Neutral Citation Number: [2023] EWHC 1669 (Admin)

Case No: CO/4887/2022

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

Cardiff Civil and Family Justice Centre
2 Park Street,
Cardiff, CF10 1ET

Date: Wednesday, 12th July 2023

Before :

MR JUSTICE EYRE

- -

Between:

THE KING (on the application of MID AND WEST WALES FIRE & RESCUE SERVICE)	**Claimant**
- and -	
HM ACTING SENIOR CORONER FOR PEMBROKESHIRE AND CARMARTHENSHIRE	**Defendant**
- and –	
MARINE ACCIDENT INVESTIGATION BRANCH	**Interested Party**

- -
- -

David Hercock (instructed by **Dolmans Solicitors**) for the **Claimant**
Keith Morton KC and Paul Reynolds (instructed by the **Government Legal Department**) for the **Interested Party**
The Defendant took no part in the hearing

Hearing dates: 21st and 22nd June 2023

- -

Approved Judgment

This judgment was handed down remotely at 10.30am on [date] by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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Mr Justice Eyre :

Introduction.

1. These proceedings arise out of the tragic death of Joshua Gardener on 17th September 2019. Mr Gardener was a young firefighter with the Claimant, the Mid and West Wales Fire & Rescue Service, who was killed in a collision between two boats operated by the Claimant in the course of a training exercise on the River Cleddau.

2. The accident was investigated by the Marine Accident Investigation Branch ("the MAIB"), the Interested Party in these proceedings. The MAIB produced a report ("the Report") dated 4th November 2020 setting out various conclusions.

3. The Defendant is to hold an inquest into Mr Gardener's death. There was a dispute between the Claimant and the Interested Party as to the approach which should be taken in that inquest to the Report and to the conclusions it contained. The Defendant received submissions from both parties and conducted a number of pre-inquest hearings. On 28th October 2022 the Defendant issued his Updated and Amended Ruling Number 3 ("the Ruling") as to the status of the Report. The effect of the Ruling as clarified in the Defendant's letter of 15th December 2022 is that the findings and conclusions of the Report as to the cause of the accident are to go before the jury as conclusive evidence of the matters they set out and will not be open to attack in the inquest.

4. The inquest into Joshua Gardener's death has not yet been held. It has been delayed in part by the time taken for the submissions to the Defendant and for his decisions and by the current proceedings. The parties are not to be criticised for making submissions to the Defendant nor for applying to the court. I am, however, conscious of the effect of the consequent delay on the family of Joshua Gardener. As his mother pointed out in an email to the court it is now nearly four years since Joshua's tragic death and the inquest into that death has not yet been held with an understandable impact on his family's ability to find closure after their loss.

5. The Claimant seeks judicial review of the Defendant's decision with permission granted by Steyn J on seven grounds. The Defendant has taken no part in the proceedings but the Interested Party resists the challenge to the Defendant's decision.

6. The issues in summary are as follows:

    i) The approach to be taken to putting the Report before the jury in the inquest and whether the approach taken by the Defendant was precluded by the requirement that the coronial proceedings be conducted fairly (ground 7). The Claimant contends that the approach set out in *R (Secretary of State) v HM Senior Coroner for Norfolk & another* [2016] EWHC 2279 (Admin) and in *HM Senior Coroner for West Sussex v Chief Constable of Sussex Police & others* [2022] EWHC 215 (QB) does not prevail over the requirement for coronial proceedings to be conducted fairly. It says that as a consequence and in the circumstances here fairness precludes the Report being treated as conclusive. Instead the Claimant says it should be allowed to ask questions challenging the criticisms of it in the Report and to give evidence in response to that criticism. The Interested Party says that the *Norfolk* approach is not limited in the way suggested by the

Claimant and that the requirement of fairness does not mean that the matters contained in the Report are to be reopened.

ii) Whether the Defendant applied the correct test for determining whether there should be a fresh investigation rather than reliance on the Report. This is ground 1. The Claimant says that in purporting to apply the test laid down in *Norfolk* the Defendant in fact applied the wrong standard. Instead of considering whether there was credible evidence that the investigation leading to the Report was incomplete, flawed, or deficient the Defendant is said to have considered whether the investigation was in fact incomplete, flawed, or deficient and thereby imposed too high a test. The Interested Party says that when the Ruling is properly considered the Defendant applied the correct test.

iii) Ground 2 alleges an error of law on the part of the Defendant. It is said that he misunderstood the law as to the applicable regulatory standards and as a consequence erred in failing to find that the Interested Party's investigation and the Report were flawed as a matter of law. The Interested Party contends that the Defendant correctly stated the law and that this challenge in any event involves a misreading of the Report.

iv) Grounds 3 – 6 form a group of similar heads of challenge. The Claimant says that in a number of respects the Defendant misunderstood the submissions being made on its behalf and/or failed adequately to engage with them in the Ruling with the consequence that there was no proper determination of its challenge and/or that the Ruling was irrational through being based on an incorrect analysis and/or that because of such a failure to engage with or understand the submissions the Defendant erred in law. The Interested Party says that when read properly and fairly the Ruling does adequately address the submissions advanced to the Defendant.

7. If the Claimant succeeds on ground 7 it seeks declarations or directions permitting it to challenge the conclusions of the Report at the inquest. Success on grounds 1 - 6 would lead to the matter being remitted to the Defendant for reconsideration on the correct basis.

The Factual Background.

8. Joshua Gardener was stationed at Milford Haven. Two fire service boats were based there. One was a Zodiac Milpro inflatable boat, callsign N207, and the other was a Delta Rigid Inflatable Boat (RIB), callsign Rescue 1.

9. Mr Gardener was one of ten firefighters who had been due to undertake a training exercise relating to the de-contamination of hazardous materials spillages on 17th September 2019. That exercise was cancelled and on 16th September 2019 the firefighters concerned discussed what alternative training should be undertaken. They decided to take the boats out for boat handling practice and flood rescue training. As a consequence the boats were taken out on 17th September 2019. Three firefighters including Mr Gardener were on the Zodiac N207 and two on the RIB Rescue 1. The boats engaged in manoeuvres in Milford Haven Waterway and the River Cleddau. In the course of those manoeuvres the boats collided and Mr Gardener was struck and killed.

10. The MAIB undertook an investigation. This resulted in the Report which was compiled by Capt. Jae Jones.

The Statutory Framework.

11. The Defendant's powers and duties are derived from the Coroners and Justice Act 2009 ("the 2009 Act").

12. Section 1 imposes on a senior coroner the duty to investigate certain deaths including the deaths of those such as Joshua Gardener who there is reason to suspect died an unnatural death.

13. The purpose of a coroner's investigation is defined by section 5(1) thus:

> "The purpose of an investigation under this Part into a person's death is to ascertain –
>
> (a) who the deceased was;
> (b) how, when and where the deceased came by his or her death;
> (c) the particulars (if any) required by the 1953 Act to be registered concerning the death".

14. Section 5(3) imposes a limit on the expression of an opinion by the coroner or jury in these terms:

> "Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than –
>
> (a) the questions mentioned in subsection (1)(a) and (b) (read with subsection (2) where applicable);
> (b) the particulars mentioned in subsection (1)(c).
>
> This is subject to paragraph 7 of Schedule 5".

15. By virtue of section 7(2)(c) the inquest into Mr Gardener's death must be held with a jury because he died in a notifiable accident.

16. Section 10 provides thus for the determinations and findings to be made:

> "(1) After considering the evidence given to an inquest into a death, the senior coroner (if there is no jury) or the jury (if there is one) must –
>
> (a) make a determination as to the questions mentioned in section 5(1)(a) and (b) (read with section 5(2) where applicable), and
> (b) if particulars are required by the 1953 Act to be registered concerning the death, make a finding as to those particulars.
>
> (2) A determination under subsection (1)(a) may not be framed in such a way as to appear to determine any question of –
>
> (a) criminal liability on the part of a named person, or
>
> (b) civil liability.
>
> (3) In subsection (2) "criminal liability" includes liability in respect of a service offence".

17. Schedule 5 paragraph 7 (1) provides that:

> "Where –

(a) a senior coroner has been conducting an investigation under this Part into a person's death,
(b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and
(c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,

the coroner must report the matter to a person who the coroner believes may have power to take such action.

18. An interested person's entitlement to examine witnesses at an inquest and the limits on that entitlement are set out in these terms at regulation 19 of the Coroners (Inquests) Rules 2013:

"(1) A coroner must allow any interested person who so requests, to examine any witness either in person or by the interested person's representative.

(2) A coroner must disallow any question put to the witness which the coroner considered irrelevant".

19. The MAIB is one of three Accident Investigation Branches, the others being the Air Accident Investigations Branch ("the AAIB") and the Rail Accident Investigation Branch ("the RAIB"). Each is the result of appointments under separate legislation and subject to different regulations but the relevant provisions mirror each other.

20. Section 267 of the Merchant Shipping Act 1995 provides for the appointment of inspectors of marine accidents and the conduct of investigations by such inspectors is governed by the Merchant Shipping (Accident Reporting and Investigation) Regulations 2012 ("the 2012 Regulations").

21. Regulation 5 of the 2012 Regulations defines the sole objective of a safety investigation thus:

"(1) The sole objective of a safety investigation into an accident under these Regulations shall be the prevention of future accidents through the ascertainment of its causes and circumstances.

(2) It shall not be the purpose of such an investigation to determine liability nor, except so far as is necessary to achieve its objective, to apportion blame".

22. The conduct of investigations is addressed in regulation 11 where sub-regulations (1) and (3) say:

"(1) If the Chief Inspector decides in accordance with regulation 8(2) and (4) and (5) that a safety investigation must be carried out, it must be undertaken by one or more inspectors at such times and places and in such manner as to appear to them most conductive to achieving the objective set out in regulation 5.

…

(3) A safety investigation may extend to cover, but need not be limited to –

(a) all events and circumstances preceding the accident together with subsequent events and circumstances;

(b) issues involving salvage and pollution connected with the accident;

(c) the conduct of search and rescue operations

… "

23. By regulation 13 the disclosure of records is prohibited subject to exceptions as follows:

"(1) Subject to the following paragraphs, the names, addresses or other details of anyone who has given evidence to an inspector must not be disclosed…

(2) Subject to paragraphs (4) and (7) the following documents or records whether held electronically, mechanically or otherwise must not be made available for purposes other than a safety investigation, unless a Court orders otherwise –

(a) subject to paragraph (3), all declarations or statements taken from persons by an inspector or supplied to an inspector in the course of an investigation, together with any notes or recordings of witness interviews;

(b) medical or confidential information regarding persons involved in an accident;

(c) any report made under regulation 6(4);

(d) copies of the report other than the final report except as mentioned in regulation 14(4)(a) or (5);

(e) all correspondence received by the Chief Inspector from parties involved in a safety investigation;

(f) evidence from voyage data recorders;

(g) the notes by an inspector or person appointed under regulation 11(2), whether written or held electronically along with any recordings or photographs;

(h) all communications between persons having been involved in the operation of the ship of ships; and

(i) Inspector's opinions expressed in the analysis of information…

(5) Subject to paragraph (6), no order must be made under paragraph (2) unless the Court is satisfied, having regard to the views of the Chief Inspector, that the interests of justice in disclosure outweigh any prejudice, or likely prejudice, to –

(a) the safety investigation into the accident to which the document or record relates;

(b) any future accident safety investigation undertaken in the United Kingdom; or

(c) relations between the United Kingdom and any other State, or international organisation"…

24. Regulation 14 provides thus in respect of the reports of investigations:

"(1) Subject to paragraph (4), the Chief Inspector must submit to the Secretary of State a report of any safety investigation conducted in accordance with regulation 11

…

(3) A report in relation to an accident must contain, but need not be limited to, the information set out in Schedule 2 which is relevant to the safety investigation…

(4) A report must not be made publicly available until the Chief Inspector has –

(a) served a notice under this regulation upon any person who, or organisation which, could be adversely affected by the report or, if that person is deceased, upon such persons or persons as appear to the Chief Inspector, at the time it is proposed to serve notice in accordance with this paragraph, as best to represent the interests and reputation of the deceased in the matter;

(b) considered the representations relating to the facts or analysis contained in the report which may be made to the Chief Inspector in accordance with –

(i) paragraph (6) by or on behalf of the persons served with such notice, or

(ii) paragraph (7), …

and the report must be amended in such manner as the Chief Inspector thinks fit.

