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IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT
[2021] EWHC 3604 (Admin)

No. CO/1177/2021

Royal Courts of Justice

Wednesday, 1 December 2021

Before:

LADY JUSTICE SIMLER
MRS JUSTICE MAY
HIS HONOUR JUDGE TEAGUE QC
(Chief Coroner for England and Wales)

B E T W E E N :

(1) ANGELA MAYS
(2) ANDREW MAYS — Claimants

- and -

HM SENIOR CORONER
FOR KINGSTON UPON HULL
& EAST RIDING OF YORKSHIRE — Defendant

MS B. DOLAN QC appeared on behalf of the Claimants.

MS J. WOLSTENHOLME appeared on behalf of the Defendant.

J U D G M E N T

(Transcript prepared from poor quality audio)

LADY JUSTICE SIMLER:

Introduction

1 On 25 July 2014 Sally Mays died aged 22 years old. I shall refer to her as "Sally" in what follows without, I hope, any disrespect. Sally had well documented and serious mental health difficulties. She made a number of attempts to take her life before 25 July 2014, and in that year alone she made 30 attendances to Accident & Emergency.

2 An investigation into her death commenced on 29 July 2014, and the inquest was opened on 31 July 2014 and closed on 23 October 2015. The inquest was conducted by Professor Paul Marks, the Senior Coroner for Kingston Upon Hull and the East Riding of Yorkshire. He determined that Sally's death engaged procedural and operational duties under Article 2 of the European Convention on Human Rights, and therefore the inquest was required to comply with Article 2. I have no reason to doubt that conclusion. Moreover, as Ms Dolan QC, who appears on behalf of the claimants in this matter, was at pains to make clear, no complaint about the Senior Coroner's conduct of the investigation and inquest is made. He was sympathetic and thorough and no issue whatever is taken with his conclusions.

3 On 25 July 2014 Sally was refused admission to a psychiatric inpatient facility at Miranda House. The medical cause of her death was mechanical asphyxia in combination with an overdose of Codeine and Nitrazepam. The Senior Coroner found that the failure to admit Sally to an acute inpatient psychiatric bed constituted neglect which had a direct causal relationship to her death later that evening.

4 Shortly after the inquest concluded it came to light that information relevant to how Sally came by her death had been withheld from the NHS Trust internal investigation and, more importantly, the Senior Coroner's inquest. That information was also not shared with the claimants.

5 The claimants are Sally's parents, Angela and Andrew Mays. They now apply to this court under section 13 of the Coroners Act 1988 with the *fiat* of Her Majesty's Attorney General for an order quashing the inquest and ordering a fresh investigation and inquest into Sally's death. They rely on the discovery of new facts and evidence since the original inquest and contend these make it both necessary and desirable in the interests of justice that a fresh investigation and inquest is held.

6 The Senior Coroner, represented by Ms Wolstenholme, has filed an acknowledgement of service making clear that he maintains a neutral stance on this application. He notes, however, and Ms Wolstenholme emphasised this point, that the claimants are not seeking a complete rehearing of the evidence, but a limited hearing only to address evidence that has come to light since the original inquest closed.

The Facts.

7 The facts can be summarised as follows. On the morning of 25 July 2014 members of the Community Psychiatric Team who were responsible for Sally's care had great concern about her wellbeing, and were of the view that admission to a psychiatric inpatient facility was urgently required. In particular, her Community Psychiatric Nurse ("CPN"), Ms Laura Elliot, was so concerned that she accompanied Sally to the Avondale Assessment Unit located at Miranda House in Hull, operated by the Hull University Teaching Hospitals NHS Trust ("the NHS Trust"). I note that the CPN is the critical contact that a vulnerable individual like Sally

has in the community. Ms Elliot must have been significantly concerned about Sally's mental state to have sought her urgent admission that day.

