



Neutral Citation Number: [2024] EWHC 3261 (Admin)

Case No: AC-2024-LON-002003

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

In the matter of an application under section 13 of the Coroners Act 1988

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 12/12/2024

Before :

LADY JUSTICE ANDREWS
MRS JUSTICE FARBEY

Between :

ELIAS CHERFAN
- and -
HIS MAJESTY'S SENIOR CORONER FOR
WEST LONDON

Applicant

Respondent

Sebastian Naughton (instructed by **Wedlake Bell LLP**) for the Applicant
Nikita McNeill (instructed by **Legal Services, Hammersmith and Fulham Council**) for the
Respondent

Hearing date: 12 December 2024

Approved Judgment

MRS JUSTICE FARBEY:

Introduction

1. The applicant is the father of Marc Antony Cherfan who died in his home in West London on around 4 October 2022. The respondent held an inquest touching on Marc's death on 14 July 2023, concluding that he died as a consequence of suicide. The applicant applies under section 13 of the Coroners Act 1988 ("the 1988 Act"), with the fiat of the Attorney-General, for an order quashing the Record of Inquest. He seeks a fresh investigation and inquest before a different coroner. We extend our condolences to the applicant and to other members of Marc's family for their sad loss.
2. The facts are not in dispute. They are fully set out in the witness statement of Andrew Dixon O'Keefe who is the applicant's solicitor. Marc was born on 3 November 1983. He had a long history of mental health problems and had received diagnoses of schizoaffective disorder, bipolar disorder and dissocial personality disorder. He had been admitted to hospital as an inpatient on a number of occasions. He took a number of prescribed drugs which, at the time of his death, included pregabalin.
3. On 4 October 2022, after the applicant had become worried, a locksmith gained entry to Marc's home followed soon afterwards by the police. Marc was found lying dead on the living room floor. A post-mortem report by a consultant histopathologist, Dr Hiam Ali, noted a "very high" concentration of pregabalin in Marc's blood, which was "well within the ranges encountered in fatalities attributed to excessive pregabalin use." Marc had suffered a subdural haemorrhage. Dr Ali concluded that the primary cause of death was the fatal pregabalin overdose which had caused Marc to collapse and suffer haemorrhage as a secondary cause of death.
4. By an email sent on 4 January 2023 on behalf of the respondent, the applicant and Marc's aunt Noha Hagggar were informed that an inquest was due to be opened at West London Coroner's Court. The applicant and Ms Hagggar were asked to send any concerns about Marc's death in writing as soon as possible. The email stated that they would be contacted again when the respondent was in a position to "proceed to inquest."
5. On behalf of Marc's family, Ms Hagggar replied by email on 6 January 2023. Her email made plain that the family were in no doubt that the overdose was accidental and stated: "We do not see the point of an inquest at this point. Marc is gone and nothing will bring him back." An inquest was opened on 10 January 2023.
6. By email to the applicant, Ms Hagggar and Marc's sister dated 3 March 2023, the respondent's Office requested a "background statement" from a family member or friend to enable the respondent to "see [Marc] as a person." No statement was provided and the family made no further contact with the respondent.
7. On 14 July 2023, an inquest hearing was held. No one other than the respondent was in court. A transcript of the hearing shows that the respondent gave a ruling in which she set out some of Marc's medical history and summarised the post-mortem report.
8. There is no mention in the ruling that the family believed that Marc's death was the result of an accidental overdose. The following findings were made:

“Medical cause of death, fatal pregabalin overdose, 2 marked subdural haemorrhage. How, when and where, found deceased at home... He had a long history of mental ill health and had been engaging with mental health services for many years. Given that this man indeed engaged with mental health services and had been on a variety of drugs for many years, I consider that he would have known the appropriate dose of pregabalin but chose to take a very substantial overdose which took his life. I therefore conclude that he would have understood the consequences of his actions and his death was therefore a consequence of suicide.”

The Record of Inquest states “suicide” as being the respondent’s conclusion as to death.

9. In subsequent correspondence, the respondent’s Office informed the applicant’s solicitors that the respondent had decided to hold an inquest in writing because the family had in correspondence stated that they did not see the point of an inquest. The inquest in writing had had to be converted “at the last moment” to a “rule 23” inquest as the “automatic documents generated by the Coronial system [had not populated] correctly.” In other words, the IT system in the respondent’s Office had failed. The respondent confirmed that the date and time of the inquest had been published online but the family had not been informed.
10. A letter before claim followed on 11 December 2023, highlighting procedural errors by the respondent. The respondent’s Office Manager responded by email on 23 January 2024, indicating that there was no objection to a section 13 application on grounds of procedural irregularity but saying that it was less clear whether there would be a different result if the inquest were reheard. The respondent proposed to adopt a neutral stance.
11. The Attorney-General signed the fiat on 22 May 2024. The present application was lodged on 10 June 2024.

