligence manslaughter to go to the jury. He accepted Mr Fitzpatrick's evidence that the use of force was reasonable and proportionate.

25. There was no breach of the duty of care and no risk of death as a reasonably foreseeable consequence of any misconduct, the coroner found. Further, the misconduct would

have to be grossly negligent which is "a very high threshold", the coroner said. The airway obstruction could not be cleared without the assistance of the medical equipment carried by the paramedics. The actions of the officers therefore could not be said to have caused the death.

26. The coroner then ruled that he would not leave a verdict of neglect to the jury, as there was no gross failure to take action in response to a need for assistance that was or should have been known to the officers; nor any clear and direct causal connection between such a failure and the death of Mr Robinson. The gaps in administering CPR at the roadside were not a gross failure. The package could only be removed by the paramedics as they had the necessary equipment.

27. The coroner then turned to article 2. The transcript of his ruling reads as follows (for clarity, I break it down into paragraphs, though the transcriber has not; and I correct a few obvious typographical errors):

> "Article 2 is engaged where there is ground for suspicion that the state may have breached either the negative duty, not to take a life, or the positive operation and duty, to safeguard life. The negative duties have not been raised in this matter. I remind myself that officers of Lancashire Constabulary were carrying out lawful stopping of the vehicle that would have been reported as stolen, and during this procedure, Mr Robinson has placed the package into his mouth, and it has become blocked in his airway.
>
> Considering the positive and operational duty, I have to have regard to whether the state agency knew or ought to have known at the time of the existence of a real and immediate risk to a detained person's life and failed to take steps within the scope of their powers which judged reasonably have been expected to avoid risk. Real and immediate risk has been defined as one that is present and continuing, rather than necessarily imminent. It should not be fanciful or trivial. It has been described in R (Kent County Council) and Coroner for Kent North-Western District, as a stringent test with a very high threshold.
>
> The court must take in account whether it is an ordinary risk of the kind that the individual in the relevant category should reasonably be expected to take or an exceptional risk. The failure to take steps at the criteria must be interpreted as in a way which does not impose and impossible or disproportionate burden on the authorities and must be judged reasonably, which includes the circumstances of the case, the ease or difficulty of taking precautions, and the resources available.
>
> In this case, I'm not satisfied that there's ground for suspicion that the state may have breached the positive operational duty to safeguard life. As I outline above, the threshold test is a high one. I do not consider that there was a real and immediate risk to Mr Robinson, the state failed to take steps within the scope of their powers, which judged reasonably, have been expected to avoid that risk. Officers of Lancashire Constabulary engaged in lawful stopping of the vehicle being driven by Mr Robinson. The situation they were confronted with escalated quickly, within a matter of seconds.
>
> It is right to say that the officers knew that Mr Robinson has placed something into his mouth. It was explained to me that they initially considered that this was a quantity of drugs. I accept that this could give rise to a risk to a person's life. When confronted with the situation though, I cannot see whether it was a failure to take steps within the scope of their powers, which judged reasonably has been expected to avoid that risk. I heard evidence that officers responded reasonably in this situation that they were confronted with, and in accordance with their accepted training.
>
> I therefore do not find that there was a failure to take steps to avoid the risks, and accordingly Article 2 is not engaged. I cannot see that there has been a breach in this

> matter. I remind myself of the recent decision in R (Gorani) v Assistant Coroner Inner West London [2022] EWHC1593[2]. I cannot identify systemic breach in this matter. There is no evidence of wrong systems and the Article 2 duty is not concerned with the individual [but] an inadequate system.
>
> I cannot see that the procedural obligation arises until there was a breach of the negative or positive obligation. I accordingly, do not consider that I should engage Article 2 in this case. … ."

28. In summing up to the jury, the coroner read to them his 15 pages of written directions and, later when the jury retired to consider their verdict, gave them copies of the written directions. He directed them uncontroversially on matters such as the need to avoid speculation and the consideration of expert evidence. The written directions also included a summary of the witness evidence, which I do not reproduce here. I will come to the claimant's criticism of that summary later. In relation to the Record of Inquest to be completed by the jury, he gave the following directions.

29. The Record of Inquest should be completed, he said, "using clear neutral words that briefly set out the facts as you find them. The actual words that you use are entirely a matter for you to decide …" ([13]). Then at [15]-[16] he directed them:

> "15. When describing the circumstances you should be brief, neutral and factual, expressing no opinion, and cannot breach s10 Coroner's and Justice Act (2009) by determining criminal liability by a named person or civil liability at all. Yet you must still make findings of fact on the central issues that have arisen so that anyone reading your findings understands the circumstances surrounding the death.
>
> 16. You must be careful with your language avoiding terms such as 'negligence', 'blame', 'fault', 'breach of duty', 'careless', 'breach of human rights' etc. which could appear to determine liability of one nature or another. You can use words such as 'inadequate', 'inappropriate', 'insufficient', 'lacking', 'unsuitable', 'unsatisfactory', and 'failure'. When completing the Record of Inquest, it is not your duty to prepare a detailed factual statement. Having heard all the evidence you may find most of the issues that you have to determine are not controversial. Indeed, who when and where may not give you any difficulties but you must still agree on these facts."