8 The nurses in the Crisis Team, who were Paddy McKee and Gemma Pearson, carried out an assessment of Sally. No doctors were involved, as was ordinarily required by the NHS Trust's own policies and procedures. During the course of that assessment, Sally was repeatedly banging her head against a wall and, at one point, attempted to strangle herself using a shoelace. She was restrained in a prone position. Nonetheless, and despite the CPN's obvious concerns, the gatekeeping nurse team, following that assessment, determined that Sally should not be admitted. Sally was in clear distress and was begging to be admitted to the Unit. Staff called the police and Sally was taken home where she was left on her own. Early that evening, after her return home by the Humberside Police, Sally took an overdose of Codeine and Nitrazepam and asphyxiated herself with a plastic bag. She called an ambulance to ask for assistance, but her request, although allocated a response time of 30 minutes, was followed by a 69 minute delay in the ambulance attending her. When the ambulance eventually arrived Sally was, sadly, no longer alive.

9 The Senior Coroner made the following important findings of fact:

(a) The concerns, actions and behaviour of the CPN were entirely appropriate and professional throughout.
(b) The assessment conducted by the gatekeeping nurse team was "lamentable" in its quality and thoroughness and gave no weight to Sally's past medical history, or her care plan. The Crisis Team failed to identify the substantial risk of fatal self-harm.
(c) The availability of a bed for Sally at the Unit was never discussed with her, and the initial gatekeeping assessment was conducted inappropriately.
(d) The usual protocol, whereby patients on whom restraint is used are medically assessed, was not followed. If the protocol had been followed Sally would have been admitted and her death would have been prevented.
(e) Sally had been allowed by Paddy McKee to use the shoelace to asphyxiate herself, and Paddy McKee suggested her shoelace only be removed when she lapsed into unconsciousness, so as to avoid using restraint on Sally.
(f) There was a failure during the assessment to treat Sally with dignity and respect.
(g) The decision not to admit Sally to hospital was both illogical and unconscionable. Neglect on the part of the Crisis Team led to her death.
(h) The refusal of admission was provocative and escalated Sally's distress and contributed to her reactive self-harming behaviour.
(i) Sally's call to the Ambulance Service was inappropriately coded and greater priority should have been assigned to her case.
(j) The call taker failed to take appropriate steps to keep Sally on the line.
(k) The ambulance failed to attend within the required 30 minutes, arriving 99 minutes after the call was placed, resulting in an additional delay of 69 minutes during which time the death could possibly have been avoided.

10 The Senior Coroner was also critical of the manner in which the NHS Trust responded to requests for information, disclosure of documentation and, more broadly, in its dealings with the Mays' family.

11 The narrative conclusion recorded by the Senior Coroner was in the following terms:

> "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:

> Sally Elizabeth MAYS was born on the 22nd January 1992 in Kingston upon Hull and died on the 25th July 2014 at Apartment 4, 1 Derringham Court, 2a Ampleforth Grove, Kingston upon Hull. The medical cause of death was 1a) Mechanical asphyxia in combination with an overdose of Codeine and Nitrazepam. Miss MAYS had long standing psychiatric problems and was diagnosed with Borderline Personality Disorder. In the last few days of her life her self-harming, risk taking and suicidal ideation increased. She was associated with the Crisis Team on two occasions on 25th July 2014 and whilst the first association did not result in inpatient admission, this had no causative effect on her subsequent death. In her second association with the Crisis Team on the afternoon of the 25th July 2014, she was inappropriately assessed, not treated with appropriate respect or dignity, was not reassessed after being restrained as she should have been or after showing increasingly worrying self-harming behaviour. Had admission occurred after her initial assessment or following the further two missed opportunities, she would have survived and not died when she did. The failure to admit her to an inpatient psychiatric bed constitutes neglect and this neglect bears a direct causal relationship to her death later that evening. A further missed opportunity to save her life probably presented itself when she was associated with the Ambulance Service and her call was not categorised appropriately and to compound this, a delay of 69 minutes over and above the intended 30 minutes arrival of the ambulance occurred. A situation in which an overdose had been taken alone was intensified by Miss MAYS placing a plastic bag over her head. Whilst her actions undoubtedly caused her death, her intentions remain unknown."