(5) The notice referred to in paragraph (4)(1) shall be accompanied by a draft copy of the report…

(6) The representations referred to in paragraph (4)(b) must be in writing and must be served on the Chief Inspector within 30 days of service of the notice referred to in paragraph (4)(b) or within such further period as may be allowed under regulation 17.

…."

25. Schedule 5 sets out the information to be included in the reports of MAIB investigations. The information is to be set out under the headings of Summary, Factual Information, Narrative Details, Analysis, Conclusions, Safety Recommendations, and Appendices.

The Report.

26. The Report began with a recital of the sole objective of the investigation as set out in regulation 5 of the 2012 Regulations. It then recorded Factual Information before turning to Analysis. At section 2.1 under the sub-heading "Aim" the purpose of the Analysis was stated to be:

> "to determine the contributory causes and circumstances of the accident as a basis for making recommendations to prevent similar accidents occurring in the future".

27. Section 3 of the Report set out the MAIB's conclusions. These were divided into two parts. The first, section 3.1, contained the conclusions relating to "safety issues directly contributing to the accident that have been addressed or resulted in recommendations". Then section 3.2 contained the conclusions on "safety issues not directly contributing to the accident that have been addressed or resulted in recommendations." The five safety issues considered in section 3.2 fell outside the scope of the coronial process and were not addressed by the Defendant.

28. The twelve conclusions in section 3.1 were as follows (with each conclusion being followed by the number of the section of the Analysis from which the Report said it was derived but with underlining added as explained below):

> "1. The firefighter on board N207 was fatally injured after being struck on the head by Rescue 1 when the two boats collided. [2.2]

2. N207 and Rescue 1 collided because they were operating at speed in close proximity when N207 turned into the path of Rescue 1. [2.2]

3. It is unclear why Rescue 1's helmsman decided to undertake a circular turn to port in the vicinity of N207, but given the speed the RIB was travelling it would have been prudent to have planned a greater passing distance from the slower boat, whose exact intentions were unknown. [2.3.1]

4. The crew of N207 were focused on their boat handling training, and the helmsman was unaware of Rescue 1's position when he turned sharply into its path. Due to the closing speed of the two vessels, his subsequent actions to avoid collision were not effective. [2.3.2]

5. Neither crew was keeping an effective lookout, and so lacked awareness of the two boats' relative positions and movements. [2.4]

6. Mid and West Wales Fire and Rescue Service's pre-activity planning requirements were not met and its SOPs were not followed, with the consequence that: no individual had responsibility for the overall activity; no-one was nominated to be in charge of Rescue 1, which had no clear task; Rescue 1 had insufficient crew, neither of whom held the qualifications required to be the RIB's helmsman; and, no steps were taken to prevent both boats operating in the same stretch of water in an uncoordinated manner. [2.5, 2.6.3]

7. It was difficult for Milford Haven fire station, which operated two boats, to comply with Mid and West Wales Fire and Rescue Service crewing requirements, which reduced the amount of on-water training and familiarisation conducted in the 12 months prior to the accident. [2.6.1]

8. At the time of the accident it is possible that Milford Haven's firefighters were suffering from a gradual erosion of the levels of practical boat handling competence, and a general reduction in their levels of safety awareness for operating their boats; in particular, Rescue 1. [2.6.2]

9. Although the firefighters crewing the boats were not wearing the head protection required by AET 5.17, it is unlikely that head protection would have been sufficient to save the firefighter's life when he was struck by Rescue 1. [2.7.1]

10. Mid and West Wales Fire and Rescue Service's procedures for boat operations had not been updated for some time, contained misleading information, and made insufficient reference to Rescue 1 as a pre-determined operational asset. [2.7.2]

11. While the standards for emergency operation will dictate stringent requirements, the ability to train and conduct familiarisation under the same procedures was difficult, and at local level this led to the divergence from Mid and West Wales Fire and Rescue Service's SOPs. [2.7.2]

12. The investigation has found that some port authorities made assumptions that FRS craft operating in their areas complied with an approved standard. However, it was apparent that Mid and West Wales Fire and Rescue Service had overlooked the requirement to operate all of its boats to an approved standard, or that within a local authority or harbour area locally required standards could apply. [2.8]"

29. The Claimant says that the Conclusions can be divided into two separate categories: type 1 and type 2 conclusions. I have underlined those which the Claimant characterised as type 2 conclusions. The Claimant said that the type 1 conclusions concerned the immediate causes and circumstances of the accident. The type 2 conclusions were those which were "further removed from the immediate circumstances of the accident and concerned matters relating to [the Claimant's] systems and procedures". The Claimant did not suggest that the distinction between the different types of conclusion had any

legal significance. Rather it was a factual distinction and the "type 1" and "type 2" designation was put forward as "a convenient shorthand way" of distinguishing between the conclusions and identifying those with which the Claimant took issue.

30. Section 4 of the Report listed the action which had already been taken by the Claimant while Section 5 made three recommendations for action by the Claimant and one recommendation for action by the National Fire Chiefs' Council. A rider to the recommendations stated that "safety recommendations shall in no case create a presumption of blame or liability".

The Issues before the Defendant and the Structure of the Ruling.

31. The Claimant took no issue with the type 1 conclusions and was content for those to be put before the jury as conclusive factual determinations. It did, however, take issue with the type 2 conclusions. It was these conclusions that the Claimant wished to challenge by cross-examination and the admission of evidence at the inquest. The Claimant said that in respect of these conclusions there was credible evidence that the investigation was incomplete, flawed, or deficient.

32. The Claimant had made a series of written submissions culminating in its fifth note to which was attached a schedule ("the Schedule") summarising the points made in that note and in the earlier submissions; referring the Defendant to the documents in which the relevant submissions were to be found; and setting out by reference to the conclusions in the Report the parties' competing cases. The body of the note made a number of overarching points. In summary, the Claimant said that the MAIB had erred in regarding the Workboat Code as applicable and in using that code as the basis for the requirements which should have been met in respect of matters such as crew numbers and the qualifications of the helmsman. A number of related points as to the applicable regulatory regime were made. Next, it was said that the MAIB's conclusions had not been presented in the correct context. There was said to have been a failure to explain that the divergence from the Claimant's procedures was the result of a decision or decisions taken at the level of the Milford Haven station with the result that the Report did not provide a full and balanced picture. In addition the Claimant said that the MAIB had failed to undertake adequate enquiries. In particular there had not been proper enquiries to triangulate or provide corroboration for the conclusion that boat familiarisation and training were difficult for those stationed at Milford Haven. The Claimant said that the MAIB's conclusion that document AET 5.17 contained misleading information lacked a proper evidential basis. It then referred the Defendant to the Schedule for the detail of its submissions. The Claimant said that the material it advanced amounted to credible evidence that the MAIB investigation was incomplete, flawed, or deficient. It then submitted that the effect of the Defendant's acceptance of that contention should be that only the type 1 conclusions should be seen as conclusive of the matters contained therein. As to the type 2 conclusions the Claimant said that it was open to the Defendant to allow them to be adduced as part of the evidence to be put before the jury. That would, however, be subject to the Claimant being able to question that evidence and for competing evidence to be called with the jury then considering all the evidence and making its findings of fact in the light of the evidence as a whole. Alternatively it was said to be open to the Defendant to decide that the scope of the inquest should not extend to the subject matter of the type 2 conclusions.

33. The Ruling began with a summary of the procedural background. At [6] the Defendant explained the purpose of the Ruling as being to:

> "determine the point of legal principle as to whether the MAIB report can be said to be "incomplete, flawed or deficient" per Norfolk (para 55-57) such as to require the circumstances of the incident to be the subject of a full investigation at the inquest, rather than for the MAIB report to stand as the basis for the factual findings as to the cause(s) of the incident."

34. Under the heading "The Norfolk Decision" the Defendant quoted the passages from *Norfolk* at [49] and [55] – [57] which I have set out below. Then the Defendant listed six legal principles which he said were to be distilled from *Norfolk* followed by a reference to the revised Memorandum of Understanding. At [13] the Defendant said:

> "Having regard to the legal principles set out above, it can be seen that the Coroner is entitled to rely on the findings and conclusions of the MAIB report as evidence of the cause of the accident and is not required to investigate the issue de novo, unless there is credible evidence that the investigation is `incomplete, flawed, or deficient'".

35. The Defendant next addressed the submissions made by the Claimant. He did so by reference to the conclusions in the Report and adopting a conclusion by conclusion approach. In respect of each of the type 2 conclusions the Defendant set out the conclusion; his understanding of the Claimant's contention; the response of the MAIB (albeit this was not done in respect of all the conclusions); and his determination in respect of the submission. The Defendant rejected the Claimant's contentions save that in respect of conclusion 3.1(8) he accepted that the reference there to possibility meant that the evidence could not even when taken at its highest establish on the balance of probabilities that the erosion referred to contributed to Mr Gardener's death. He proposed to address that by way of directions to the jury or the exclusion of parts of the Report.

36. The Defendant completed his analysis of the submissions by saying, at [15]:

> "For the reasons given above I am not satisfied that MWWFRS have established that the MAIB report is incomplete, flawed and/or deficient in accordance with Norfolk."

37. The Defendant then gave directions as to the evidence which would be put before the jury. These were supplemented by the Defendant's letter of 15th December 2022. In that the Defendant said that he had not made a final ruling on whether Capt. Jones should be called to give evidence and he said further submissions on that would be invited in due course. However, he did make it clear that cross-examination of Capt. Jones with a view to attacking the findings in the Report would not be permitted by reason of being contrary to the Ruling.

The Approach to be taken to the MAIB Investigation and to the Report.

38. The starting point is the decision of the Divisional Court in *Norfolk*. In that case the coroner was conducting an inquest into four deaths which had been caused by a helicopter accident. The accident had already been investigated by the AAIB and the court was considering the judicial review of the coroner's decision to order that body to disclose to her the cockpit voice and flight data recorder. It was rightly common ground before me that the same approach is to be taken to a report resulting from an investigation by any of the three Accident Investigation Branches. Although expressed

in different language the regulations with which the courts were concerned in *Norfolk* and *West Sussex* were to the same effect as the 2012 Regulations.

39. Singh J concluded that such an order was prohibited by regulation 18 of the Civil Aviation (Investigation of Air Accidents and Incidents) Regulations 1996 unless the effect of Schedule 5 of the 2009 Act was to authorise the coroner to make such an order. The judge found that the Act did not give the coroner such a power and he set out at [45] –[49] the considerations which led him to that conclusion.

40. At [49] Singh J said:

> "Finally, in my view, it is important to emphasise that there is no public interest in having unnecessary duplication of investigations or inquiries. The AAIB fulfils an important function in that it is an independent body investigating matters which are within its expertise. I can see no good reason why Parliament should have intended to enact a legislative scheme which would have the effect of requiring or permitting the Coroner to go over the same ground again when she is not an expert in the field. The Coroner's functions are of obvious public importance in this country and have a long pedigree. In recent times they have to some extent been extended, as Ms Hewitt has reminded this Court, in order to ensure compliance with the procedural obligations which may have been imposed on the state by Article 2 of the Convention rights. However, none of that, in my view, points to, still less requires, an interpretation of Sch. 5 to the 2009 Act which would have the effect for which Ms Hewitt contends..."