30. Later, after summarising the evidence, the coroner directed the jury as follows, at [77]-[94] (omitting certain immaterial parts):

> "77. … the proceedings in evidence at an inquest shall be directed solely to ascertaining the following matters namely: -
>
> i Who the deceased was
>
> ii. How when and where the deceased came by his death
>
> iii. The particulars for the time being required by the registration acts to be registered concerning the death

[2] As Mr Rule KC for the claimant pointed out, the correct citation is [2022] EWHC 1680 (Admin); (2023) 192 B.M.L.R. 38. *Gorani* was a medical care case where arguable breach of the "systems duty" was alleged. Members of the family also submitted to the coroner in this case that there were systemic errors.

78. …. you have to identify … the person who died, record how, when and where he came by his death, how meaning – by what means and in what circumstances - and record the registrable particulars in paragraph 5 of the inquisition.

79. Remember neither the Coroner nor the jury shall express any opinion on any other matter. In the past juries and Coroners have sought to make recommendations or given advice to society and others with regard to things that need changing or disapproving of certain courses of action. That is not allowed and must not be done. I have the power to bring matters to the attention of authorities to help society learn lessons and to prevent future fatalities, should I deem my duty to be engaged.

80. s10 Coroner's and Justice Act (2009) is equally important. This states that no determination shall be framed in such a way as to appear to determine any question of: -

b. Criminal liability on the part of a named person or: -

c. Civil liability

81. Those matters are not part of the Coroner's jurisdiction they are matters for other courts and other times and other places and certainly not part of your function.

82. Once you have agreed the facts, … only then should you consider … how to complete paragraphs 3 and 4 of the inquisition i.e. the time place and circumstances and the Conclusion. Remember that you are not deciding issues between parties. Your duty is to find the facts and a conclusion from the evidence and this duty must transcend your feelings of sympathy for particular people, you have to reach a conclusion even if that conclusion seems to be unkind or may appear critical of some person or persons, but remember no-one is on trial, and you are not here to determine criminal or civil liability.

Boxes 1 and 5

83. Boxes 1 and 5 are not controversial …. .

84. I will concentrate on boxes 2, 3 and 4 of the record of inquest, as the evidence for the rest of the inquisition is not controversial in that there was only one version given by all witnesses.

Box 2: Cause of death

85. You should enter into this box the medical cause of how Mr Robinson died.

Box 3: By what means did the deceased come by his death?

86. You should record at paragraph 3 a short, neutral account of the time place and circumstances in which the deceased came by [his] death, without naming any other person or appearing to determining either criminal or civil liability.

Box 4: Conclusion

87. Then at paragraph 4 you should enter your conclusion …. a Coroner does not owe a duty to leave every conceivable verdict to a jury, but in effect merely those which "reflect the general thrust of the evidence". I have to ask myself, Is there evidence on which a jury properly directed could properly make a finding to the appropriate standard of proof? plus … "Would it be in the interests of justice, that is, safe as opposed to perverse or unsafe for the jury to make such a finding on the evidence before it? Bearing in mind the Chief Coroner's Guidance on this I do not leave you the option of returning a conclusion of unlawful killing and this is because I do not believe that the evidence is available to support

such a conclusion, and it follows that it would be unsafe to leave such a conclusion for you to return in any event.

88. I am going to leave you two conclusion[s] to consider, the first is a conclusion called 'misadventure', this might be applied where a person deliberately undertakes a task that goes wrong, causing their death. By way of example, if a boxer hits an opponent causing fatal results, the initial blow could not be described as accidental, but the outcome was not intended.

89. I am also going to leave to you the conclusion of a narrative. This is a short factual account of how the death came about.

90. …. your conclusions should be reached on the balance of probabilities, ie. what is more likely than not, they do not have to be reached beyond all reasonable doubt. If you do consider that a narrative conclusion is appropriate then I would remind you of s5(3) and s10 of Coroners and Justice Act (2009), these provide:

91. 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 who the deceased was, how, when and where the deceased came by his or her death, the particulars (if any) required by the 1953 Act to be registered concerning the death.

92. s10 Coroner's and Justice Act (2009) states that no determination shall be framed in such a way as to appear to determine any question of:

d. Criminal liability on the part of a named person or: -

e. Civil liability

93. Within that framework, you can write your own wording. Narrative conclusions can be framed in such terms as:

a) Mr Smith was swimming in the sea when he encountered difficulties and drowned;

b) Mr Smith was swimming in the sea when he had been advised by members of the coastguard not to do so. He encountered difficulties and drowned;

c) Mr Smith was swimming in the sea when he had been advised by members of the coastguard not [to] do so. He had been provided with inaccurate and outdated tidal information. He encountered difficulties and drowned;

d) Mr Smith was swimming in the sea when he had been advised by members of the coastguard not [to] do so. He had been provided with inaccurate and outdated tidal information. He encountered difficulties and drowned. Emergency assistance had been summoned, but arrived outside of its guideline timeframe. This was a missed opportunity to provide emergency assistance, but it is unknown if such assistance would have altered the eventual outcome.

94. The above are merely examples to give you some guidance as to how a narrative conclusion can be framed. Should you choose to return a narrative conclusion, the choice of wording is for you to determine, within the legal framework I have outlined to you."

31. While the jury was out, the coroner considered "auxiliary issues". He referred back to Dr Forrest's evidence that there should be placed into the training programme for police officers "something around [in] and out of hospital choking events". The coroner said he did not think it was for him to make comments about giving that issue higher priority than other issues in training programmes. Rather, he said, he was minded to:

> "write a letter of concern and [weave] the comments that we have from Dr For[r]est [so] as to try to have some national unanimity on that issue."