12 As already indicated, following the conclusion of the inquest on 23 October 2015, it was discovered that certain information had been withheld during the inquest. The information came to light as a result of a note produced by Debbie Barratt, Assistant Director of the NHS Trust, dated 27 October 2015. That note reads as follows:

> "I had a conversation yesterday morning at about 9.15 a.m. with Laura Elliot, staff nurse, who has been working with me for a few weeks during the inquest of SM, in an attempt to keep her in work whilst the process is ongoing. During the conversation Laura was reflecting on the inquest and said that she had learnt the importance of documenting everything as a result. Laura went on to say that she had had a conversation with Dr Fofie in the car park at Miranda House as she was leaving on 25th July 2014, after the assessment with SM and the two members of staff from the Crisis Team. Laura said that she was upset and that Dr Fofie asked her what was wrong. Laura explained what had happened to Dr Fofie, who told her that everything would be all right, that SM would settle down or be picked up by a service.
>
> Laura said that she had not documented this conversation and that she had had a conversation with Dr Harkness about this some months later and they had felt that it would look like they were not being helpful by bringing new information to light at that late stage. I told Laura that this was new information to me."

13 This was the first recorded account of the conversation in the car park between Laura Elliot, the CPN, and Dr Fofie. The note produced by Debbie Barratt was sent to the Senior Coroner, and the Senior Coroner informed the police of it. The only account as yet provided by Dr Fofie in relation to that car park conversation, was provided in an interview about his involvement in Sally's case in July 2015, when he was interviewed by the NHS Trust as part of its internal review of what happened. The document was disclosed to the claimants after the *fiat* was obtained. Significantly, Dr Fofie was asked: "Was patient A discussed with you at all on either 24 or 25 July?" His response was as follows:

> "I did not remember being involved in a discussion in our daily review meeting. I know that on the 25th July 2014 I was not contacted. I have always encouraged staff and my Junior Doctors to phone me so we can talk about anything. We may not always get things right, but at least we have multi-disciplinary discussions."

14 The conversation in the car park between Ms Elliot and Dr Fofie took place, according to the information currently available, shortly after Sally had been refused admission. Ms Elliot was leaving the Unit and met Dr Fofie in the car park. She raised concerns with Dr Fofie about the assessment. According to Ms Barratt's note, Dr Fofie's response was to reassure her that Sally would be fine and she would either "settle down or be picked up by a service."

15 Since the grant of the *fiat*, further material has been produced. However, none of the material presently available enables the full facts about that conversation to be established.

16 There have also been a number of further investigations since the inquest ended, but again none of those has been concerned with establishing the facts relating to what happened in the car park that day. Those investigations included a second internal investigation into the actions of Ms Elliot, conducted by the Associate Medical Director and Head of Corporate Governance of the NHS Trust. The investigation appears to have been disciplinary in nature, and was conducted in private. Perhaps more significantly, only Ms Elliot was interviewed. The investigators did not seek any account from Dr Fofie.

17 The draft report into that investigation has not been finalised, and no outcome has been made public. However, the incomplete report was disclosed to the claimants after the *fiat* was obtained, and it records a sequence of events that includes the following:

> "LE [Laura Elliot] was leaving work and walking over to her car [on 25 July] when she came across KF [Dr Fofie] who she suspects was also leaving work.
>
> LE & KF began conversing (cannot remember the exact words) but revolved around the fact that she looked visibly upset. She discussed her frustrations about what had happened and how she had been treated.
>
> The aim of the conversation was not to pass on clinical responsibility to KF, but to offload her emotions & frustrations. Given her good working relationship with KF, she felt comfortable discussing these issues and believed KF was being supportive of her as she was upset.
>
> LE briefly discussed the case and felt she obtained some reassurance from KF given their prior knowledge of SM that things would be ok. At

> this time she believed this was not exceptional in the context of SM's previous behaviour patterns.
>
> LE cannot remember the exact phrases used, but feels that the text used within the ToR [the judge's reference] was both inaccurate and was taken out of context. She does not recall KF saying 'It's just Sally and she'll be all right', and the sentence: 'probably not advisable to speak about it' was not correct and was taken out of context. She feels it makes it appear as though it was some sort of secret conversation when there was not.
>
> After returning home, LE discussed the case with KH (her supervisor at the time) who agreed with the action plan and her management of the case."

