Neutral Citation Number: [2025] EWHC 1672 (Admin)

Case No: AC-2024 LON-002129

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 3 July 2025

Before:

LORD JUSTICE JEREMY BAKER
and
MR JUSTICE BUTCHER

- -

Between:

His Majesty's Senior Coroner for West Yorkshire (Western District)	**Claimant**
- and -	
(No Defendant Being Named)	**Defendant**

- -
- -

Ms Alison Hewitt (instructed by **City of Bradford Metropolitan District Council's Legal Department**) for the **Claimant**

Hearing date: 1 July 2025

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Approved Judgment

This judgment was handed down remotely at 2.00 pm on 3 July 2025 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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LORD JUSTICE JEREMY BAKER

Lord Justice Jeremy Baker and Mr Justice Butcher:

Introduction

1. The Claimant is the Senior Coroner for West Yorkshire (Western District).

2. The claim is brought under section 13(1)(b) of the Coroners Act 1988, as amended, ("the 1988 Act"), with the fiat of the Attorney General dated 15 May 2024, for an order that:

   (i) the determination and findings of the investigation and inquest held into the death of Leonardo Pronesti be quashed and

   (ii) the Claimant do conduct a fresh investigation and hold a fresh inquest into the death.

3. By an order dated 30 January 2025, May J granted permission to the Claimant to file the Part 8 claim form without naming a defendant, pursuant to CPR Part 8 r.8.2A(3)(4) and CPR Part 3 r.3.1(2)(m).

4. Moreover, the time for service of the claim form required by 49EPD.20.3(3) having expired, the time for service of the claim form was extended to 13 February 2025, pursuant to the court's power under CPR Part3.2(a).

Chronology

5. The Deceased, (formerly known as Liam Christopher Shaw, who had changed his name by deed poll to Leonardo Pronesti), was born on 17 February 1996. He was therefore, 21 years of age when he died, on 25 December 2017.

6. The Deceased had a history of mental health difficulties and self-harm with suicidal ideation. He had been under the care of mental health services, intermittently, since the age of 15 years. During this period, he suffered anxiety and depression and some psychosis, including paranoid thoughts and hallucinations. He was also thought to have a personality disorder.

7. He was last seen by his community psychiatric nurse, on 3 July 2017.

8. On 21 December 2017, a package was left at the Ravensleigh Resource Community Mental Health Unit in Dewsbury. One of the nurses at the unit examined the package which was partly torn open, which permitted him to see the Deceased's name inside, together with documentation which, he was later to state, "*seemed likely to be indicators of suicidal ideation/preparation, although no suicide note*." As a result of this the nurse attempted unsuccessfully to contact the Deceased, following which he alerted the police, who indicated that they would make a welfare check at the Deceased's home, and local hospitals.

9. Later on 21 December 2017, the Deceased was admitted to Pinderfields Hospital in Wakefield with a suspected overdose of prescribed medication.

10. On 22 December 2017, the Deceased denied any suicidal intent and was discharged from hospital, with a referral back to the community mental health team.

11. On 25 December 2017, the Deceased's mother contacted the police as she was concerned that, contrary to previous arrangements which she had made with the Deceased to join her for Christmas Day, the Deceased had not attended at her home.

12. The police attended at the Deceased's home on 25 December 2017 in order to conduct a welfare check on the Deceased who was found hanging in the hallway with cuts to his wrists. He was pronounced dead at the scene.

13. On 27 December 2017, the Deceased's death was reported to the West Yorkshire (Western District) Coroner's Office.

14. On 29 December 2017, a post-mortem examination was carried out upon the Deceased by Dr Richard Knights, who considered that the medical cause of death was "*1a: Asphyxia (Hanging)*".

15. On 3 January 2018, an Inquest was opened concerning the Deceased's death, and over the following 6 months evidence was gathered for the purposes of the inquest. At some point during this period, the package of documents, which had been left at the mental health unit on 21 December 2017, was delivered to the coroner's officers' office in Bradford.

16. Unfortunately, this office was located at a different address to the Coroners, and although the file of evidence subsequently provided to the Assistant Coroner, who heard the inquest, contained various witness statements gathered during the course of the investigation, it did not contain the package containing the documents.