41. Lord Thomas CJ agreed with Singh J and said at [55] – [57]:

> "55. I consider it important to underline the significance of paragraph 49 of the judgment of Singh J in the light of the submission made to us on behalf of the coroner that she had a duty to conduct a full inquiry into the accident as a death had occurred during the accident. The submission reflected the tendency in recent years for different independent bodies, which have overlapping jurisdictions to investigate accidents or other matters, to investigate, either successively or at the same time, the same matter. On occasions each body considers that it should itself investigate the entirety of the matter rather than rely on the conclusion of the body with the greatest expertise in a particular area within the matter being investigated. The result can be that very significant sums of money and other precious resources are expended unnecessarily.
>
> 56. The circumstances of the present case provide an illustration of what in many cases will be the better approach. There can be little doubt but that the AAIB, as an independent state entity, has the greatest expertise in determining the cause of an aircraft crash. In the absence of credible evidence that the investigation into an accident is incomplete, flawed or deficient, a Coroner conducting an inquest into a death which occurred in an aircraft accident, should not consider it necessary to investigate again the matters covered or to be covered by the independent investigation of the AAIB. The Inquest can either be adjourned pending the publication of the AAIB (as the Memorandum of Understanding between the Coroners Society and the AAIB and others dated May 2013 (MoU) suggests) or proceed on the assumption that the reasons for the crash will be determined by that report and the issue treated as outside the scope of the Inquest.
>
> 57. It should not, in such circumstances, be necessary for a coroner to investigate the matter *de novo*. The coroner would comply sufficiently with the duties of the coroner by treating the findings and conclusions of the report of the independent body as the evidence as to

> the cause of the accident. There may be occasions where the AAIB inspector will be asked to give some short supplementary evidence: see, for example. *Roger v Hoyle* [2015] QB 265 at paragraph 94. However, where there is no credible evidence that the investigation is incomplete, flawed or deficient, the findings and conclusions should not be reopened. It is clear that the terms of the Coroners (Inquests) Rules 2013 require some further elucidation to set out clearer provisions to deal with these issues; no doubt the Chief Coroner can in conjunction with the Coroner's Society and other interested partis consider what is necessary. It would also be desirable for the Chief Coroner to reconsider the terms of the MoU with the AAIB in the light of the judgments in this case and for the future be responsible for the guidance and arrangements contained within the MoU".

42. The proceedings in *West Sussex* also arose out of an air accident. The Divisional Court was considering the coroner's application for an order for the production of certain material. There the AAIB had already produced a report in respect of the accident and the coroner was seeking the material in issue so as to assess whether there was credible evidence that the AAIB's investigation had been incomplete, flawed, or deficient (see at [98] and [100]).

43. At [45] and following the President set out the applicable coronial law beginning with the proposition that:

> "When conducting an investigation into a death, the Coroner has a duty to conduct a full, fair and fearless investigation: see the well- known observations of Sir Thomas Bingham MR in *R v HM Coroner for North Humberside and Scunthorpe ex parte Jamieson* [1995] 1 QB 1 at 26."

44. At [48] it was noted that it was common ground that the coroner was to follow the approach set out in *Norfolk.*

45. In deciding whether to grant the order sought the court had to balance the harm which would be caused by the disclosure against the benefit which would result from it. The court concluded that there was no public interest in disclosure which would outweigh the harm which would result if disclosure were to be ordered.

46. At [123] Dame Victoria Sharp P, delivering the judgment of the court, noted the great importance of coroners' inquests but also pointed out that a coroner's investigation fulfilled "a similar and overlapping role to the AAIB" namely "to consider the cause of an accident" in order to answer the questions directed by section 5 of the 2009 Act.

47. At [124] reference was made to the evidential value which an AAIB report had as a consequence of the status and expertise of that body. Although the passage quoted is said to have been from the judgment of Lord Thomas CJ in *Norfolk* it appears in fact to have been a quotation from the judgment of Christopher Clarke LJ in *Rogers v Hoyle* [2014] EWCA Civ 257, [2015] QB 265.

48. At [125] – [127] the court explained that there was no public interest in the reinvestigation by a coroner of matters which had already been investigated by an Accident Investigation Branch. Attention was drawn to the requirement identified by Lord Thomas CJ that there be credible evidence that the investigation was incomplete, flawed, or deficient which was described as "an important control mechanism" and as being "intended to cover the rare case where there might be an obvious deficiency in an AAIB's investigation."

49. At [128] the court rejected the coroner's submission that she was entitled to obtain material with a view to determining whether there was credible evidence that the AAIB report was incomplete, flawed, or deficient. It said this would seriously undermine the purpose of the test which was "avoiding duplication of investigation by a non-expert body".

50. Then, at [130,] the court said that a coroner should be "very slow to find credible evidence that an expert investigation was incomplete, flawed, or deficient". It also noted at, [133(2)], that the fact that there were experts who took a different view on a particular point from that of the AAIB did not mean that there was arguably credible evidence that the AAIB's investigation had been incomplete, flawed, or deficient.

51. At [135] the court concluded that there was no credible evidence that the AAIB investigation was incomplete, flawed, or deficient and repeated, at [137], the principle that there should not be duplicative investigations.

52. For the Claimant Mr Hercock said that the circumstances of *Norfolk* and *West Sussex* were very different from those of the current case and that the views expressed by Lord Thomas in the former case were *obiter*.

53. I do not agree. It is right that in both those cases the court was concerned with the question of the material which should be available to a coroner but in each case it was doing so in the context of addressing the interrelation between the investigation to be undertaken in an inquest and that already undertaken by an Accident Investigation Branch. It follows that in each case the court was concerned with the same question as the coroner here.

54. I turn to the status of the approach set out by Lord Thomas.

55. The assessment of the public interest and the conclusion as a matter of principle that there was no public interest in the duplication of investigations was a step in the reasoning which led Singh J to conclude that the 2009 Act did not change the existing position. That assessment of the public interest was clearly part of the *ratio decidendi* of his judgment with which Lord Thomas agreed.

56. In his judgment Lord Thomas explained the consequences of that conclusion as to the public interest for the approach which should be taken by a coroner where there had already been an Accident Investigation Branch investigation. That was not part of the reason for the conclusion that the coroner had no power under the 2009 Act to make the order with which the court was concerned. In addition Lord Thomas made it clear that he was not laying down an inflexible rule (see the reference at [56] to "what in many cases will be the better approach"). It was nonetheless a reasoned analysis by high authority as to the consequences which the court's assessment of the public interest had for the approach to be taken by coroners.

57. In *West Sussex* the court was considering whether there was a benefit to set against the harm which the proposed disclosure would cause. The conclusion that there was no such benefit was dependent on the application of the test laid down by Lord Thomas in *Norfolk*. That is because the court said that there would be no benefit in the coroner obtaining material in order to consider whether the AAIB investigation was incomplete, flawed, or deficient. That in turn was because, in light of the applicability of the test

laid down in *Norfolk,* it was not legitimate for the coroner to engage in that exercise (namely seeking material not currently before her and then using such material to consider the adequacy of the investigation). It follows that the court's conclusion was predicated on the proposition that the *Norfolk* approach was the correct one for the coroner to follow.

58. It is to be noted that in *West Sussex* it was common ground that the approach to be followed by the coroner was that laid down in *Norfolk*. It follows that the court did not hear argument to the contrary. Nonetheless the court expressed agreement with that approach in the clearest of terms: see at [126] – [128] and [131]. In those circumstances the correctness of the *Norfolk* approach was not only re-iterated but was adopted as the reason for the conclusion reached by the court. It cannot be said that the application of the *Norfolk* approach was in some way *obiter* in *West Sussex*: rather it was the basis of the decision.

59. Does the requirement that the coroner proceed fairly make a difference and mean that in the current circumstances the *Norfolk* approach should not be followed?

60. In his skeleton submissions Mr Hercock said that the observations in *Norfolk* "cannot reasonably be read as having been intended to displace the duty on [the Defendant] to adopt a fair procedure/comply with the rules of natural justice". In support of his argument Mr Hercock referred me to the decision of the Privy Council in *Mahon v Air New Zealand Ltd* [1984] 1 AC 808 at 820F – 821C invoking the decision of the Court of Appeal in *R v Deputy Industrial Injuries Commissioner ex p Moore* [1965] 1 QB 456 per Willmer LJ at 476A – G. In particular Mr Hercock said that the second rule of natural justice as identified there by the Privy Council was applicable namely that where a finding was to be made which might adversely affect a person's interests then the decision maker had to listen fairly to any relevant evidence conflicting with such a finding and to "any rational argument against that finding" which the person potentially affected may wish to raise. Mr Hercock said this principle applied in an inquest even when the report of an Accident Investigation Branch was not incomplete, flawed, or deficient provided that a rational basis was advanced for challenging a particular conclusion in such a report.

61. It is not open to me as a matter of authority to adopt that approach. On two occasions a divisional court has articulated the *Norfolk* approach as that which is to be followed. In *West Sussex* the President did so after having set out at the forefront of her analysis of coronial law the coroner's duty to conduct a "full, fair and fearless investigation". It cannot credibly be suggested that the members of the court in *Norfolk* in some way overlooked the need for coronial proceedings to be conducted fairly. The need for fairness and the requirements of natural justice cannot be said to create an exception to the approach laid down in those cases. The same conclusion is reached as a matter of principle when the nature and purpose of coronial proceedings; the requirement that they be conducted fairly; and the regulations governing investigations by the MAIB are considered together as follows.

62. Regard must be had at all times to the nature of coronial proceedings. When delivering the judgment of the court in *R v N Humberside Coroner ex p Jamieson* [1995] QB 1 Sir Thomas Bingham MR surveyed the authorities relating to such proceedings. He noted, at 17F, the observations of Lord Lane CJ in *R v South London Coroner ex parte Thompson* (1982) 126 SJ 625 distinguishing between an inquest and criminal

proceedings and making the point that the purpose of an inquest is solely the establishment of facts. At 23G - 26D the Master of the Rolls stated a number of conclusions which flowed from his analysis of the authorities. Of note for current purposes are those at (3) – (5) and (14) where attention was again focused on the particular purpose of inquests and the consequent differences between the procedure applicable to inquests and that which is required in contested proceedings determining criminal or civil liability. What fairness requires when a person is at risk of a finding of liability may not be required when there is no such risk and where the proceedings have the different purpose of identifying the cause of a death. The same point was made in *R (Hambleton & others) v Coroner for the Birmingham Inquests (1974)* [2018] EWCA Civ 2018, [2019] 1 WLR 3417 at [46].

63. As noted above the MAIB's investigation was governed by the 2012 Regulations. These provided at regulation 14(4) – (6) for a person who could be adversely affected by the MAIB's report to be given an opportunity to make representations as to the facts or analysis in the report and for such representations to be considered by the Chief Inspector before publication of the report. The Claimant does not say that it was not given such an opportunity here although it does say that the MAIB's conclusions as expressed in the Report remained flawed. The relevant point is that a party at risk of being adversely affected by such a report will have had an opportunity to make representations and for those to be considered by an independent and expert body. The MAIB's status as such a body is of particular significance in this regard. Fairness requires that the Claimant should have an opportunity to advance the arguments it wishes to advance in relation to the conclusions reached by the MAIB but does not require that it has an opportunity to do so afresh in a different forum (here the inquest) when those arguments have already been advanced to and considered by the MAIB or at the lowest when the Claimant had already had an opportunity of advancing them.

64. Moreover, such representations will have been advanced and considered in the context of an investigation as to which there is no credible evidence that it is incomplete, flawed, or deficient. As will be seen below where the investigation can credibly be said to have been incomplete, flawed, or deficient the position is different. The issue at this stage of the consideration is whether fairness requires that a party has a further opportunity to address matters which have already been addressed in an investigation which cannot credibly be said to have been incomplete, flawed, or deficient. At the lowest it is not self-evident that fairness requires such duplication as a matter of principle.