The incomplete report also records the fact that after Ms Elliot found out about the death of Sally on the Sunday, she discussed with KH (on the Monday) whether she should have documented the informal discussion she had with Dr Fofie in the car park. The conclusion reached by KH was that it was not necessary to do so.

18 The incomplete report also records the fact that there was a further discussion between Ms Elliot, Dr Harkness and another member of the outpatient team about whether or not that conversation should have been documented, and both agreed with the *status quo*, in other words that it need not have been, or be, documented. Dr Harkness, however, agreed to speak with Dr Fofie about whether there was a need to document the informal conversation with Ms Elliot; and the document records: "GH fed back to LE that KF said not to worry, and that she had done everything she could at the time." A note that needs be read with the report, records that there was never a direct meeting between Dr Fofie, Dr Harkness and Ms Elliot; and the external investigator, Mr Wrae, who was employed by the NHS Trust to investigate the management of Sally, was critical of the fact that Ms Elliot had not escalated the case to the Consultant at the time, albeit recognising that Ms Elliot took the view that this was a nurse met service, and that the explanation had been appropriate. The report goes on to say:

> "After the external investigation, KF spoke with LE over the telephone and he reassured her that escalation to a consultant was not required and was not current practice at the time. He agreed with LE that the discussion within the car park was informal and there was no need to take any further action."

19 The internal NHS investigation led to the referral of certain members of staff concerned to their professional regulatory bodies. I make clear at this point that it was no part of those investigations to consider what happened in the car park or to establish the nature of the conversation and what flowed from it; neither the NMC nor the GMC did that. It is, however, significant, in my judgment that the GMC case examiner's reasoning for concluding that no action should be taken against Dr Fofie refers to the meeting that Dr Fofie had with Ms Elliot in the car park in the following terms:

> "Dr Opoku-Fofie said he saw the CPN [Laura Elliot] in the car park and walked over to her, with the intention of asking how a different patient was doing. The first part of the discussion was about that patient. The CPN then told him she had been at the building for a gatekeeping

> assessment by the Crisis Team, but the patient had not been admitted and was taken home by the police. The CPN told him she had not been happy with how she and Ms Mays were spoken to by the Crisis Team. Dr Opoku-Fofie said this was a chance encounter, and he did not get the impression the CPN had been specifically waiting to speak to him about the patient. She did not ask him to intervene.
>
> Dr Opoku-Fofie accepted that the CPN spoke to him during the inquest, after she had given evidence. She asked whether, in response to questions about whether she had escalated her concerns, she should tell the Coroner about their conversation in the car park. Dr Opoku-Fofie told the police that, having discussed it, he and the CPN agreed that this had not been a clinical conversation, it did not amount to an escalation of concerns and therefore they agreed she would not mention it to the Coroner.
>
> Dr Opoku-Fofie told the police that in retrospect he wished they had decided to tell the Coroner, however, at the time he did not want to give the impression the conversation was something more than it really was."

20 The examiner's decision also records the fact that Dr Harkness:

> "told the police that the CPN spoke to him during the inquest about the fact that she had been questioned closely at the inquest about why she did not escalate her concerns about the decision not to admit Ms Mays.
>
> . . . However, Dr H told the CPN it may be helpful to her to disclose the discussion with Dr Opoku-Fofie, as this would demonstrate that she had at least mentioned the matter to a consultant and they did not react with great concern. Dr H said the CPN gave the impression, in response, that the conversation had not been of any clinical relevance."