32. The coroner did not propose, he said, to make a PFD report. Such a report must be made in the circumstances stated in the Coroners and Justice Act 2009, Schedule 5, paragraph 7. Where those circumstances are present, a PFD must be made in accordance with the process stated in the Coroners (Investigations) Regulations 2013, regulation 28. The coroner proposed instead to send a non-statutory letter of concern. He would need to identify the recipients. The letter, addressed to "Dear Sirs", was prepared and sent. It was dated 31 July 2022.

33. In the letter, the coroner referred to the circumstances of Mr Robinson's death, to the jury's verdict and to the comments of Dr Forrest and his position as medical director of the Anaesthesia, Trauma and Critical Care Group, the body that provides professional training and clinical governance oversight to Lancashire Constabulary. The coroner noted in the letter that Dr Forrest had expressed the view that removal of drug packages and subsequent management should be "highlighted nationally to senior officers".

34. Enhanced training on such incidents "may be beneficial possibly on a scenario based life support training programme based on the incident involving Mr Robinson", the coroner wrote. The recipients were "the appropriate persons who have authority to examine the provision of training at a national level and how this may be adapted and/or expanded in light of this case". They were asked to reply to "confirm your response to these concerns, and how such learning points may be considered in light of the above."

35. The jury's verdict was misadventure, as I have said. The matter then proceeded slowly towards a judicial review hearing; proceedings were issued and permission to proceed was eventually granted. The procedural history, which I do not set out here, culminated in the hearing before me.

Issues, Reasoning and Conclusions

First ground of challenge; article 2 of the ECHR

36. For the claimant, Mr Philip Rule KC made the following main points. He submitted that the coroner should have determined that the circumstances of Mr Robinson's death were such that the procedural obligation on the state arose to conduct an inquest involving an enhanced investigation, meeting the procedural duty under article 2 of the ECHR; and that the coroner was wrong to decide that article 2 was not engaged.

37. There were two routes to that conclusion, Mr Rule submitted. The first was that this court should hold that the circumstances of the death meant that article 2 applied automatically to this inquest because the facts of the case fell into a category of cases the facts of which necessarily gave rise, in every case falling within the category, to a legitimate ground to suspect state responsibility in the form of a breach of one of the state's substantive article 2 duties.

38. Mr Rule said that Mr Robinson died of non-natural causes while in police custody. That meant his death was in the self-evidently "suspicious" category automatically triggering the article 2 enhanced procedural obligation: see Popplewell LJ's comments on the Supreme Court's decision in *R. (Smith) v Oxfordshire Assistant Deputy Coroner* [2011] 1 AC 1, in his judgment in *R. (Morahan) v. West London Assistant Coroner* [2021] QB

1205, DC, at [97]-[100] (approved by the Supreme Court in *R. (Maguire) v. HM Senior Coroner for Blackpool & Fylde* [2023] UKSC 20, per Lord Sales JSC at [13]-[17]).

39. At [122(5)], Mr Rule pointed out, Popplewell LJ identified the categories in which the state's procedural article 2 obligation arises automatically as including killings by state agents, suicides or attempted suicides and unlawful killings in custody, suicides of conscripts and suicides of involuntary mental health detainees; and added that the jurisprudence was developing and "these categories cannot be considered as closed".

40. Mr Rule suggested that I should if necessary extend the categories, which are not closed, to cover the facts of this case. I asked him to put in writing possible definitions of the category into which I should decide the present case falls. In response, he proposed five possible definitions:

(1) unnatural death occurring while in the involuntary (whether lawful or unlawful) custody or control of the state;

(2) unnatural death occurring while in the involuntary custody or control of the police following the deceased committing an intentional act liable to cause himself harm;

(3) unnatural death occurring while in the involuntary custody or control or the police at a time when the arresting or detaining officers are aware that the person has swallowed a package that consequently poses a risk to life;

(4) death in police custody or control after the deceased entered a physical or mental state needing medical emergency care, of which the police were or should have been aware; and

(5) death occurring after the use of force by police officers to effect or in the course of an arrest or physical control.

41. The second possible route to a mandatory article 2 compliant inquest was, Mr Rule submitted, that on the facts here there was clearly an arguable breach by state agents of the positive operational duty under article 2 to protect life. The operational duty arose because the police officers knew or ought to have known that there was a real and immediate, i.e. present and continuing, risk to Mr Robinson's life.

42. Mr Rule submitted that there was an arguable breach of that duty by the officers. The threshold for an arguable breach is not a high one, he said; see *Morahan*, per Popplewell LJ at [75] and [102] discussing the various formulations of the arguability threshold in other cases. It was sufficient that the suggested breach was not merely fanciful; it could credibly be suggested and should have led the coroner to rule that he must hold an article 2 inquest. Had the coroner done so, said Mr Rule, he would and should have allowed the jury to make "judgmental" rather than neutral findings.

43. That, said Mr Rule, would have left to the jury issues such as whether the officers unreasonably failed to handcuff or otherwise secure both Mr Robinson's hands more promptly, to prevent him putting the package in his mouth; whether excessive force was used against him; whether the officers failed adequately to assess the risk to Mr Robinson from handcuffing and restraining him on the ground with a package in his mouth; whether they were at fault for not slapping him on the back; whether they should have stood him up and given him abdominal thrusts; whether they should have started CPR earlier and called the paramedics sooner; and whether their training was adequate.