65. The circumstances arising out of a death, here the tragic death of Joshua Gardener, are to be considered as a whole. The duplication of investigations and of proceedings has been authoritatively found to be contrary to the public interest. That is because where there has already been an investigation by an Accident Investigation Branch such duplication will involve a further investigation by a less expert body. Not only does such a course run the risk of an unsound conclusion being reached but it is also likely to cause unnecessary expense and delay. That is itself harmful to others and contrary to the public interest. I have already noted the impact on the family of Joshua Gardener of the delay in concluding the inquest into his death. The effect on persons in such a position is relevant when considering what is required by fairness towards the Claimant.

66. It is, accordingly, wrong to characterise the *Norfolk* approach as being incompatible with the requirements of fairness or in some way displacing those requirements. As I

have already said both there and in *West Sussex* the court was well-aware of the need for coronial proceedings to be fair. Rather those courts were confirming that fairness did not require reinvestigation before the coroner in circumstances where there had already been an investigation by an independent expert body and where there was no credible evidence that the investigation in question was incomplete, flawed, or deficient.

67. Mr Hercock limited his contention that fairness required that a person potentially adversely affected by an Accident Investigation Branch report be able to challenge such a report at an inquest to those cases where there was a rational basis for the challenge. He derived that potential limitation from the reference to "any rational argument" in *Mahon v Air New Zealand* at 820H but this does not advance matters. As a matter of case management cross-examination on the basis of contentions for which there was no rational basis would be excluded anyway. In addition if the test for permitting such a challenge was its rationality it would then be necessary for the coroner to determine whether there was a rational basis for the challenge. This would involve the coroner engaging in consideration of matters in respect of which the relevant Accident Investigation Branch is to be regarded as having the greater expertise. Moreover, the proposed approach is wholly inconsistent with that set out in *Norfolk* and *West Sussex* because it would involve a focus on particular conclusions rather than on the investigation as a whole. As I will consider further below the authorities are clearly concerned with the duplication of an investigation and with the public interest in avoiding that.

68. The effect of the public interest in avoiding duplication of an investigation is that an investigation by an Accident Investigation Branch should not be duplicated unless there is credible evidence that the earlier investigation was incomplete, flawed, or deficient. Where there is such credible evidence then the public interest against duplication falls away. This is because the public interest is in avoiding the duplication of properly conducted investigations. Alternatively the public interest in avoiding the duplication of investigations is in those circumstances outweighed by the coroner's duty to investigate and by the underlying public interest in the proper investigation of the circumstances of a death. It then becomes necessary for the coroner to investigate *de novo* and to proceed as he or she would have done if there had been no investigation by the Accident Investigation Branch in question. That is because the alternative would be to proceed on the basis of an investigation which can credibly be said to have been incomplete, flawed, or deficient. The matter is one of the balancing of various public interests and especially the interest in the proper investigation of a death against the interest in the avoidance of duplication. If the investigation cannot credibly be said to have been flawed, incomplete, or deficient then the public interest against duplication prevails. Conversely if there is credible evidence that the investigation was incomplete, flawed, or deficient then the public interest in proper investigation prevails and the coroner cannot seek to rely on an investigation which was potentially flawed.

69. Mr Hercock at points in his submissions sought to place emphasis on the Report and on certain of the conclusions set out in it rather than on the investigation by the MAIB. He contended that some of the conclusions in the Report should be allowed to be adopted by the coroner but not others. In short he said that those conclusions with which the Claimant did not take issue could be put before the jury as conclusive of the matters

stated in them but that the Claimant should be entitled to challenge others. For the following reasons I disagree and in my judgement such an approach is not permissible.

70. The judgments in *Norfolk* and *West Sussex* make it clear that the focus of attention is to be on the investigation rather than on the particular conclusions reached by the relevant Accident Investigation Branch. As already noted the significant factors are the public interest in avoiding duplication and the specialist expertise of the Accident Investigation Branch. The coroner is not to be drawn into the exercise of considering whether the conclusions reached in the investigation are correct. If the Accident Investigation Branch has conducted an investigation which cannot be said on the basis of credible evidence to have been incomplete, flawed, or deficient then the coroner is to approach matters on the footing that there has already been an investigation by the body best placed to come to a conclusion on the subject-matter of that investigation. It is not appropriate in such circumstances to seek to disentangle the conclusions and to accept some and not others. Such an approach would involve the coroner or a jury seeking to reach a conclusion on a matter in respect of which there had already been an investigation by a better qualified body and this would involve the duplication which was found in *Norfolk and West Sussex* to be contrary to the public interest. Conversely where there is credible evidence that the investigation was incomplete, flawed, or deficient then none of the conclusions can be adopted and there must be a fresh investigation for the reasons of the public interest in proper investigation of deaths which I have set out above.

71. I do not exclude the possibility of a different approach being appropriate where an investigation can properly be regarded as having been divisible and where there is credible evidence that particular elements or aspects of the investigation were incomplete, flawed, or deficient while others were not. Such might be the case if for example different inspectors had addressed different and discrete parts of an investigation and the approach of one of those inspectors could credibly be said to have been incomplete, flawed, or deficient. However, that is very far from being the position here and I do not need to consider that question further.

72. A further subsidiary factor explaining why the emphasis is to be on the investigation as a whole rather than on particular conclusions is the restriction in regulation 13 of the 2012 Regulations on the MAIB disclosing the details of the persons who have given evidence to an inspector or of various of the documents or records obtained. If it is open for some of the conclusions of an investigation to be challenged there is a risk that there will be disclosure of information which will reveal the identity of persons who have given evidence to an inspector. In addition there is a risk that the coroner or jury will have to decide the validity or otherwise of a conclusion while having only an incomplete understanding of the basis for that conclusion because of the limitations on the information the Accident Investigation Branch can provide. Mr Hercock submitted that the former risk could be avoided by the coroner exercising control over the questions which could be asked but the risk of disclosure or of a "jigsaw" identification would remain. Moreover, the risk that the jury would have to reach a conclusion with only partial information would remain and would be real. When the validity of a conclusion is being challenged the identity and position of those whose evidence has provided the basis for the conclusion are clearly relevant factors (and potentially factors of great weight) in assessing the validity of the conclusion but that information would not be available to the jury.

73. The all or nothing effect of the decision that in a particular case the coroner or jury cannot rely on the report of an Accident Investigation Branch is a further factor why the requirement that there be credible evidence that the investigation is incomplete, flawed, or deficient is to be seen as a high hurdle. Minor criticisms of the investigation or of some of the conclusions reached cannot amount to credible evidence for these purposes. The requirement that there be credible evidence that the investigation was incomplete, flawed, or deficient is a high hurdle. It is not sufficient that with hindsight it is possible to say that the investigation could have been conducted differently; or that the conclusions could have been better expressed; or that an error was made in some aspect of the conclusions. An inspector does not have to be and cannot be infallible and, therefore, an investigation which cannot be said to have been incomplete, flawed, or deficient could still result in an incorrect conclusion. The public interest in avoiding duplication remains even in those circumstances and a person's ability to point to an error in the report resulting from an Accident Investigation Branch investigation does not mean that the investigation was flawed. There may, however, be cases where the error can properly be seen as credible evidence that the investigation was conducted on a false premise and was, as a consequence, incomplete, flawed, or deficient.

74. It follows that it was not open to the Defendant to regard the approach set out in *Norfolk* and *West Sussex* as *obiter* nor as optional. Nor is that approach subject to qualification in circumstances where fairness is said to require a different approach. The consequence is that the relevant conclusions of an investigation by an Accident Investigation Branch are to be accepted by a coroner without further investigation unless there is credible evidence that the investigation was incomplete, flawed, or deficient.

75. The all or nothing effect of the *Norfolk* approach means that the Claimant's contention that some of the conclusions set out in the Report should be retained while others were discarded was misconceived as I have just explained. It also means that the course proposed by the Claimant of putting the Report before the jury but directing the jury to decide between that and the competing evidence was not open to the Defendant. If the Defendant had found that there was credible evidence that the investigation by the MAIB had been incomplete, flawed, or deficient then the fruits of that investigation could not be relied on at all and the inquest would have to be based on a *de novo* investigation. This effect also has consequences for the current grounds of challenge. Grounds 3 – 6 focus on the Defendant's determination in respect of the Claimant's submissions as to particular conclusions in the Report. The all or nothing effect of applying *Norfolk* means that the Defendant's consideration of those submissions had to be focused not on whether there was disagreement with a particular conclusion but on whether there was credible evidence that the investigation was incomplete, flawed, or deficient with an incorrect conclusion being potentially but not necessarily such evidence.

Ground 7: the Fairness Challenge.

76. The argument as to the fairness of his proposed approach was not addressed by the Defendant in the Ruling. That is not surprising because it was not put to him in those terms. Instead it featured only as an aspect of the Claimant's submissions to the effect that there was credible evidence that the investigation was incomplete, flawed, or deficient.

77. This ground of challenge falls away in light of the conclusion I have reached as to the approach which the Defendant was required to take to the MAIB investigation. The fairness or otherwise of the *Norfolk* approach was not a matter for the Defendant and he could not proceed on the basis that fairness required a different approach to be adopted.

78. The Claimant and the MAIB both expressed reservations as to the Defendant's provisional view that Capt. Jae Jones, should not be called to give evidence. However, it is clear both from the Ruling and from his letter of 15th December 2022 that the Defendant's decision in that regard was provisional by way of contrast to his final decision that the conclusions in the Report could not be challenged. Therefore, this cannot be a basis for challenge to the Ruling.

79. It follows that ground 7 fails.

The Approach to be taken to the Ruling.

80. Grounds 1 and 3 – 6 turn at least in part on the approach to be taken to the interpretation of the Ruling. Determination of ground 1 requires consideration of whether the Defendant applied the correct test while grounds 3 - 6 will require a determination as to whether the Defendant adequately grappled with the submissions made to him and whether there was a demonstrable flaw in his reasoning.

81. The Defendant had to set out his reasoning sufficiently clearly and fully for the parties and this court to understand the reasons for the decision reached; to see that the correct legal test was applied; to know that the matters needing determination had been addressed; and to be satisfied that the decision was not the result of demonstrably flawed reasoning. If the Ruling was deficient in those regards it would be liable to be quashed on the basis of one or more of an error of law; a failure to give reasons; or irrationality (as to which see *R (Law Society) v Lord Chancellor* [2018] EWHC 2094 (Admin), [2019] 1 WLR 1649 at [98]).

82. It remains necessary to consider the approach to be taken to reading the Ruling when considering whether those requirements were met.

83. For the MAIB Mr Morton KC and Mr Reynolds referred me to authorities warning of the need to have regard to real as opposed to merely forensic doubt as to the reasons for a decision (*South Gloucestershire Council v Secretary of State for Housing, Communities, and Local Government* [2019] EWHC 181 (Admin) at [38]); cautioning against "over-zealous linguistic analysis" *(Poshteh v Kensington & Chelsea Royal LBC* [2017] UKSC 36, [2017] AC 624 at [39]); and counselling in favour of reading decision letters "in a straightforward down-to-earth manner, without excessive legalism or criticism" (*Wokingham BC v Secretary of State for Housing, Communities, and Local Government* [2019] EWHC 3158 (Admin)).

84. In my judgement the approach to be taken to the interpretation of decision letters sent by housing officers or the decisions of planning inspectors or those in similar positions with which those authorities were concerned is not directly applicable to the interpretation of the Ruling. There are similarities and the points made in the preceding paragraph are in large part matters of common sense applicable to the interpretation of very many decisions. Nonetheless it has to be remembered that the Ruling was a court

ruling given by the Defendant after a series of pre-inquest hearings and in response to formal legal submissions. The Ruling was not an explanation of how an administrative or executive discretion had been exercised. Instead it was setting out the Defendant's understanding of the law and purporting to apply that understanding to the submissions made and to the facts of the case. In light of those considerations the approach to the reading of the Ruling is to be more closely akin to that applicable to the reading of a judgment under appeal than to that applicable to a decision letter remembering nonetheless that the exercise is being undertaken in order to determine whether the Ruling is flawed on public law grounds and not to determine whether it was wrong.