It is clear from these documents that both Consultants, who knew Sally and had previous responsibility for her, took conscious decisions, both before and during the inquest, to withhold information about that car park conversation. The professional regulatory investigations were closed in January 2020 and July 2020 respectively, without any disciplinary action being taken but, more significantly for present purposes, without establishing the facts relating to the conversation in the car park.

21 There was also a criminal investigation into these matters by Humberside Police. Part of that investigation included an investigation into alleged offences of perverting the course of justice. The conclusion reached in relation to that alleged offence was that there was insufficient evidence to prosecute the medical professionals because, although information about the meeting between Dr Fofie and Ms Elliot was not disclosed to the Senior Coroner, giving rise to the allegation that there was a deliberate withholding of the information, the evidence suggested that it was withheld because it was not considered clinically relevant and not because there was an intention on the part of the individuals involved to pervert the course of justice.

22 The claimants challenged that decision by way of a Victims' Right to Review, but the decision remained unchanged. Significantly, it was no part of the criminal investigation to consider

the nature of the conversation on 25 July in the car park, and whether that conversation represented a further missed opportunity to save Sally's life. The result is that no public body – independent or otherwise – has, as yet, investigated or established the facts of what actually happened in the car park that day between Ms Elliot and Dr Fofie, or considered whether, or to what extent, there was an opportunity for Dr Fofie to reverse the poor assessment decision by admitting Sally to the Unit.

The Legal Framework.

23 Section 13 of the Coroners Act 1988 (as amended) provides as follows:

> " 13 **Order to hold Investigation**.
>
> (1) This section applies where, on an application by or under the authority of the Attorney-General, the High Court is satisfied as respects a coroner ("the coroner concerned") either—
>
> (a) that he refuses or neglects to hold an inquest or an investigation which ought to be held; or
>
> (b) where an inquest or an investigation has been held by him, that (whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise) it is necessary or desirable in the interests of justice that an investigation (or as the case may by, another investigation) should be held.
>
> (2) The High Court may—
>
> (a) order an investigation under Part 1 of the Coroners and Justice Act 2009 to be held into the death either—
>
> (i) by the coroner concerned; or
>
> (ii) by a senior coroner, area coroner or assistant coroner in the same coroner area;
>
> (b) order the coroner concerned to pay such costs of and incidental to the application as to the court may appear just; and
>
> (c) where an inquest has been held, quash any inquisition on, or determination or finding made at that inquest."

The power contained in section 13(1)(b) is broad: "new facts or evidence" has been held to encompass evidence that was not available at the time of the original inquest, as well as evidence that was available and was not provided but would have been both relevant and admissible.

24 The principles governing applications made under section 13 are now well established. They were first set out *in Her Majesty's Attorney General v Her Majesty's Coroner for South Yorkshire West* [2012] EWHC 3783 (Admin) by Lord Judge, the Lord Chief Justice, at paragraph 10, where he said the following:

> ". . . The single question is whether the interests of justice make a further inquest either necessary or desirable. The interests of justice, as they arise in the coronial process, are undefined, but, dealing with it broadly, it seems to us elementary that the emergence of fresh evidence which may reasonably lead to the conclusion that the substantial truth about how an individual met his death was not revealed at the first inquest, will normally make it both desirable and necessary in the interests of justice for a fresh inquest to be ordered. The decision is not based on problems with process, unless the process adopted at the original inquest has caused justice to be diverted or for the inquiry to be insufficient. What is more, it is not a pre-condition to an order for a further inquest that this court should anticipate that a different verdict to the one already reached will be returned. If a different verdict is likely, then the interests of justice will make it necessary for a fresh inquest to be ordered, but even when significant fresh evidence may serve to confirm the correctness of the earlier verdict, it may sometimes nevertheless be desirable for the full extent of the evidence which tends to confirm the correctness of the verdict to be publicly revealed. . ."