17. The Assistant Coroner heard the inquest on the 29 August 2018. He heard oral evidence from PC Nugent and from Mark Thornton, whilst the remainder of the evidence was read. It is apparent from the transcript of the inquest that there were some references to letters and envelopes, and some handwritten notes from the Deceased were placed before him. However, in his subsequent witness statement, the Assistant Coroner states that he did not appreciate that the package of documents existed and he made no enquiry concerning them.

18. As a result of this and on the basis of the evidence which was before him, the Assistant Coroner found and recorded in the Record of Inquest that,

> *"On 25 December 2017, Leonardo Pronesti was found hanging as a result of his own actions at his home address. He died as a result of asphyxiation caused by hanging but there was insufficient evidence to indicate that he intended to take his own life".*

19. Subsequently, on 13 December 2018, following an enquiry from the Deceased's family, the contents of the package of documents were located in a drawer in the coroner's officers' office in Bradford. When the package was opened it was found to contain hundreds of pages of the Deceased's notes, messages, letters, and drawings, which included many references to suicidal ideation.

20. On 21 February 2019, the documents were provided to the Assistant Coroner, who considered them. On 5 March 2019, he provided a written note to the effect that the

documents would have been relevant to his findings at the inquest and, had he taken account of them, he would probably have recorded a conclusion of suicide.

21. Following a meeting with the Deceased's mother and step-father (who, sadly, has subsequently died), the Claimant applied to the Attorney-General for a fiat to enable him to bring this claim. Although the application was made on 27 February 2020, the fiat was not granted until 15 May 2024. These proceedings were then issued on 24 June 2024.

The Legal Framework

22. The matters which are to be ascertained at an inquest are set out in section 5 of the Coroners and Justice Act 2009, ("the 2009 Act"), which provides:

> *"5 (1)The purpose of an investigation under this Part into a person's death is to ascertain— .*
>
> *(a) who the deceased was; .*
>
> *(b) how, when and where the deceased came by his or her death; .*
>
> *(c) the particulars (if any) required by the 1953 Act to be registered concerning the death. .*
>
> *(2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death. ..."*

23. In so far as section 5(2) of the 2009 Act is concerned, this reflects the requirement for an inquest to comply with the procedural obligation arising under Article 2 of the European Convention on Human Rights ("ECHR"), where the death resulted, or may have resulted, from an arguable breach of a substantive duty owed under Article 2.

24. In *Rabone v Pennine Care NHS Foundation Trust* [2012] 2 AC 72, it was established that where the Deceased was under the care of mental health services at or before the time of their death, but not in detention under the Mental Health Act, an operational duty may arise if there has been an assumption by the State of responsibility, the Deceased was sufficiently vulnerable, and there was a real and immediate risk of suicide.

25. In so far as the present proceedings are concerned, section 13 of the 1988 Act provides as follows:

> *"(1) This section applies where, on an application by or under the authority of the Attorney-General, the High Court is satisfied as respects a coroner either –*
>
> *(a) ...*

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

26. In relation to the exercise of the High Court's statutory powers under this section, in *Attorney General v HM Coroners for South Yorkshire (West) and West Yorkshire (West)* [2012] EWHC 3783 (Admin) the Lord Chief Justice at [10] stated that,

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

27. Furthermore, in *In the Matter of the Inquest into the Death of Michael Vaughan* [2020] EWHC 3670 (Admin), Coulson LJ emphasised that a fresh inquest may be ordered if

the Court considers that it is either necessary or desirable (or both) for a fresh inquest to be held, that "*desirability*" is more easily achieved than "*necessity*", and that the question of desirability will be influenced by the extent to which the deceased person's family would like a further investigation to be conducted.

Grounds of Claim

28. The Claimant submits that there has been an insufficiency of inquiry and/or a procedural error and/or the discovery of new facts and evidence in relation to the inquest carried out by the Assistant Coroner and that it is necessary and/or desirable, in the interests of justice, for another investigation and inquest to be held.