44. If this had been an article 2 inquest, Mr Rule further submitted, the coroner would have had discretion to leave to the jury matters that were possible, even if not probable, causes of death. The coroner set the bar too high when requiring proof of cause of death on the balance of probabilities. He could have left the jury to address those central disputed issues on the basis that some or all could possibly have contributed, more than minimally or trivially, to death (see e.g. *R. (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] 4 WLR 157, DC, at [41]-[42]).

45. Mr Rule also suggested that the jury may have been wrongly directed that they must choose between a simple verdict of misadventure or a narrative verdict and that the jury may have misunderstood and not appreciated that it was open to them to return both a verdict of misadventure in box 4 and a narrative in box 3, the same defect as identified by the Court of Appeal in *R (P) v. HM Coroner for the District of Avon* [2009] EWCA Civ 1367, [2010] 112 BMLR 77.

46. For the chief constable, Ms Rebecca Hirst submitted that the coroner conducted the inquest in a manner that was akin to an article 2 inquest, receiving evidence sufficiently wide in scope to satisfy the enhanced procedural obligation, if it should arise; and deliberately and lawfully leaving open until after the evidence his decision on whether article 2 was engaged. He was right to decide, having heard the evidence and received submissions, that the article was not engaged.

47. Ms Hirst contended that the "automatic" article 2 categories should not be extended to cover the facts of this case. While not exhaustive, the categories should continue to include the requirements envisaged in all those so far identified: either that the deceased is in a custodial setting or that there is reason to suspect state responsibility for the death. In her skeleton argument, she submitted that "it is the level of responsibility by the state towards the individual in their dealings with the individual that dictates whether the automatic nature of an Article 2 inquest arises."

48. Here, Ms Hirst argued, Mr Robinson was not yet fully under the control of the officers when he placed the package in his mouth. They had secured one of his hands but he used his still free other hand to do so. He was not in a custodial setting when he put the package in his mouth. The coroner was therefore right to ask himself whether there was an arguable breach of the positive operational duty by the officers. Ms Hirst accepted that a failure to take reasonably available measures which might have had a real prospect of altering the outcome would be sufficient.

49. She submitted that the coroner was right to avoid hindsight and right to find that there was no arguable breach of any positive operational duty to protect life. The question was whether there was sufficient evidence on the balance of probabilities, without it amounting to speculation, that reasonable steps were not taken to prevent a real and immediate risk to life; and that failure had a real prospect of altering the outcome or mitigating the harm.

50. In oral argument, Ms Hirst referred to Lord Dyson's categories of case where the operational duty, derived from *Osman v. United Kingdom* (1998) 29 EHRR 245, had been held to exist; see *Rabone v. Pennine Care NHS Trust* [2012] 2 AC 72, at [15]-[18]. Ms Hirst pointed out (as noted by Lord Hope in *Mitchell v. Glasgow City Council* [2009] 1 AC 874, at [30]-[31]) the test that must be met for the operational duty to arise is "a high one" where the claimed duty is "to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another" ([31]).

51. In *Osman* itself, Lord Hope noted at [31], the Grand Chamber had said at [116] that:

> "such an obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities. Accordingly, not every claimed risk to life can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising."

52. The coroner was right, Ms Hirst argued, to conclude that there was no arguable breach of that duty. The evidence was that the placing of the package in the mouth was a voluntary act. The officers were entitled to use and did use reasonable force to restrain Mr Robinson. Their medical skills were limited; they did not have the training or the tools to detect and remove the package; when he became unresponsive, they acted reasonably in removing the handcuffs, calling an ambulance and administering CPR.

53. As for causation of death, it would be no more than speculation to suppose that any failure or delay on the officers' part contributed materially to the death. No witness was able to say at what point the package became lodged to create a complete blockage of the airway. The uncontradicted evidence was that no resuscitation would be successful as long as the airway was blocked. There was no failure to take reasonably available measures that might have had a real prospect of altering the outcome.

54. For the coroner, Mr Pojur confined his neutral submissions to stating the tests when determining whether article 2 applies to a particular inquest. In particular, he reminded me that the "real and immediate risk" test is separate and distinct from the question whether there is a suspicion of state responsibility, such that article 2 is engaged automatically. He refrained from any partisan submissions on whether the coroner was right to find that it was not engaged here, but reminded me of the evidence (some of which I have already mentioned) that was before the coroner to guide him on that issue.

55. Having considered the rival contentions, I have reached the following conclusions. First, I do not see any good reason to extend the existing categories of case in which article 2 applies automatically. The circumstances of the death must be such that "they fall into a category which necessarily gives rise, in every case falling within the category, to a legitimate ground to suspect state responsibility by way of breach of a substantive article 2 obligation" (Popplewell LJ in *Morahan* at [122(7)]).

56. The legitimate grounds for suspicion "connotes the same threshold of arguability as has to be satisfied in cases where the enhanced investigative duty does not arise automatically" (*ibid.* at [122(8)]). Thus, the arguable breach must be discernible from the case falling within the relevant category, without more. Popplewell LJ noted in his next (ninth) proposition that the type of death is important; "[d]eaths from natural causes are not to be treated in the same way as suicides or unlawful killings".

57. The cause of death here was misadventure, i.e. doing an intended act with unintended fatal consequences for the doer. Mr Rule's first and second categories (unnatural death occurring while in the involuntary custody or control of the state; or while in the involuntary custody or control of the police following the deceased committing an intentional act liable to cause himself harm) are too wide. They would capture cases where, for example, police officers encounter and arrest a drug addict on the street who is in the throes of dying from an overdose taken before the arrival of the police officers.