In *Her Majesty's Senior Coroner for the Eastern Area of Greater London v Whitworth and Kovari* [2017] EWHC 3201 (Admin) at paragraph 23, the Divisional Court held, that where the new facts and evidence made it clear that the evidence heard by a coroner was insufficient to provide a full picture as to the circumstances of the death this can render the investigation insufficient through no fault of the coroner and that both the public interest and the interests of the bereaved families may require that the evidence be heard. It was also emphasised in that case by Holroyde LJ that it was not incumbent on a section 13 claimant to show that the conclusions likely to be reached at a fresh inquest were, in fact, likely to be different.

25 More recently, in *Farrell v Her Majesty's Coroner for North East Hampshire* [2021] EWHC 778 (Admin) Popplewell LJ held that fresh evidence:

> "31… will militate in favour of a fresh inquest, even where no criticism can be made of the coroner . . . Conversely the absence of such a possibility is a powerful, though not conclusive factor against it. Sometimes there will be an additional factor which means that it is in the interests of justice to have a fresh inquest even where there is no realistic prospect of a different conclusion. Paragraph 10 of the judgment of Lord Judge CJ in the Hillsborough case quoted above confirmed that the nature and magnitude of that national disaster was one . . . There may also be cases in which there has been an insufficiency of investigation in which a fresh inquest is desirable to allay the concerns of affected parties, so that justice is not only done but seen to be done, despite the predictability of the same
> outcome . . ."

26 There is also a wider context in this case, that stems from the Senior Coroner's conclusion that one function of this inquest was to satisfy the United Kingdom's investigative obligations (both in terms of having proper procedures for investigating deaths and, more specific, substantive obligations to establish an Article 2 compliant investigation).

27 It is unnecessary to set out in detail the jurisprudence concerning Article 2 and sufficient for present purposes to state that the procedural duty under Article 2 will only be triggered if it is arguable that the State has breached one of the substantive Article 2 obligations, the former being parasitic on the latter. Here, for the reasons given by the Senior Coroner, the procedural Article 2 duty was triggered because the NHS staff arguably owed Sally a direct operational duty: those staff who refused to admit Sally, arguably knew, or ought to have known at the material time, of the existence of the real and immediate risk to her life and failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk. In other words, by failing to assess Sally properly and offer her hospital admission at a time when she was perceived by her community care team to be at real risk of suicide, and was, by reason of her mental state, extremely vulnerable, there is a credible suggestion that the NHS Trust staff in question breached a substantive Article 2 duty to protect Sally's life so that an Article 2 compliant investigation into her death was required.

28 As to the nature of the investigation required, the minimum requirements for such an investigation are set out in *Jordan v United Kingdom* [2001] EHRR 52 paragraphs 106 to 109, subsequently endorsed by the House of Lords in *R(on the Application of Amin) v Secretary of State for the Home Department* [2003] UKHL 51 at 25. For the investigation to satisfy Article 2 it must be initiated by the State or the public body itself. It must be "independent from those implicated in the events". It must be effective in the sense that it is capable of leading to the establishment of the relevant facts and to the identification and punishment of those responsible. It must be prompt and "there must be a sufficient element of public scrutiny of the investigation or its results." The requirements to have an effective investigation were explained by the Strasbourg Court in *Mustafayev v Azerbaijan* (Application no. 47095/09) ECHR 4 May 2017 as follows:

> "72. The investigation must be effective in the sense that it is capable of leading to the establishment of the facts and, where appropriate, the identification and punishment of those responsible . . . This is not an obligation of result, but of means. The authorities must take the reasonable steps available to them to secure the evidence concerning the incident. Any deficiency in the investigation which undermines its ability to establish the cause of death, or identify the person or people responsible, will risk falling foul of this standard . . ."