29. In support of this claim, the Claimant relies upon the following matters:

    i. The documents which had been left at the unit on 21 December 2017 were not before the Assistant Coroner when he held the inquest and reached and recorded his findings of fact and his conclusion.
    ii. The documents are relevant to the Deceased's state of mind and intentions in late December 2017. The Assistant Coroner has indicated that their contents would have been relevant to his conclusion as to the death and the question of whether the Deceased died as a result of suicide and, given their content, this may be thought to be self-evident.
    iii. Further, the documents give rise to issues which ought to have been, but were not, investigated and it may be that the evidence, taken as a whole, caused the procedural duty under Article 2 of the ECHR to be engaged.
    iv. Accordingly, the requirements of section 5 of the 2009 Act, and the requirements of the procedural duty arising under Article 2 of the ECHR, may not have been met.

30. In these circumstances, it is submitted that this court should quash the determination and findings of the Assistant Coroner in relation to the death of the Deceased, and order the Claimant to conduct a fresh inquest into his death.

The views of those directly affected by the application

31. In accordance with para. 20.3 of Practice Direction 49E, the Claim Form together with the Hearing Bundle was served upon the following persons, as "*persons directly affected by the application*"

    i. The Deceased's Mother, Angela Pronesti,
    ii. South West Yorkshire Partnership NHS Foundation Trust, being the Trust responsible for the Ravensleigh Resource Community Mental Health Unit and Pinderfields Hospital, and
    iii. West Yorkshire Police.

32. Initially, the Deceased's mother was understandably reluctant for a further inquest to be held but, having been spoken to more recently, she now supports the application for

a further inquest taking place, indicating that she wanted those involved to be accountable for "*not looking after her son better*".

33. Moreover, both the South West Yorkshire Partnership NHS Foundation Trust and West Yorkshire Police have taken a neutral stance to the application.

Discussion

34. It is clearly most regrettable that the Assistant Coroner was not provided with the package of documents which was left, presumably by the Deceased, at the Ravensleigh Resource Community Mental Health Unit on 21 December 2017.

35. We have been provided with copies of the documents which, on their face, appear to reflect clear suicidal ideation on the part of the Deceased, such that they were obviously relevant to the Assistant Coroner's inquiry. In these circumstances, we can well understand the view expressed by the Assistant Coroner, both in his initial note and as confirmed in his witness statement dated 20 October 2019, that had he been provided with the documents during the course of the inquest, he would probably have recorded a conclusion of suicide.

36. Furthermore, if this had been the conclusion which he reached, it is arguable that section 5 of the 2009 Act would have required the Assistant Coroner to have considered whether and to what extent both the South West Yorkshire Partnership NHS Foundation Trust and the West Yorkshire Police had complied with an operational duty owed to the Deceased to protect his life under Article 2 ECHR.

37. In this regard, it is arguable, given the nature of the indication which those receiving the package gained about the unopened contents of the package, that the documents ought to have been investigated further at that time, in order for those at the unit to have been in a better position to have assessed the level of risk to the Deceased's life. This in turn may have influenced the steps which were necessary to seek to locate the Deceased and to share the information more widely with other properly interested parties. In any event, the actions taken both by the police, and those responsible for the Deceased's care at the Pinderfields Hospital, is likely to require examination in order to assess their adequacy.

38. In these circumstances, not only do we consider that it is necessary, in the interests of justice, that another investigation into the death of the Deceased should be held, but bearing in mind the current indication from the Deceased's mother, it is clearly desirable that a further investigation takes place.

Conclusion

39. Accordingly, as there are no contrary submissions from either of the other parties directly affected by the application, we will grant the application, quash the determination of the Assistant Coroner and findings of the investigation and inquest held into the death of the Deceased, and order the Claimant to conduct a fresh investigation and hold a fresh inquest into the death of the Deceased, under Part 1 of the 2009 Act.

40. We would add only two matters. Firstly, to record our gratitude for the clarity of the submissions which were made by Alison Hewitt on behalf of the Claimant. Secondly, to record our concern about the delay which was occasioned by the Attorney-General in granting the fiat in this case, which we anticipate will not only have caused further unnecessary anxiety to the Deceased's family, but may have an adverse impact on the quality of the evidence available to those responsible for conducting the fresh investigation and fresh inquest into the death of the Deceased. In these circumstances, a copy of this judgment will be sent to the Attorney-General.