58. In that example, there is no legitimate ground for suspecting state responsibility for the death by breach of a substantive article 2 obligation. The suggested third and fourth

categories (deaths in custody or state control where a package is swallowed with consequential risk to life before or during arrest; or where there is some other reason why emergency medical care is clearly needed) likewise do not raise, *per se*, the required legitimate ground for suspecting state responsibility.

59. I interject that the swallowing of a package did not occur here, despite accounts that it did. The peril to Mr Robinson's life arose when the package was *not* swallowed. If it had been, his airway may have remained unblocked. It is relatively common for suspects to swallow packets of drugs during arrest or to avoid detection. The risk to the suspect may be slight or it may be severe. The "risk to life" proposed in Mr Rule's third formulation is not something police officers are trained or qualified to assess.

60. The fifth category proposed by Mr Rule is death occurring after the use of force by police officers to effect or in the course of an arrest or physical control. But a death may, unfortunately, occur in cases falling within that formulation, without any arguable state responsibility by way of breach of a substantive article 2 obligation. It would capture a case where, for example, a suspect escapes from the clutches of an arresting officer and then dies having jumped into a river or into the path of a passing vehicle.

61. All the suggested categories involve death by misadventure coupled with some involvement of state agents, usually police. They are not cases of suicide or unlawful killing. Misadventure cases are not apt to attract the automatic application of article 2 because the misadventure may be unpredictable; the state agents may bear no blame for it; and it may require urgent medical attention beyond their expertise, where the state's obligation would be, at most, to call for it and do their best with first aid meanwhile.

62. I therefore conclude that the coroner was right to ask himself whether there was, on the evidence before him, an arguable breach of the positive operational duty to protect Mr Robinson's life. I have set out above *in extenso* his ruling on article 2. In reminding himself of the law, the coroner referred first to the question whether the operational duty arose, applying the "real and immediate risk to a detained person's life" test. He referred to the need for the risk to be "present and continuing" rather than "imminent".

63. I find no fault with these legal directions. The description of the test as "a stringent test with a very high threshold" comes from *R. (Kent County Council) v Coroner for Kent North-West District* [2012] EWHC 2768 (Admin) per Foskett J and HHJ Peter Thornton QC (judgment of the court) at [43]). The court held, reversing the coroner's decision, that the operational duty did not arise. It was a tragic case involving the death of a 14 year old boy from an overdose of methadone; but the immediate risk was a risk of harm, not a risk to life.

64. At [43], the judgment of the court stated:

> "It is of importance to remember that, in the context of the operational duty, it has been said that the test of "real and immediate risk to life" is "a stringent one" (per Lord Brown of Eaton-under-Heywood in *Van Colle v Chief Constable of the Hertfordshire Police* [2009] 1 AC 225, para.115), "with a very high threshold" (per Lord Hope of Craighead at para.69) and that it provides a "high hurdle" (per Lord Carswell in *Re Officer L* [2007] 1 WLR 2135). The stringent nature of the test is demonstrated by the circumstances of *Van Colle*: no breach was found in the situation where a defendant about to be tried for theft murdered the chief prosecution witness despite the police having been aware of a series of threats and intimidation by the defendant towards him."

65. The coroner went on to differentiate between "an ordinary risk of the kind that the individual … should reasonably be expected to take" and "an exceptional risk". The failure to take steps "must be interpreted … in a way which does not impose an impossible or disproportionate burden on the authorities and must be judged reasonably, which includes the circumstances of the case, the ease or difficulty of taking precautions, and the resources available."

66. Those passages, as I read them, referred correctly to the high threshold required to establish the *existence* of the operational duty. They did not refer, incorrectly, to a "very high threshold" for discerning an *arguable breach* of that duty, where it arises, for the purposes of triggering the state's enhanced investigative duty to carry out an enhanced article 2 "*Middleton*" inquest rather than an ordinary "*Jamieson*" inquest. As Popplewell LJ and other judges have pointed out, the threshold for discerning a possible breach is the lower one of arguability.

67. It is true that the coroner referred then to being "not satisfied that there's ground for suspicion that the state may have breached the positive operational duty …" and "[a]s I outline above, the threshold test is a high one." But he must have meant by the "threshold test" the test of real and immediate risk to life, as he said in the next sentence:

> "I do not consider that there was a real and immediate risk to Mr Robinson, the state failed to take steps within the scope of their powers, which judged reasonably, have been expected to avoid that risk."

68. I find no serious fault with his legal directions beyond observing that they could have been expressed more clearly. He may at times have conflated the duty with a breach of it, but not in a way that led him into error applying the law to the facts. He went on to consider the facts. I have set out his reasoning above. While acknowledging that the officers knew Mr Robinson had placed something into his mouth and accepting that "this could give rise to a risk to a person's life", he could not see:

> "a failure to take to take steps within the scope of their powers, which judged reasonably has been expected to avoid that risk. I heard evidence that officers responded reasonably in this situation that they were confronted with, and in accordance with their accepted training."

69. In my judgment, the coroner's reasoning was sound and his conclusion correct, although not very clearly expressed. If the operational duty arose at all, it was not arguably breached because the officers did not fail to take reasonable steps within their powers to protect Mr Robinson's life. Although arguably they should have commenced CPR a few minutes earlier, that would probably not have made any difference to the outcome.

70. I would add that some of the criticisms were far fetched and informed by hindsight: that the officers failed to handcuff Mr Robinson sooner, to prevent him putting the package in his mouth; and failed to carry out a risk assessment before restraining him on the ground with the package in his mouth. At the time, they were concerned that Mr Robinson might produce a weapon or try to seize one of their pistols.