The application

29 The claimants' case is brought on two grounds. First, the discovery of new facts and evidence since the original inquest makes it necessary and desirable in the interests of justice that a fresh investigation and inquest is held. Secondly, it is contended that the suppression of the facts and evidence meant that the inquest did not meet the requirements for full compliance with Article 2 of the Convention. These grounds were set out fully and clearly, and developed in writing in the claimants' skeleton argument by Ms Dolan. They were also helpfully developed in oral submissions for which this court is most grateful.

30 In short summary Ms Dolan submits that both the quashing of the original inquest and the ordering of a fresh inquest are necessary and desirable in the interests of justice in this case.

First, the full facts relating to the circumstances leading to Sally's death were not known when the inquest was conducted. Fresh evidence regarding the conversation in the car park between Dr Fofie and Ms Elliot demonstrates that there was, at least arguably, a lost opportunity to intervene at its lowest and, at its highest, a possibility that the decision to refuse admission to Sally would have been reversed so that there was another opportunity to save Sally's life that was missed. Information about that conversation was clearly relevant to the inquest and worthy of scrutiny both by the Senior Coroner and the public. Without the necessary public scrutiny of this evidence the narrative conclusion made at the inquest is incomplete. Secondly, and relatedly, the fact that the Senior Coroner did not have these material facts available to him at the time of the inquest means that the investigation of the circumstances surrounding Sally's death was insufficient to meet the State's obligations under Article 2.

31 Ms Dolan submits that if these facts had been disclosed at the time required, there would have been a meaningful opportunity to question witnesses about the conversation and determine what happened, the actions and inactions of those involved and whether, as she has submitted, this was another missed opportunity to provide Sally with the care that she required. She contends that this renders the inquest proceedings incompatible with Article 2, and for that reason also the inquest should be quashed.

Discussion and conclusion

32 I accept the submissions made on behalf of the claimants by Ms Dolan. Applying the guidance given by Lord Judge in the *South Yorkshire (West)* case, I have concluded that fresh evidence is now available which may reasonably lead to the conclusion that the full facts concerning the circumstances leading to Sally's death were not revealed at the inquest and that an order for a fresh inquest under section 13 is now both necessary and desirable. My reasons, in short, follow.

33 First, it is significant, in my judgment, that the Senior Coroner rightly concluded that this was an Article 2 inquest for the reasons already given. Secondly, it is clear that the evidence regarding the conversation between Dr Fofie and Ms Elliot in the car park is relevant and potentially highly material to the inquest issues. The accounts given by Dr Fofie and Ms Elliot have changed over time, and the facts have not yet been investigated or established in any other relevant, independent, public investigation. Nor is it possible to discern precisely what happened and what was then done from disclosed documents, to enable this court to establish those facts.

34 While it may be unlikely that a fresh inquest will substantially alter the Senior Coroner's ultimate conclusions in this case, since he found that Sally's death could have been prevented and identified several failures on the part of the NHS Trust, it does seem to me that a fresh inquest is likely to lead to additional findings of fact being made. That is important. The conversation in the car park potentially represented another opportunity to provide the appropriate care and assistance that Sally required. On the account given by Ms Elliot to Debbie Barratt, she raised concerns about the way Sally's case was dealt with by the gatekeeping nurses. She raised those concerns very soon after the assessment took place, with Dr Fofie, (a Consultant Psychiatrist), who had both knowledge and experience of Sally, and who was in a position to review the admission decision. Had both parties to the conversation been called to give evidence at the inquest about what was said, their decision making, their actions and inactions, it is inconceivable that the Senior Coroner would not have made findings of fact about them and there is, at the very least, the possibility that those findings would have revealed a yet further missed opportunity to save Sally's life. Such a finding, if made, is likely to have been recorded and reflected in the findings of fact made by the Senior Coroner.