85. As a consequence the following points are of note:

i) The Ruling is to be read realistically and as a whole.

ii) It is to be remembered that the Ruling was concerned with a single matter namely the status of the Report and that it was being provided to legally represented parties who knew both the factual background and the terms of the submissions which had been made.

iii) The Ruling was, moreover, given in the context of an inquest which had the important but limited purpose of determining the cause of Joshua Gardener's death. In that setting the particular context of the Ruling was determining whether there was credible evidence that the MAIB's investigation had been incomplete, flawed, or deficient. That determination was being made against the background of authority stating that a coroner should be slow to find that there was such credible evidence and that it would only be in rare cases that an Accident Investigation Branch's investigation could properly be said to have been incomplete, flawed, or deficient.

iv) It was not necessary for the Defendant to address every minor issue at length nor necessarily at all. In particular, the Defendant did not need to deal with every argument advanced in favour of a proposition provided that he demonstrated that he had addressed the substance of the case being advanced and had shown why he accepted or rejected it. Clearly disagreement with a submission cannot be an indication that the submission has not been understood. In addition the fact that the Defendant summarised a submission in language different from that used by the Claimant does not of itself mean that the submission was not properly understood though I have to be alert to the fact that the way in which a submission was summarised may indicate a lack of understanding on the part of the Defendant.

v) The Defendant was entitled to express his conclusions shortly. Those reasons did not need to be elaborate and nor did he have to give "reasons for his reasons" (see *Staechelin & others v ACLBDD Holdings & others* [2019] EWCA Civ 817 per Lewison LJ at [39]).

vi) The Ruling should not be subject to a "narrow textual analysis. Nor should be it be picked over or construed as though it was a piece of legislation or a contract" per Lewison LJ in *Volpi v Volpi* [2022] EWCA Civ 464, [2022] 4 WLR 48 at [2(vi)] (see also to the same effect *DPP Law v Greenburg* [2021] EWCA Civ 672 per Popplewell LJ at [57]).

86. I have referred, at [32] above, to some of the material before the Defendant but the point is worthy of further attention. The Claimant and the MAIB had each made five sets of written submissions to the Defendant. Those of the Claimant culminated in its Fifth Note. This was 7 pages long containing 33 paragraphs. It was accompanied by the Schedule which summarised the Claimant's earlier position; the MAIB's response; and the Claimant's reply to that response – the reply making a number of new points. The Schedule was 19 pages long with four columns of text in a small font (albeit with empty spaces in parts of some of the columns) and cross-referring to other material. In particular the Claimant referred the Defendant to its Second Note (of 52 paragraphs and 13 pages) and to Asst Chief Fire Officer Cray's first witness statement (of 27 pages and 90 paragraphs). A short further witness statement from Mr Cray accompanied or followed the Fifth Note. The Claimant's submissions made a number of points based on a close textual analysis of the Report. The MAIB had responded in kind with its final submission running to 22 pages and 56 paragraphs and saying that it was to be read alongside the statements of Captains Jones and Moll which were a total of 25 pages.

87. The material put before the Defendant went well beyond that which was appropriate in the light of *Norfolk* and *West Sussex*. As already seen the courts in those cases explained that a coroner was only to go behind an Accident Investigation Branch investigation in the "rare case where there might be an obvious deficiency" in the investigation (see *West Sussex* at [127]). In such a rare case it should be possible for a party to identify the obvious deficiency shortly and concisely. While it may be necessary for the text of the Accident Investigation Branch report to be considered it should be possible if there is an obvious deficiency for that to be shown without the need for lengthy arguments based on a close reading of the text let alone criticism of the language in which the conclusions were expressed.

88. Here the Defendant had to address the submissions made to him but he was entitled to do so shortly and on the basis that he was dealing with a point of legal principle for the purpose of deciding the evidence to go before the jury. He was not required to enter into the details of the textual analysis of the Report let alone to set out his reasoning with the degree of detail which would have been appropriate if he been delivering a judgment on the construction of a statute or of a commercial contract.

Ground 1: did the Defendant apply the Correct Legal Test?

89. The Claimant contends that although the Defendant stated the principles to be derived from *Norfolk* correctly he did not apply them correctly. It is said that the Defendant applied a higher test and that rather than considering whether the Claimant had shown there was credible evidence that the investigation was incomplete, flawed, or deficient he considered whether the Claimant had satisfied him that the investigation was in fact incomplete, flawed, or deficient.

90. There are two aspects of the Claimant's argument. First, it is said that the Defendant's articulation of the principles to be derived from *Norfolk* was taken *verbatim* from the ruling of HM Senior Coroner Ormond-Walshe in the Sandilands inquest. This is said to indicate that the Defendant had not derived the principles from his own analysis of the decision in *Norfolk*. The posited failure by the Defendant to conduct his own analysis of *Norfolk* is then said to support the contention that the wording of his conclusions showed that he had in fact failed properly to understand the relevant principles. This is on the basis that if the Defendant had not himself analysed *Norfolk* a

failure properly to understand and so to apply the approach to be derived from it is more readily explicable. The second aspect of the argument is that the language of the Defendant's conclusions is relied upon as indicating the adoption of a higher test than merely considering whether credible evidence of an incomplete, flawed, or deficient investigation had been produced.

91. The adoption by the Defendant of another's wording as a distillation of the effect of *Norfolk* does not mean that the Defendant had not himself considered that decision. It is rather an indication that the Defendant found the wording to be in accord with his understanding of the effect of that decision. It is to be noted that the Defendant did not simply cut and paste the principles as stated in the Sandilands case. In the fourth principle he emboldened the words "incomplete, flawed, or deficient". This had not been done by HM Senior Coroner Ormond-Walshe in her ruling in the Sandilands case. This shows that the Defendant did not copy those principles into the Ruling without thinking and without applying his mind to their proper formulation. The Claimant, in a contention rather at odds with the assertion that the distillation was recited by the Defendant without thought, sought to say that the emboldening of those words but not the preceding reference to credible evidence was significant. It said that this showed the Defendant focusing on the substance of the failing rather than on the question of whether there was credible evidence and that this supported the contention that the wrong test had been applied. I disagree. The fourth principle begins with a reference to the absence of credible evidence and the emboldening of the words "incomplete, flawed, or deficient" is entirely consistent with the Defendant choosing to emphasise the matter of which there had to be credible evidence.

92. The Claimant supported this ground by reference to the wording of the Ruling. It correctly noted that at a number of points the Defendant referred to not being satisfied that or it not being established that the investigation or sections of the Report were incomplete, flawed, or deficient. However, those passages must be read in the context of the Report as a whole and there are two aspects of that context which are relevant.

93. The first is that the Ruling contains repeated enunciations of the correct *Norfolk* approach. That approach is set out not just at [10] where the distillation of the principles appears but also at [2] and [13]. In addition although the Claimant says that the test was incorrectly expressed at [6] I do not agree. There the Defendant said that the issue was whether the Report "can be said to be `incomplete, flawed, or deficient'". That is at least equally compatible with the correct principle (save for the reference to the Report rather than the investigation) as with the alleged incorrect test. The Report could only be "said" to be incomplete, flawed, or deficient if there was credible evidence that it was.

94. In light of that assessment the approach summarised thus by Popplewell LJ in *DPP Law v Greenburg* at [58] is relevant:

> "… where a tribunal has correctly stated the legal principles to be applied, an appellate tribunal or court should, in my view, be slow to conclude that it has not applied those principles, and should generally do so only where it is clear from the language used that a different principle has been applied to the facts found. Tribunals sometimes make errors, having stated the principles correctly but slipping up in their application, as the case law demonstrates; but if the correct principles were in the tribunal's mind, as demonstrated by their being identified in the express terms of the decision, the tribunal can be expected to

> have been seeking faithfully to apply them, and to have done so unless the contrary is clear from the language of its decision. …"

95. In that case the Court of Appeal was considering a judgment of an employment tribunal but the approach stated there is of general application and is to be borne in mind when it is said that although a lower court has correctly stated the relevant legal principles or the applicable test it has not in fact applied those principles or that test. Here in order to accept the Claimant's contention that the Defendant applied the wrong test I would have to find that in the course of a short ruling (some 17 pages of widely-spaced text) the Defendant in fact applied a test different from that which he had repeatedly said was to be applied and which had been set out in the submissions of both the Claimant and of the MAIB. I have to be alert to the fact that it is possible for a person to state a test correctly but then to apply a different test. Nonetheless the repeated expressions of the correct test make this unlikely and such a conclusion would have to follow clearly from the language used and/or the result achieved before it could safely be reached. It is here that the second aspect of the context becomes significant.

96. That second aspect is the text immediately alongside those parts of the Ruling which are said to show the wrong test being applied. It is correct that the way in which the Defendant expressed his conclusions at [14(4)(iv)], [14(9)], [14(18)], [14(23)], and [15] could, if read in isolation, be seen as the Defendant concluding that the Report or investigation were not incomplete, flawed, or deficient. Those passages are not, however, to be read in isolation. Instead their immediate context is highly relevant. Thus the conclusion at [14(9)] was preceded by the discussion at [14(6) – (8)] assessing the strength of the evidence advanced by the Claimant. Similarly [14(18)] and [14(23)] were preceded by an analysis of the strength of the Claimant evidence.

97. I am satisfied that when seen in context and read fairly the passages on which the Claimant relies show the Defendant saying that the evidence produced by the Claimant was not capable of establishing that the investigation or the Report were incomplete, flawed, or deficient. It followed that there was not credible evidence of incompleteness, flaw, or deficiency. The Defendant was very far from applying a different test from that laid down in *Norfolk*. The Defendant was not, for example, saying that credible evidence had been advanced but that having assessed that evidence against other evidence he had concluded on balance that the investigation was not incomplete, flawed, or deficient. Rather he was considering the material advanced by the Claimant in order to see if it was capable of establishing that the investigation was incomplete, flawed, or deficient. The question of whether the correct test was applied is a matter of substance not of language and is one of whether the test being applied was in reality that derived from *Norfolk*. The presence or absence of a formulaic reference to "credible evidence" is not determinative and I am satisfied that in reality the correct test was applied.

98. Accordingly, ground 1 is dismissed.

Ground 2: the alleged Error of Law in relation to the applicable Standards.

99. The Claimant says that the Defendant erred in law in failing to accept that there was credible evidence that the investigation was incomplete, flawed, or deficient by reason of having been based on the wrong regulatory standards. The relevant challenge for the purposes of ground 2 was in relation to conclusion 3.1(6) and in particular to the

reference to neither of the crew members on Rescue 1 having the "required" qualifications to be the helmsman of the RIB.

100. Before the Defendant the Claimant had argued that the conclusion was flawed in two related respects. The first was that the MAIB had applied standards derived from the Claimant's own internal requirements and from its Standards of Operating Procedure rather than those lower standards which were applicable as a matter of law. Second, it was said that the MAIB had erred in applying to the accident standards derived from the Workboat Code when that code did not apply to the operation of the Claimant's boats. The Claimant submitted evidence and advanced arguments as to the non-applicability of the Workboat Code and as to the relevant regulatory regime. This resulted in responsive evidence from the MAIB, in the form of a statement from Capt. Jones, and supporting submissions to the effect that the Workboat Code did apply.

101. At the pre-inquest hearing and in the submissions made to the Defendant there was extensive argument as to the applicable regulatory regime. The Defendant described this debate as "somewhat sterile". At [14.4(ii)] he said that the Claimant's invocation of the Health and Safety Executive's Guidance in relation to the application of the principle of reducing risk to the "ALARP" (as low as reasonably practicable) level was "misplaced". That was because the Claimant was "not being saddled with the higher standards of others" but instead reference was being made to the standards which the Claimant had itself drawn up and which it was to be taken to have accepted could be achieved.