71. For those reasons, I consider that the coroner was justified in his decision, after hearing evidence sufficient in scope to comply with article 2, that the article did not apply. The first ground of challenge does not succeed.

Second ground of challenge; the coroner's summing up

72. Mr Rule submitted that even on the footing that an article 2 inquest was not required, the coroner's summing up was defective. It did not seek out and record as many of the facts as the public interest requires, he said. The coroner had "failed to elicit the findings and determinations to the question of how Ronald died" as required by section 10 of the Coroners and Juries Act 2009, was how he put it in his skeleton argument. The family were "left without any answers to what is independently and judicially made (by the jury) of the police conduct seen on the video and evidenced in the inquest".

73. Specifically, Mr Rule criticised the summing up for making only brief mention of the force used to restrain Mr Robinson; the mechanisms used to restrain him; insufficient reference to the video footage (which the jury viewed); no mention of an attempt forcibly to compel Mr Robinson to spit out the package; no mention of them placing him prone on the ground with their weight on his chest; insufficient emphasis given to the evidence of a Mr Steven Logan, an electrician who happened to witness the struggle and thought the police use of force excessive; not reminding the jury of the timing of the call for an ambulance or first commencement of CPR.

74. Mr Rule argued that the coroner should have placed more weight on criticisms of the officers' actions by expert witnesses, for example by Mr Dunn on delayed start of CPR; and by Dr Forrest of a missed opportunity to administer slaps to Mr Robinson's back. The coroner did mention the view of Mr Fitzpatrick that the degree of force used was reasonable. He should, said Mr Rule, have told the jury they were free to reject that view; it may not have been causative of death on the balance of probabilities but it might have made a difference if less force had been used.

75. He reproached the coroner with not identifying "the central issues", notably whether the officers were to blame for the death because of the manner in which they restrained Mr Robinson, the degree of force used, the delay in starting CPR, the delay in calling an ambulance and the handover to the paramedics. He did not give the jury a questionnaire. He should have reminded them about the timing of events, from the start of the incident, to the commencement of CPR, to the departure of the ambulance.

76. Mr Rule complained that the coroner should not have given the jury the choice between a short form "misadventure" verdict and a brief non-judgmental narrative verdict. He should, Mr Rule submitted, have invited the jury that they could include both in the Record of Inquest: a misadventure verdict in box 2 and a narrative verdict in box 4. The jury "may have interpreted the directions as requiring a choice between the two", Mr Rule said in his skeleton argument. Even in a non-article 2 inquest, he said, there is no bar to a short form verdict combined with a brief and non-judgmental narrative.

77. For the chief constable, Ms Hirst pointed to the central significance of Dr Forrest's evidence that Mr Robinson could not be resuscitated successfully until the object was removed because the airway was blocked; and, Ms Hirst pointed out, neither Dr Forrest nor anyone else could say at what point the package had formed a total blockage of the airway. The issue remained one of speculation, she submitted. The evidence of Mr Fitzpatrick on the question of restraint was not met by any request from the family members to call evidence of their own on the subject of restraint; although the family members were represented by solicitors and counsel through four pre-inquest hearings.

78. Ms Hirst reminded me that the jury saw the video evidence and heard oral evidence in detail from the witnesses over four days, which they had an opportunity to assess. That

included the officers, the paramedics, the electrician Mr Logan and the experts. The jury were correctly told that it was for them to assess that evidence and that they were the judges of fact. The jury were told several times that they had to agree "the factual circumstances" and reach their conclusions "from those circumstances"; and "on the balance of probabilities". The summing up of the evidence was brief but adequate. An inquest is an inquisitorial and relatively summary process (*R. (Morahan) v. West London Assistant Coroner* [2023] KB 81, per Lord Burnett CJ at [7]).

79. The jury were told they could reject expert evidence and if they decided to return a narrative verdict they could use words such as as "inappropriate", "insufficient", "lacking", "unsuitable", "unsatisfactory", and "failure". They were given guidance on how to draft a narrative verdict, using the example of a death by drowning. It was not for the coroner to *require* the jury to return a narrative verdict in box 4, rather than a short form misadventure verdict. The jury was entitled to opt for the short form misadventure verdict, she submitted.

80. Ms Hirst referred me to the chief coroner's guidance document called "Guidance No. 17" dated 7 September 2021 on "use of short-form and narrative conclusions and with a view to achieving greater consistency across England and Wales" (paragraph 1). (The word "conclusion" is now commonly used to describe what used to be and sometimes still is, as in this judgment, called the verdict of the coroner or jury at the inquest.) A narrative conclusion is not mandatory, Ms Hirst submitted, in either an article 2 inquest or a non-article 2 inquest (see paragraphs 23-24 and 32-33 of Guidance No. 17).

81. Mr Pojur, for the coroner, submitted neutrally that the issue was whether the jury was adequately directed on the evidence and whether it was "reasonable … to permit the jury to choose between a short form conclusion of misadventure or a narrative conclusion without giving them the option to return a hybrid of both, in Box 4 of the Record of Inquest". He noted that Guidance No. 17 encourages short form conclusions "[w]herever possible" as this has "the advantage of being simple, accessible, and clear for statistical purposes" (paragraph 15).

82. Mr Pojur informed the court that the coroner invited interested parties present to make submissions before the written summing up was read to the jury and none were made; that the coroner told the jury he was not going to recite ("regurgitate") all of the evidence, just the "general thrust of the evidence"; and that the jury were reminded that they were the judges of fact, warned against speculating and told what language they could and could not use.