35 The role played by a narrative conclusion in affecting organisational policy and contributing to lessons learned is also relevant. It has the potential to assist public bodies in identifying areas of weakness in their systems, structures, policies and management of a case; and in their assessment procedures, oversight and safeguarding of vulnerable patients. This contribution was highlighted by the Supreme Court in *R(Maughan) v Her Majesty's Senior Coroner for Oxfordshire* [2020] UKSC 46. Full findings of fact about the car park conversation might contribute to ensuring that lessons are learned following Sally's tragic death. In my judgment, it is in the interests of justice to order a fresh inquest consistently with those principles and the principles set out in the *South Yorkshire (West)* case.

36 The wishes of Sally's parents are also relevant, as the authorities make clear, in determining whether the ordering of a fresh inquest is desirable. They must, of course, be weighed with other factors including the resources and time required to hold the fresh inquest. But as Popplewell LJ observed in *Farrell* (referred to above) justice must not only be done but must be seen to be done, and family members must be given meaningful opportunities to make sense of the circumstances that led to the death of their loved-one. In this case, it is through no fault of the claimants that neither Ms Elliot nor Dr Fofie gave the evidence about the discussion in the car park. This came to light only after the inquest and that must have been both frustrating and distressing to them. It has, I imagine, prevented them from obtaining the closure they sought regarding their daughter's death at the earliest opportunity and has, no doubt, prolonged their grief. In these circumstances too I consider it to be desirable for a fresh inquest to be ordered.

37 As I said at the outset, there is and can be no criticism whatever of the Senior Coroner in this case, and no suggestion by the claimants that the initial inquest fell short in any way, or fell short of the *Jordan* criteria or Article 2 looked at on its own. Rather, the complaint is that the procedural obligations under Article 2 have not been fully discharged by the inquest since new evidence has come to light which was not then considered. Looking at the *Jordan* criteria, and focusing in particular on the conversation in the car park, nobody has investigated that conversation in an independent public investigation. Nor has there been a process to enable all the relevant facts about that conversation to be established, so that the investigation has not been effective in that sense. As Ms Dolan observed, the only public scrutiny that has, to date, occurred in relation to the car park conversation has been in the course of this hearing. That has been inconclusive, however, given the absence of any opportunity to establish the facts. Nor has there been any involvement of Sally's family into the investigations that have to date occurred.

38 For all those reasons, and accepting Ms Dolan's submission, I am satisfied that the State has not yet discharged its investigative obligations under Article 2, to conduct an independent and public investigation into the circumstances of Sally's death, and for that reason too, it seems to me that the inquest must be quashed and a fresh inquest ordered.

39 Ms Dolan made clear that it is no part of the claimants' case to seek to re-run those matters already heard and determined by the Senior Coroner. Nor is she seeking a new investigation of the withholding of information about the conversation itself. She has suggested, and Ms Wolstenholme agrees, that a proportionate and lawful approach to any fresh inquest would be to admit the transcript of the earlier proceedings as documentary evidence under Rule 23 of The Coroners (Inquests) Rules 2013. If the Senior Coroner considers ultimately that this is an appropriate course to adopt, that would enable the fresh inquest to focus on the fresh evidence at what would be a relatively short hearing. It will, however, be a matter for the Senior Coroner to determine how best to conduct a further inquest in this case. The fresh evidence may bear on the evaluation of evidence previously received, and may affect earlier findings. This court cannot, in any event, tie the Senior Coroner's hands. Accordingly, it will

be a matter for the Senior Coroner to determine how precisely to conduct the further investigation and inquest now ordered.

40 In conclusion, for the reasons I have given, this is a case where the criteria in section 13 are satisfied. It is both necessary and desirable in the interests of justice to quash the inquest and to order a fresh inquest in order for the new evidence concerning the conversation in the car park to be investigated and for the facts in relation to that to be established. Article 2 produces the same result, and if my Lady and my Lord agree, that is the order I would make.

MRS JUSTICE MAY: I agree

HIS HONOUR JUDGE TEAGUE: I also agree.

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CERTIFICATE

Opus 2 International Limited hereby certifies that the above is an accurate and complete record of the Judgment or part thereof.

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This transcript has been approved by the Judge.