102. It was only after he had characterised the arguments in that way that the Defendant proceeded, at [14.4(iii)], to consider the applicable regulatory regime. The Defendant then set out in short terms why he rejected the Claimant's argument that the Workboat Code was not applicable.

103. At ground 2 the Claimant says that the error of law consisted of the Defendant's rejection of its argument as to the inapplicability of the Workboat Code and his consequent rejection of the contention that the MAIB's conclusion at 3.1(6) amounted to credible evidence that the investigation was incomplete, flawed, or deficient. The conclusion at 3.1(6) is said to have amounted to such evidence because it demonstrated that the MAIB was measuring the Claimant's actions "against a standard of safety which was higher than it was legally entitled to impose on [the Claimant]". In the Statement of Facts and Grounds that assertion was followed by 27 paragraphs of analysis of the Merchant Shipping (Small Workboats and Pilot Boats) Regulations 1988; the Workboat Code; the HSE Guidance; the Rescue Boat Code; and the Rescue Boat Code for the Fire and Rescue Service.

104. In its Detailed Grounds of Resistance the MAIB said, at [39] and [40], that it was not a regulator applying a regulatory code but was seeking to establish as a matter of fact what caused the accident and that conclusion 3.1(6) was concerned with saying that the Claimant's own procedures had not been followed. Then, at [47], the MAIB said that the applicability or otherwise of the Workboat Code was "not a material question of law for the Coroner to decide" and that "analysis of that technical guidance is several steps removed from the question of whether there is credible evidence that the MAIB's report is incomplete, flawed, or deficient." It then, however, proceeded to set out its case as to why the Workboat Code had been applicable.

105. The skeleton arguments and the oral submissions to me continued those approaches and I heard submissions as to the various regulations and codes.

106. The Claimant accepted that the conclusions of the Report did not refer expressly to a failure to comply with the Workboat Code. It is apparent (and was accepted) that the MAIB believed that the Workboat Code was applicable. There was reference to the regulatory regime at sections 1.7.3 and 2.8. Conclusion 3.1(12) was based on the analysis at section 2.8 and made reference to "requirement to operate all of [the Claimant's] boats to an approved standard". I will deal below with the challenge made in ground 6 to the Defendant's approach in respect of conclusion 3.1(12).

107. The Claimant's contention before the Defendant as to conclusion 3.1(6) was misconceived essentially for the reasons given by the MAIB in the Detailed Grounds of Resistance. The Claimant's error flows from interpreting the Report as if it involved the MAIB applying a "regulatory standard" and then criticising the Claimant for having failed to meet that standard. This reading of the Report appears clearly from Mr Cray's witness statement. It is apparent that Mr Cray is aggrieved at what he sees as criticism of the Claimant for failing to comply with regulations to which it did not believe it was subject. That is a misunderstanding both of the nature of the MAIB investigation and of what the Report actually says.

108. The objective of the MAIB investigation was set out at regulation 5 of the 2012 Regulations. It was to ascertain the cause and circumstances of the accident with a view to preventing future accidents. The language of the Report and, in particular, of the conclusions shows that the investigation was conducted in accordance with that objective which had been recited on the first page of the Report. The meaning of conclusion 3.1(6) is clear and unambiguous. It did not say that there had been a failure to comply with the Workboat Code or with any other regulatory regime let alone that such a failure had caused the accident. Instead it said that the Claimant's own pre-activity planning requirements had not been met and the Claimant's standard operating procedures had not been followed. It then listed a number of matters which were said to have been "the consequence" of those failures. Those consequences included the fact that "Rescue 1 had insufficient crew, neither of whom held the qualifications required to be the RIB's helmsman". Those were amongst the matters said to have directly contributed to the accident. It is apparent that the sufficiency of the crew and the required qualifications were being assessed by reference to the Claimant's pre-activity planning requirements and its standard operating procedures and not by reference to the Workboat Code or any other regulation. This interpretation follows from the clear language of conclusion 3.1(6) and to the extent that confirmation is needed it is provided by reference to sections 2.5 and 2.6.3 of the analysis from which the conclusion is derived and which make the meaning clear. Conclusion 3.1(6) set out a finding of fact as to which the applicability or non-applicability of the Workboat Code was wholly irrelevant.

109. Further reinforcement for that reading of the Report and of the MAIB's approach comes from the recommendations made by the MAIB. Recommendation 2020/130 was that the Claimant should:

> "Undertake a review of the crewing and staff qualification requirements for boats within MWWFRS to determine appropriate levels for familiarisation, training and emergency operations status and include the requirement within revised procedures and guidance."

110. It is of note that this recommendation was entirely focused on the revision of the Claimant's own requirements and procedures. There was no suggestion there or in the other recommendations that this was on the footing that there had been a failure to comply with applicable regulations.

111. In those circumstances the Defendant did not err in law in rejecting the argument that conclusion 3.1(6) was credible evidence that the investigation had been incomplete, flawed, or deficient by reason of having proceeded on the basis of an incorrect understanding of the applicable regulations. The MAIB's belief that the Workboat Code applied played no part in that conclusion.

112. The Defendant's supplemental conclusion that the Workboat Code did apply was separate from his principal determination in respect of conclusion 3.1(6) and the latter was not dependent on the former. The Defendant's determination in relation to the Claimant's contention based on conclusion 3.1(6) would have remained the same regardless of his finding as to whether the Workboat Code applied or not. The debate as to the applicability of the Workboat Code was not just "somewhat sterile" but was irrelevant to this point and the Defendant would have been entitled simply to decline to engage with it at this stage in the Ruling. As will be seen the applicability of the Workbook Code is relevant to the submission relating to conclusion 3.1(12) which is the basis of ground 6 in this claim. I will consider the question in relation to that ground but it does not arise in relation to conclusion 3.1(6).

113. If the MAIB had proceeded in this conclusion on the basis that a particular regulatory regime had applied and that the matters set out in conclusion 3.1(6) had been caused by a failure to comply with such a regime the position might have been different. If in those circumstances the regulatory regime in question had not been applicable as a matter of law there may well have been scope for saying that the conclusion and potentially the investigation was flawed by reason of having proceeded on a false basis. That was not the position here. The MAIB did believe that the Workboat Code applied but that did not affect the conclusion expressed at 3.1(6).

114. Ground 2, therefore, fails.

<u>Ground 3: the alleged Error of Law as to the relevant Matters and Conclusion 3.1(6).</u>

115. Here the Claimant contends that the Defendant erred in law in his approach to the submissions in relation to conclusion 3.1(6).

116. The Claimant had submitted that the reference to "insufficient crew" was incomplete because it omitted reference to the fact that there were available at the Milford Haven station sufficient trained personnel to operate both boats in accordance with the Claimant's procedures and that the decision as to the actual crewing of the boats was taken at the station on the day of the accident.

117. The Defendant addressed this point at [14(4)(i)] saying:

> "The fact that there may have been available fire service personnel elsewhere who could have manned the boats in question to increase the numbers aboard is irrelevant to this issue in my judgment. The relevant factual issue is simply the number actually aboard at the time and not the existence of others elsewhere. The potential availability of others elsewhere does not make the finding in this respect *incomplete*."

118. The Claimant says that the Defendant erred in law in his assessment of what was relevant. It says that the fact that there were at the station sufficient qualified personnel to operate both boats on the day of the accident was relevant to the issues which would be before the jury. This together with the Claimant's point that the decision as to the crewing of the boats was made at Milford Haven station on the day of the accident is said to have been relevant to the question of whether or not it was difficult to comply with the Claimant's procedures. The Claimant says that it should have been before the jury for there to be a complete picture. In Mr Hercock's skeleton submissions this was also characterised as being a failure to grapple with the Claimant's evidence and/or to appreciate its significance.

119. There is no substance to this ground of challenge which fails for the following reasons. The Claimant's initial challenge was to the wording of the conclusion which was said to have been incomplete. It was that challenge which the Defendant addressed in the Ruling. The assertion that the conclusion was incomplete was misconceived. A disagreement of this kind as to the wording of a conclusion in the Report with the assertion that more ought to have been said to give a fuller picture does not come close to amounting to credible evidence that the investigation was incomplete, flawed, or deficient. In any event, the wording of conclusion 3.1(6) was perfectly clear. The reference was to an insufficiency of crew on Rescue 1 at the time of the accident and that insufficiency was said to be the result of a failure to apply the Claimant's own procedures. The question of whether this was due to a decision taken at Milford Haven station or because the Claimant's procedures were difficult to apply or both was immaterial to the point being made in this conclusion. The Defendant's decision that the finding was not incomplete was rational and lawful and, indeed, inevitable.

120. The ground of challenge latches on to the Defendant's use of the words "irrelevant" and "relevant" and to construct from the use of those words an argument based on the Claimant's case as to what will be relevant to the issues before the jury. That argument is misconceived because it involves taking the words of the Ruling out of context. In context the Defendant was simply saying that whether there were or were not sufficient potential crew members available elsewhere was irrelevant to the facts that there were not sufficient crew members on Rescue 1 at the time of the accident and that this was a consequence of the failure to follow the Claimant's procedures and saying that it was those facts with which the conclusion was concerned. The Defendant's analysis in that respect did not involve either an error of law or a failure to address the case being advanced.

121. The Claimant places considerable emphasis on the argument that the failings on the day of the accident were the result of decisions taken at Milford Haven station rather than being inherent in its system. An aspect of this is the Claimant's disagreement with conclusion 3.1(7). I will consider that in due course below but conclusion 3.1(6) relates to the sufficiency of the number of crew members on the boat on the day of the accident and is unaffected by this argument of the Claimant.

Ground 4: the Failures alleged in the Defendant's Determination of the Challenge to Conclusions 3.1(7), (8), and (11).

122. Conclusions 3.1(7), (8), and (11) made related points as to the difficulty which the firefighters based at Milford Haven had in complying with the Claimant's crewing requirements; as to the consequences of that for the amount of training undertaken; and

as to the effect on the departure from the Claimant's Standard Operating Procedures and its crewing requirements.

123. Underlying the Claimant's challenge to these conclusions is a fundamental disagreement with the proposition that it was difficult for the firefighters based at Milford Haven to comply with the Claimant's crewing requirements or to undertake the appropriate training. It sees such difficulties as there were as having resulted from the approach adopted at Milford Haven rather than any inherent difficulty in compliance. The Claimant sees criticism of it as a service as unjustified. However, disagreement even strong disagreement with the MAIB's conclusions does not without more amount to credible evidence that the MAIB's investigation was incomplete, flawed, or deficient. In addition the relevance of the distinction between failings at the level of the Claimant as a force and at the level of the station at Milford Haven to the issues which will need to be addressed at the inquest in order to answer the statutory questions is limited at the highest.

124. The Claimant mounted a detailed attack on these conclusions. That attack had two limbs. First, there was criticism of the investigation. It was said that the decision by the MAIB not to consider the position at other stations operated by the Claimant but instead to consider the position at Milford Haven and the approach adopted by other fire and rescue services with coastal responsibilities meant that the investigation was incomplete, flawed, or deficient. Second, the Claimant set out a detailed critique of the findings that there had been difficulties in compliance and as a consequence insufficient training.

125. The Defendant rejected these challenges. He accepted Capt. Moll's explanation for the approach which the MAIB had taken to the investigation and concluded that the decision not to look at other stations operated by the Claimant did not make the investigation incomplete, flawed, or deficient. He found that the fact that Mr Cray's view that the inadequate crewing of Rescue 1 was the result of the approach taken at Milford Haven conflicted with the findings of the MAIB did not without more mean that the report was incomplete, flawed, or deficient. He accepted that the Claimant's training records provided a sufficient basis for the MAIB's conclusions. At [14(11)] he said that the finding as to a possible erosion of competence was "an entirely legitimate and balanced finding or, putting matters the other way round, it has not been demonstrated to be flawed or incomplete". However, the Defendant did accept that conclusion 3.1(8) having been expressed by reference to possibility could not be used as the basis for a finding that such erosion had contributed to Mr Gardener's death. He explained that this would be addressed by way of the directions to the jury or by way of an exclusion from the material put before them.