83. Turning to my reasoning and conclusions, I do not think there is much force in the criticisms of the summing up. In my judgment, it was adequate. I understand the disappointment of the family members that the jury decided against a narrative verdict. But they were not obliged to return one. In my judgment, the coroner elicited the findings and determinations the public interest required. All the relevant facts were before the jury. The scope of the inquest was wide because of the possible application of article 2, as explained above.

84. The claimant's arguments rest on the proposition that the police officers were in some way to blame for Mr Robinson's death. The claimant does not, as I understand it, blame the paramedics. Clearly, the jury did not accept that the officers were to blame. That does not mean the coroner failed to elicit the findings the public interest required. It means only that those findings were not the ones the family members hoped for. That

was not surprising because the coroner ruled out unlawful killing and ruled out neglect. The claimant does not challenge the decision not to leave those conclusions to the jury.

85. The summing up of the evidence was not biased in favour of the police. I reject any suggestion that it was. There was expert evidence that the force used by the officers was not excessive. Their suspect was in a car reported stolen; the officers were armed and the suspect was fairly perceived as a flight risk and had a hand in a pocket at one stage. Without the use of hindsight, this was a dangerous situation in which the officers were entitled to look to their own safety and prevent the suspect from escaping.

86. The coroner did not direct the jury that they must find the use of force was reasonable. He was entitled to sum up to them Mr Fitzpatrick's view that it was reasonable, while directing them that they were not bound to agree with that view. They could see for themselves what was recorded on video. The coroner did mention Mr Logan's evidence, though not his inexpert view that the use of force seemed excessive. He was 60 feet away and not necessarily aware of any danger to the safety of the officers and that they were lawfully apprehending a man getting out of a car reported stolen.[3]

87. I accept the chief constable's submission that a summing up need not rehearse the evidence in forensic detail and that the issues were not very complicated. The jury was being reminded of evidence they had seen and heard for themselves only days earlier. They were not being introduced to the evidence for the first time. They knew the officers had tried to get Mr Robinson to spit out the package. The coroner quoted Mr Logan's and PC Reeve's evidence on that point (in the summing up, see paragraphs 30 and 44, respectively).

88. The jury knew Mr Robinson had become unresponsive and that the officers had commenced CPR and called an ambulance. The coroner summed up Mr Dunn's evidence that "there was a delay of a number of minutes in the commencement of CPR, although it is difficult to say whether this had any effect on the eventual outcome" (paragraph 59). The coroner included (paragraph 61) the observation that there was "an absence of information being passed between those emergency responders at the scene. The scene was described as a dynamic and fast moving situation, but the emergency responders could have communicated more effectively."

89. The jury knew the officers were unaware Mr Robinson's airway became fully obstructed. They also knew that no witness, including the medical experts, could say when that happened. They knew the officers attributed his unresponsiveness to the influence of drugs in a swallowed package. They knew the officers could not be expected to detect the blocked airway and remove the package. It was not incumbent on the coroner to go through the timeline in the video evidence; nor to administer a questionnaire to the jury.

90. I accept that the summing up does not make clear whether the jury had to choose between a short form verdict of misadventure or a longer, but still brief, narrative verdict. It would have been better if the coroner had told the jury in terms that they could return a "hybrid" verdict. I would not go as far as to say the jury were told in terms that they must choose between those two alternatives. Paragraphs 87 to 95 of the

[3] Counsel for the family asked Mr Logan: Q. "[a]re you able to assist the coroner and the jury as to how he was being restrained?" A. "Pretty forceful, excessively in my opinion." Q. "I don't want your opinion, but if you can tell the court what was being done by the officer to make you think that way." A. "I've used the same force myself to protect myself. … Putting your arms around someone's neck from behind and squeezing."

summing up are capable of meaning the jury did have the option to return both misadventure and a narrative conclusion. The word "conclusions" in the plural is used, as well as "conclusion" in the singular, if the accuracy of the transcript is assumed.

91. It is a pity that none of the parties' representatives asked the coroner to clarify his direction and tell the jury whether the two conclusions he left to them were alternatives or not. But I do not regard that as fatal to the integrity of the inquest. A narrative verdict could not have added much to the short form misadventure verdict. It could have added a few sentences about the nature of the misadventure, but it could not have contradicted the proposition that the death was by misadventure, i.e. the unintended consequence of an intended act by the deceased.

92. I am aware of no authority that a jury can be compelled to return a narrative conclusion, whether in addition to or instead of a short form conclusion, and whether in an article 2 or non-article 2 inquest. The fact that the jury did not return a narrative verdict does not demonstrate that they were wrongly directed. They evidently preferred the simple "misadventure" verdict to the narrative verdict they could have given.

93. In the light of the evidence called, the withdrawal of unlawful killing and neglect and the verdict of misadventure, it is not realistic to suppose that any narrative would have laid the blame for Mr Robinson's death at the door of the police. I do not think the jury were materially misdirected or unreasonably directed about how to complete box 4 of the Record of Inquest. I therefore reject the second ground of challenge.

Third ground of challenge; mandatory prevention of future deaths report

94. Section 32 of and paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 require a senior coroner investigating a death to make a report where "(1) … (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 … ."

95. Where those conditions are met, the coroner must "report the matter to a person who the coroner believes may have power to take such action" (paragraph 7(1) of Schedule 5). The duty to report has been considered by Garnham J (Macur LJ agreeing) in *R. (Gorani) v HM Assistant Coroner for Inner West London* [2022] EWHC 1680 (at [94] to [96]); and by the Divisional Court in *R. (Dillon) v HM Assistant Coroner for Rutland and North Leicestershire* [2022] EWHC 3186 (Admin).

96. The claimant submits that the coroner did not discharge his duty to make a PFD report. In the statement of facts and grounds it is asserted that he evaded his statutory duty to do so and that to write a "letter of concern" instead was contrary to that duty and to the chief coroner's guidance document called "Revised Guidance No. 5" dated 4 November 2020. Mr Rule submitted that there was a duty not a discretion to make a PFD report here because, as he put it in the grounds:

> "[t]he duty is to report upon anything revealed by the investigation giving rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and 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."

97. Mr Rule submitted that the coroner's decision not to make a PFD report was "wrong in principle". He relied on the statements in Revised Guidance No. 5 that "[a] report does not have to relate to a death in similar circumstances" ([19]); "[a] coroner may shed light on a system failure that has regional or even national implications" ([21]); a report "should be clear, brief, focused, meaningful and, wherever possible, designed to have practical effect" ([4]); "[e]ven if facts are disputed, that does not prevent the making of a report" ([44]); and "[g]iving rise to a concern is a relatively low threshold" ([11(2)]).

98. Ms Hirst submitted that it was for the coroner to decide whether the criteria were met, triggering the obligation to make a PFD report. While the threshold requirement that there is "a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future" is a low one, the Revised Guidance No. 5 recognises at [40]-[42] that a letter of concern may be appropriate in exceptional cases, including where the matter of concern does not relate to a risk of future deaths.

99. For the coroner, Mr Pojur took me to the written report of Dr Forrest which ended with a passage under the heading "Actions as a result of this incident". Dr Forrest informed the coroner as follows:

> "I have recommended through the Clinical Governance Group, that the removal of drug packages and subsequent management should be highlighted nationally to senior officers in each force. This occurrence is not isolated to Lancashire Constabulary and police officers with enhanced first aid should be better prepared to deal with such an incident. We would suggest they undergo scenario-based learning as part of their basic life support training. I have highlighted this risk in current training and included a scenario of this type in the latest round of Lancashire Constabulary enhanced first aid training."

100. In my judgment, this ground of challenge turns on whether the coroner was required as a matter of rationality to form the view that each of the criteria in (b) and (c) of paragraph 7, Schedule 5 to the 2009 Act was satisfied. To put the point the other way round, the claimant would have to establish that the coroner would be acting irrationally if he were to have formed the view that one or both of the two criteria were not met.

101. There were clearly reasons why he might have formed the view that the first criterion (risk of other deaths) was met. It is, in my judgment, to be inferred from the letter of concern and the evidence before the coroner that he was concerned about a risk of other deaths in the future. Dr Forrest's recommendation and the coroner's letter implied that they perceived such a risk. Dr Forrest's recommendation was clearly aimed at reducing it. The coroner's letter proposed that Mr Robinson's case be used as a case study.

102. However, I do not think he irrationally failed to form the view that "action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk …". He did not want to dictate priorities in the training agenda. He wanted to highlight Dr Forrest's comments and elicit a response to them. The view he stated in the letter, based on that of Dr Forrest, was that the issue of removing drugs packages and subsequent management should be "highlighted nationally" and that "enhanced training … on such incidents, *may be beneficial*" [my emphasis].

103. Although the coroner did not say so explicitly, that seems to me to fall short of forming the view that "action should be taken ….". Rather, he sought to sound out those with the power to take such action on what *their* view was on whether action should be taken.

That seems to me a properly considered and rational view to take and is not out of line with what is said on the subject in Revised Guidance No. 5. The third ground of challenge therefore also fails.

Conclusion

104. I have found none of the grounds of challenge made out. The third ground, had it succeeded, would not have led to a direction for a fresh inquest. I would have hesitated long before directing a fresh inquest even if either or both of the first two grounds had succeeded. The scope of the inquest was wide and the evidence plentiful and thorough. The cause of death was undisputed. Aside from the bar on judgmental language in a narrative verdict, the conduct of the inquest was akin to an article 2 inquest.

105. Even in an article 2 inquest, the authorities do not support the existence of any power to compel a narrative verdict. The growth of narrative verdicts, spurred by the advent of article 2 and encouraged by grieving and aggrieved families of the deceased, has to be balanced against discouragement of lengthy narrative accounts of the circumstances of a death. Here, the short form misadventure verdict clearly pointed to the view of the jury that the officers were not significantly to blame for Mr Robinson's death.

106. The evidence supported that proposition. It was obvious the officers thought Mr Robinson had swallowed something, did not realise his airway was completely blocked, attributed his unresponsiveness to the effect of drugs, would probably have called for medical help sooner if they had realised his airway was blocked (despite absence of signs of choking), could not be expected to detect and remove the blockage themselves and called the paramedics once they realised this was a medical emergency.

107. Any fresh inquest would be likely to lead to those findings being the subject of the same evidence called again and the findings being repeated. Any narrative verdict would be likely to state those findings or the gist. Thus, a fresh inquest would elicit no new material facts. It would merely give a fresh jury the opportunity to agree or disagree with the last one, on the same facts. That would not be justified. I might well, therefore, have declined to direct a fresh inquest even if I had found the inquest was defective.

Disposal

108. For those reasons, the claim for judicial review is dismissed.