126. The Claimant says that the Defendant failed properly to understand its contentions and that such failure and/or misunderstanding meant that the Defendant did not address the contentions and/or addressed them on a false basis. As a consequence he reached conclusions which would not have been open to him if he had addressed matters on the correct basis.

127. It is clear that the Defendant did understand and did properly address the contention that the investigation was incomplete, flawed, or deficient by reason of the decision not to look at the position at other stations operated by the Claimant. The MAIB gave an explanation for the decision it had taken in that regard. The Defendant said that he had

considered that explanation and had accepted it. He was entitled to do so and there is no public law ground of challenge shown in that regard. The decision as to how best to conduct an accident investigation is very much a matter within the expertise of the Accident Investigation Branch rather than that of the court. As a consequence considerable weight must be given to a deliberate and reasoned decision by an Accident Investigation Branch that an investigation should be conducted in a particular way. It is possible for such a decision to be so flawed as to provide credible evidence that the investigation was incomplete, flawed, or deficient but a coroner should be wary before coming to such a conclusion and here the Defendant was entitled to accept Capt. Moll's explanation.

128. The Claimant's criticism of this aspect of the Ruling shows a degree of misunderstanding of the explanation given by the Defendant and results from a "failure to see the wood for the trees" and pursuit of a misplaced narrow textual analysis. Thus at [14(7)] the Defendant said:

> "…the point was made that, whilst enquiry was made of other stations, it became apparent that Milford Haven station operated two boats when other fire stations did not such that a `decision was made not to attempt to make comparisons with other stations that would be of limited value'".

129. The Claimant says that this showed a misunderstanding on the part of the Defendant because in fact enquiry was made of other services rather than other stations. It is, however, apparent that the Defendant derived this point from Capt. Moll's statement at [12] and from that of Capt. Jones at [17] and following. The point being made there on behalf of the MAIB was that it had learnt that no other of the Claimant's stations operated two boats and that this had led it to conclude that inquiry of the approach at those other stations was not necessary. Whether that knowledge came through enquiry "of" those other stations (in the sense of contacting those stations) or by enquiring "about" those stations is immaterial. The Defendant understood and was addressing the essential point namely the reason for the MAIB's decision.

130. The Claimant places considerable emphasis on the Defendant's references to the training records. It says that the Defendant's references to the figure of 31% of the Milford Haven station staff being out of date for practical boat handling and his proceeding on the footing that there was no dispute about that figure or the facts within the training records was wrong. It says that this had the consequence that the Defendant addressed matters on a false basis and did not properly consider the challenge. I disagree. The position was that the Claimant did not in fact dispute either the raw data or the figures as figures. There was considerable dispute as to the proper interpretation of those figures and as to their relevance to the accident. The Claimant contended that the MAIB was mistaken both as to the way in which the figures were to be interpreted and as to the conclusions which it drew from its (the Claimant would say mistaken) interpretation. The Defendant was right not to descend into that debate and the approach he applied at [14(11)] was entirely in accord with that derived from *Norfolk*. As was explained in *West Sussex* at [133(2)] the fact that an expert takes a different view from the MAIB on a particular matter does not without more amount to credible evidence that the latter's investigation was incomplete, flawed, or deficient. Moreover, as I have already noted the Defendant had concluded that conclusion 3.1(8) should not be put before the jury (or that they should be directed to place no weight on it) and so the

alleged misunderstanding as to the basis for the challenge to that conclusion does not advance matters.

131. In a related point the Claimant contends that the Defendant was in error in saying, at [14(5)], that the Claimant did not suggest that the finding as to a reduced amount of training at Milford Haven was wrong and, accordingly, in proceeding on that basis. However, that interpretation of the evidence was entirely open to the Defendant. The Claimant did produce training records and detailed reference was made to them in the evidence of Mr Cray. The natural reading of that material was that the Claimant was saying that there had been training; that it had been adequate; that any inadequacy was the result of decisions taken at Milford Haven; and that there were no difficulties preventing compliance with the training requirements. I have re-read that evidence and the Claimant's submissions to the Defendant with this point in mind. The Claimant does not state in terms that there had been no reduction in training. As just noted the focus of the submissions and evidence was elsewhere. If the fact of reduction was said to be material and to be in issue then it was incumbent on the Claimant to express the point clearly and unequivocally. The Defendant is not to be criticised for failing to see that there was an issue as to this and, indeed, on my reading of the papers it was not in issue although its causes and consequences were.

132. I come back to the point that the Defendant understood that the Claimant disagreed with the MAIB as to the proper interpretation of the history; as to the conclusions to be drawn from the history; and as to their relevance to the accident. He explained shortly but adequately that the disagreement did not amount to credible evidence that the investigation was incomplete, flawed, or deficient and no public law failing is shown in that regard.

133. Therefore, ground 4 fails.

<u>Ground 5: the alleged Failure properly to address the Claimant's Challenge to Conclusion 3.1(10).</u>

134. Conclusion 3.1(10) made three points in respect of the Claimant's procedures for boat operations namely that they had not been updated for some time; that they contained misleading information; and that there was insufficient reference to Rescue 1 as a pre-determined operational asset.

135. The Claimant's challenge to this conclusion was contained in three paragraphs of Mr Cray's first witness statement and in three paragraphs of the Claimant's second note. The Schedule drew attention to those. The Claimant contended that document AET 5.17 was not misleading and that the illustrations in it could not have contributed to the accident. It also said that the absence of reference to Rescue 1 as a pre-determined operational asset was similarly incapable of having contributed to the accident.

136. The Schedule also summarised the MAIB's response to this challenge and then set out the Claimant's reply to that response. Although the reply began with reference to document AET 5.17 it considerably expanded on the original line of challenge saying at some length that the conclusion was flawed; that the matters in question could not have contributed to the accident; that the relevant decisions were taken at the level of the local station; and that "the MAIB's analysis is incomplete, and its conclusions flawed and deficient."

137. The Defendant addressed this aspect of the matter shortly in the Ruling. He referred to the findings in the analysis in the Report and said that those were accurately reflected in conclusion 3.1(10). He said that the Claimant's focus on document AET 5.17 overlooked the "much more fundamental failures" in its operating procedures. At [14(16) –(17)] the Defendant made it clear that he did not regard the MAIB's conclusions in this regard as mere criticisms of the Claimant's paperwork. He went on to explain the ways in which the failings which had been identified were relevant to the risk of boat collisions. He did not say in express terms that the failings were potentially causative of the accident but his meaning was entirely clear. He did say in terms that the Claimant's procedures failed to appreciate and properly to grapple with the risk of collisions between boats. Manifestly such a failure had the potential to contribute to an accident in which there was such a collision.

138. The Defendant then said that even if the photographs in document AET 5.17 were not misleading this was a "small detail in an otherwise significant catalogue of criticism" which was not sufficient to cross the *Norfolk* threshold.

139. The Defendant addressed directly the conclusion in the Report and the Claimant's challenge to it as that challenge had been put in Mr Cray's statement and in the Claimant's second note. Those were the documents to which he had been referred by the Schedule. The Defendant explained in clear terms why he rejected that challenge. The Defendant did not engage in detail with the MAIB's response nor with the Claimant's reply to that. The Defendant is not to be criticised for that and his failure to do so did not amount to a failure properly to deal with the case before him. This is particularly so as the Claimant's response in large part amounted to the expression of a different opinion from that of the MAIB as to the potential causative relevance of the failings (with which the Defendant did deal) or the expression of a different view from that reached by the MAIB (a matter which as the court in *West Sussex* explained at [133(2)] did not amount to credible evidence that the investigation was incomplete, flawed, or deficient).

140. This ground accordingly fails.

Ground 6: the alleged Failings in the Defendant's Consideration of the Challenge to Conclusion 3.1(12).

141. The alleged public law failings in the Defendant's treatment of the challenge to conclusion 3.1(12) fall into three categories although the Claimant breaks them down further. The Defendant is said to have been wrong in law in proceeding on the footing that the Workboat Code applied. Next he is said to have misunderstood the Claimant's submissions and as a consequence to have failed to address them on a proper basis. Finally, the Defendant is said to have failed to grapple with and/or properly to address the Claimant's case in respect of the causal relationship between the subject matter of the conclusion and the accident with the result that his treatment of the issue was logically flawed.

142. The second and third of those lines of attack can be addressed shortly.

143. The language used by the Defendant at [24] could have been more precise but it does not show any misunderstanding of the Claimant's case. The Defendant was right to say that the Claimant was not in truth challenging the factual background to ground 3.1(12)

but was rather taking issue with the view that the Workboat Code was applicable and disputing the relevance of these matters to the causation of the accident. The Defendant was right to see that as the thrust of the Claimant's contention and also right to point out that the fact that the issue was a national one did not affect its relevance to the issues to be considered at the inquest.

144. The Defendant addressed the issue of causation shortly but there was no failure on his part to grapple with that issue and the conclusion reached was properly open to him. The point in essence was that the MAIB's assessment was that if the Claimant had appreciated the need (as the MAIB believed there to be) to comply with an approved standard then that would in practice have led to Rescue 1 being operated by a more experienced helmsman. The MAIB took the view that the absence of such an experienced helmsman contributed to the accident in circumstances where the boats were being manoeuvred at speed when in close proximity and when the ability to react quickly was of importance. The Claimant takes a different view but that does not mean that it could credibly be said that the MAIB investigation was incomplete, flawed, or deficient. This part of the Defendant's Ruling showed a proper appreciation of the issues and he was not required to explain his reasoning at greater length.

145. I turn to the contention that the Defendant erred in law. Conclusion 3.1(12) was based on the MAIB's belief that the Workboat Code applied and that the code laid down an approved standard with which the Claimant should have complied. The Defendant agreed that as a matter of law the Workboat Code applied. The Claimant says that was wrong and the Workboat Code was not applicable. It adds that if the Defendant had proceeded on the correct legal basis he would have seen that the MAIB had conducted the investigation and drawn up the Report on the basis of a mistaken view of the applicable law. That should have caused him to conclude that there was credible evidence that the investigation was incomplete, flawed, or deficient.

146. The Defendant said that the area was one of "regulatory complexity". The question is not complex in the sense that it is necessary to work through a considerable quantity of regulation. It is, however, far from straightforward in large part because the relevant provisions do not contain definitions of the relevant terms and because there is considerable scope for legitimate disagreement as to their correct interpretation.

147. The starting point is section 85(1)(a) of the Merchant Shipping Act 1995. This provides that:

> "(1)The Secretary of State may by regulations (in this Act referred to as "safety regulations") make such provision as he considers appropriate for all or any of the following purposes—
>
> (a)for securing the safety of United Kingdom ships and persons on them, and for protecting the health of persons on United Kingdom ships"

148. The Merchant Shipping (Small Workboats and Pilot Boats) Regulations 1998 ("the Workboats Regulations") are made under that power. The Workboat Code is a code of practice issued pursuant to those regulations and the relevant edition for current purposes is that issued in 2018.

149. Regulation 3 of the Small Workboats Regulations contained the following definition amongst others:

"`small vessel'" means a ship of less than 24 metres in load line length;
`small workboat' means a small vessel in commercial use other than for sport or pleasure, including a dedicated pilot boat, not being used as:

(i) a tug or salvage ship;

(ii) a ship engaged in the surveying of harbours or the approaches thereto; or

(iii) a hopper barge or dredger;

…

`vessel in commercial use' includes any vessel, including any pleasure vessel within the meaning of regulation 3 of the Merchant Shipping (Vessels in Commercial Use for Sport or Pleasure) Regulations 1993(7), while it is in possession of a broker, ship repairer or other such person for the purposes of his business."

150. Regulation 4 provided that:

"(1) Subject to paragraph (2) below, these Regulations shall apply to—
(a) small workboats which are United Kingdom ships wherever they may be;
(b) other small workboats operating from United Kingdom ports whilst in United Kingdom waters; and
(c) pilot boats, not being small workboats, which are United Kingdom ships wherever they may be.
(2) Regulation 5 shall not apply to—
(a) dedicated pilot boats, of whatever size; or
(b) pilot boats which are not small workboats."

151. The Merchant Shipping (Vessels in Commercial Use for Sport and Pleasure) Regulations 1998 came into force four months after the Workboats Regulations.

152. By regulation 3 of those regulations they applied to "any vessel used for sport or pleasure which is not a pleasure vessel" and "pleasure vessel" was defined as being:

"(a) any vessel which at the time it is being used is:
(i) (aa) in the case of a vessel wholly owned by an individual or individuals, used only for the sport or pleasure of the owner or the immediate family or friends of the owner; or

(bb) in the case of a vessel owned by a body corporate, used only for sport or pleasure and on which the persons on board are employees or officers of the body corporate, or their immediate family or friends; and

(ii) on a voyage or excursion which is one for which the owner does not receive money for or in connection with operating the vessel or carrying any person, other than as a contribution to the direct expenses of the operation of the vessel incurred during the voyage or excursion; or

(b) any vessel wholly owned by or on behalf of a members' club formed for the purpose of sport or pleasure which, at the time it is being used, is used only for the sport or pleasure of members of that club or their immediate family, and for the use of which any charges levied are paid into club funds and applied for the general use of the club; and

(c) in the case of any vessel referred to in paragraphs (a) or (b) above no other payments are made by or on behalf of users of the vessel, other than by the owner."

153. In November 2016 an Operational Working Agreement was drawn up between the Health and Safety Executive, the Maritime and Coastguard Agency, and the MAIB.

The purpose of this agreement was to outline the principles to be applied when selecting which of those organisations should take the lead in investigating particular maritime accidents. Annexed at Table 4 to the agreement was an "`at a glance' guide to jurisdiction". This was broken down by reference to type of vessel and location of the accident with the bodies with jurisdiction identified in respect of each category. For each type of vessel there was also a section headed "comments" explaining the basis for the allocation of responsibility. For the vessels described as "Local Authority owned and operated craft (Police, Fire, etc)" the commentary said "these are straightforward commercial vessels".

154. The Rescue Boat Code was originally drawn up in 2005 under the lead of the Royal National Lifeboat Institution. It was the product of the work of a working group consisting of representatives of that body and the Maritime and Coastguard Agency and a number of other bodies but not including representatives of the fire and rescue services nor the MAIB.

155. This code explained its rational thus at section 1.1:

> "The Maritime & Coastguard Agency (MCA) and a number of Rescue Boat Organisations providing rescue facilities around the United Kingdom recognised that the role of the Rescue Boat Organisation was not specifically covered by any formally recognised national standard, given that the MCA's existing Codes for safety of small vessels were not applicable as these rescue boats did not operate on a commercial basis, and their exposure to risk was limited by both the short distances over which they operated, and the limited time over which they were in operation."

156. That code defined "commercial" and "rescue boat" as:

> "`Commercial', for the purposes of this Code only, describes the use of a Rescue Boat on a voyage or excursion which is one for which the owner / organisation receives money for or in connection with operating the Rescue Boat or carrying any person, other than as a contribution to the direct expenses of the operation of the Rescue Boat incurred during the voyage or excursion."
>
> "`Rescue Boat' means a boat designed, constructed, maintained and operated to the Rescue Boat Code and includes rescue boats operated by life-saving/ life guarding clubs. A Rescue Boat can be defined as operating for the 'public good', either on a voluntary or professional basis, but not on a commercial basis. It may be appropriate for some other organisations that operate dedicated Rescue Boats, such as the Fire Brigade, Airport Authorities, Police etc. to come under the terms of this Code."

157. In November 2021 and as a consequence of the Report the Rescue Boat Code for the Fire and Rescue Service was drawn up. The purpose of this code was said to be to provide standards for rescue boats operated by fire and rescue services for water and flood rescue activities. It did not extend to other activities such as firefighting. It said that for those other activities the agencies "should comply with the following additional relevant standards". Those other standards were said to include the Workboat Code where the agencies were operating or training beyond the limit of categorised waters or were operating a vessel 7m or greater in length.

158. The code defined "commercial" in these words:

> "'Commercial', for the purposes of this code only, describes the use of a rescue boat on a voyage or excursion for which the fire and rescue service receives money, including

> operating the rescue boat or carrying any person other than during an emergency, search and rescue (SAR) operation or training activity."

159. The core argument for the Claimant is that "commercial use" is not defined in the Workboat Regulations other than through the provision that vessels are in such use when in the possession of brokers, ship repairers, or such persons for the purposes of their businesses. Accordingly, the question becomes one of whether use by the Claimant of these boats was "commercial use" as a matter of the ordinary meaning of those words. On that basis, the Claimant says, its use of the boats could not be seen as having been a commercial use. By way of support for that argument the Claimant points to the understanding of those who drew up the Rescue Boat Code both as to whether the Workboat Code covered boats operated by bodies such as the RNLI but also as to the potential appropriateness of fire and rescue service boats coming under the terms of the Rescue Boat Code (which would not have been necessary if they had been covered by the Workboat Code).

160. The MAIB says that the general understanding of those who had considered the effect of the Workboat Regulations for the purpose of determining their responsibilities and the approach to be taken had been that the regulatory regime drew a distinction only between vessels in commercial use and pleasure vessels and all small boats were to be seen as either one or the other. It pointed to the Operational Working Agreement of 2016 as showing the considered and collective understanding of the Health and Safety Executive and the Maritime and Coastguard Agency as well as of the MAIB. It noted that this understanding had previously been shared by the Claimant which had formerly caused Rescue 1 to be certified under the Workboat Code. The MAIB said that the two sets of regulations dating from 1998 had been intended to create a comprehensive regime for the regulation of small workboats. It says that the Claimant's interpretation of the Workboat Regulations would mean that there was an unnecessary and undesirable *lacuna* with a category of small workboats being unregulated in circumstances where there was no rationale for that exclusion and where it would be inconsistent with the purpose of the regulations. As to the Rescue Boat Code the MAIB says that there is a distinction between boats operated by charitable bodies such as the RNLI and those operated by public bodies such as the Claimant. It also points to the Rescue Boat Code for the Fire and Rescue Service which contemplates that use of such boats by a fire and rescue service will, at least in some circumstances, be commercial use.

161. The MAIB also prayed in aid the inclusive definition of "vessel in commercial use" in the Workboat Regulations. However, in my judgment that does not advance matters. The reference there to "other such person" must be read as referring to persons acting in a similar line of business to ship brokers or repairers. When that is done the provision is merely making it clear that even if a vessel would not otherwise be regarded as being in commercial use it would be so regarded when in the possession of a person operating such a business and possessing it for the purposes of that business. That provision has no relevance to the question of whether the boats operated by the Claimant were in commercial use within the meaning of the Workboat Regulations.

162. The Defendant expressed his conclusion thus at 1[14(4)(iii)]:

> "Taking matters shortly I am not persuaded by the MWWFRS's arguments to the effect that the Workboat Code did not apply at the time. This is because (a) I agree that word 'commercial' in the Workboat Code needs to be read in the context of the exclusion of

> sport or pleasure (b) [the Claimant]had accepted the applicability of the Workboat Code and historically coded the boat accordingly (when used as a dive boat - see p.12 of the MAIB report) (c) I do not find that s1.1 of the Rescue Boat's Foreword mandates that the workboat code did not apply (d) I agree that it would be a surprising state of affairs if FRS boats were unregulated by somehow falling into a lacuna between the various codes and finally (e) do not find that the advent of the subsequent Recue Boat Code for the Fire and Rescue Service assists me in making a determination as to the applicable standard (especially one that was self-imposed by [the Claimant]) at an earlier point in time, not least because it must be read as a whole and not cherry-picked in relation to crewing requirements."

163. The question is not a straightforward one. The interpretation of the Workboat Regulations has to be a matter of considering the language used in context. The context is primarily that of the Workboat Regulations themselves and of the 1995 Act under which they were made. The proper interpretation of legislation is a matter for the courts and it is possible even for those with expertise in a particular field of work or regulation to be mistaken as to the true effect of a provision. It follows that I can derive little assistance from the views of others whether those others be the parties to the Operational Working Agreement or the compilers of the Rescue Boat Code and still less the Rescue Boat Code for the Fire and Rescue Services which was drawn up after the accident and as a result of the Report.

164. There is very real force in the Claimant's argument that "commercial" and "use" are normal words of everyday language and that in the absence of a special definition in the Workboat Regulations they are to be given their normal meaning. In normal usage "commercial use" means for the purposes of commerce. The Claimant was not engaged in commerce and applying the ordinary meaning of the language employed it is hard to see the Claimant's use of the boats as being commercial use.

165. Account does, however, have to be taken of the context in which the words appear. The Workboat Regulations were made under section 85(1)(a) of the Merchant Shipping Act 1995 and for the purpose identified there. The language of that provision is strongly indicative of the purpose of creating a comprehensive regulatory framework covering all United Kingdom ships. The combined effect of the Workboat Regulations and the Merchant Shipping (Vessels in Commercial Use for Sport and Pleasure) Regulations can sensibly be read as being to draw a distinction between pleasure vessels and all other boats. Those of the other boats which are used commercially for sport and pleasure are covered by the latter regulations while all other boats, other than pleasure vessels, are governed by the Workboat Regulations. This would create a comprehensive regime of the kind which the 1995 Act appears to envisage.

166. The MAIB's interpretation is also supported, although to a limited extent, by the exclusion from the small workboat definition of tugs and salvage ships, ships engaged in surveying harbours, and hopper barges and dredgers. The fact of that exclusion is a potent indication that but for such exclusion such vessels would have been regarded as in commercial use and so within the definition of small workboat. Some at least of such boats and probably many of them would be operated by local authorities or harbour authorities and other bodies which would in normal usage not be seen as commercial. The need for this exclusion goes a short way in indicating that that use would otherwise be commercial for the purposes of these regulations.

167. More significant is the fact that although the Claimant's boats are not most naturally to be described as being in commercial use they are naturally described as being workboats. The purpose of the Workboat Regulations does appear to be to provide a comprehensive regime for such boats. If boats used by fire and rescue services are not within the scope of the Workboat Regulations then a significant category of workboats would fall outside the regulatory regime. There would not appear to be any rational basis for such an exclusion which would detract from the comprehensive regime which the Act and the regulations are seeking to create.

168. A further factor is that although it is not the most natural reading of "commercial use" the reading of those words as connoting a distinction between use by a business or organization including a public agency such as the Claimant for its purposes and use by the owners of a vessel for their own sport or pleasure is a reading which is possible as a matter of the meaning of the words. It follows that the reading for which the MAIB contend and which serves best the purpose of the legislation is not an impossible or artificial reading although it is not the most natural one.

169. I am satisfied that the proper interpretation of "in commercial use" is to be derived from the context in which those words are used. Although the point is finely balanced I have concluded that when proper regard is had to that context and to the purpose of the Act and of the Workboat Regulations the words have a wider meaning than would otherwise be the case and that they extend to the use of workboats by a fire and rescue service.

170. The consequence is that the Workboat Code did apply to the Claimant's boats and both the MAIB and the Defendant proceeded on a correct understanding of the law such that there was no error of law on the part of the Defendant and this ground also fails.

Conclusion.

171. Thus each of the grounds advanced has failed and the claim is to be dismissed.