The court’s powers

12. Section 13 of the 1988 Act provides, so far as material, 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 (‘the coroner concerned’) either

—
(a) that he refuses or neglects to hold an inquest or an investigation which ought to be held; or

(b) where an inquest or an investigation has been held by him, that (whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise) it is necessary

or desirable in the interests of justice that an investigation (or as the case may 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 of and incidental to the application as to the court may appear just; and

(c) where an inquest has been held, quash any inquisition on, or determination or finding made at that inquest.”

13. The principles governing the application of section 13 are well-established. In *Sutovic v HM Coroner for Northern District of Greater London* [2006] EWHC 1095 (Admin), the Divisional Court held at para 54:

“The power contained in section 13(1)(b) [is] stated in very broad terms. The necessity or desirability of another inquest may arise by reason of one of the listed matters ‘or otherwise’. Notwithstanding the width of the statutory words, its exercise by courts shows that the factors of central importance are an assessment of the *possibility* (as opposed to the probability) of a different verdict, the number of shortcomings in the original inquest, and the need to investigate matters raised by new evidence which had not been investigated at the inquest...”

14. In *Attorney General v Coroner of South Yorkshire (West)* [2012] EWHC 3783 (Admin), Lord Judge CJ considered the correct approach to section 13 and held at para 10:

“...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 precondition 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.”

15. On any application for a further inquest the court will always give considerable weight to the views of the family involved (*The Inquest Into The Death Of Michael Richard Vaughan* [2020] EWHC 3670 (Admin), para 10, per Coulson LJ).

Coronial procedures

16. Section 9C of the Coroners and Justice Act 2009 (“the 2009 Act”) makes provision for inquests without a jury to be conducted either at a hearing or, if the senior coroner decides that a hearing is unnecessary, in writing. Pursuant to section 9C(2), the senior coroner is not to decide that a hearing is unnecessary unless:

“(a) the coroner has invited representations from each interested person known to the coroner,

(b) no interested person has represented on reasonable grounds that a hearing should take place,

(c) it appears to the coroner that there is no real prospect of disagreement among interested persons as to the determinations or findings that the inquest could or should make, and

(d) it appears to the coroner that no public interest would be served by a hearing.”

17. In Revised Guidance No 29 (dated 28 June 2022), which deals with Inquests in Writing and Rule 23 Evidence, the Chief Coroner states that there are many “straightforward and uncontentious cases” in which a hearing in writing might be appropriate. The Guidance gives a number of examples of cases that may be suitable for a written procedure, including “suicides in the community where the events are clear.” However, the Guidance reminds coroners that, in order for an inquest in writing to take place, the coroner must both invite representations from each interested person and “consider that there is no real prospect of disagreement as to the inquest’s determinations or findings” (para 7).

18. The Guidance stipulates that:

“10. If a coroner considers that an inquest in writing may be suitable in a particular case, the coroner should open the inquest in the usual way and adjourn it pending consideration of the form the inquest should take.

11. The coroner should notify the interested persons that the coroner is considering holding an inquest in writing, as there is clear evidence of who the deceased is, when and where he or

she died and how the death came about, and there appears to be no real prospect of disagreement as to the determination, findings or conclusion that the inquest should make. The coroner should tell the interested persons that if they are not content for the inquest to be held in writing, they need to write to the coroner requesting a hearing and explaining why one is needed.”

19. The same Guidance reminds coroners that rule 23 of the Coroners (Inquests) Rules 2013 (“the Rules”) allows written evidence to be admitted at an inquest hearing if certain conditions are met. The Guidance states that coroners can conduct an inquest hearing in a courtroom by admitting written evidence in the form of what the Guidance calls a “documentary” hearing. Such a hearing is not the same as an inquest in writing.
20. If a hearing is to take place, rule 9(1) of the Rules provides that a coroner must notify the next of kin of the deceased of the date, time and place of an inquest hearing within one week of setting the date. That provision is mandatory.

The parties’ submissions

21. On behalf of the applicant, Mr Naughton submits that there has been an “irregularity of proceedings” within the meaning of section 13(1)(b) on two principal grounds. First, the inquest hearing was conducted without giving notice to the applicant as required by rule 9. The importance of informing Marc’s family about the inquest was such that it was necessary or desirable in the interests of justice that another investigation should take place.
22. Secondly, the original decision to hold an inquest without a hearing breached section 9C(2) of the 2009 Act and the Guidance because the respondent had not notified the family, as interested persons, that she was considering holding an inquest in writing. She had breached section 9C(2)(a) and paragraphs 7 and 11 of the Guidance because she had not invited representations from the family about whether a hearing was unnecessary. She had breached section 9C(2)(c) and paragraph 7 of the Guidance because she had failed to consider the family’s position that Marc had died of an accidental overdose. It could not, therefore, reasonably have appeared to her that there was no real prospect of disagreement among interested persons as to the determinations or findings that the inquest could or should make.
23. On behalf of the respondent, Ms McNeill accepted that the inquest hearing proceeded in breach of rule 9 and that this amounted to a procedural irregularity for the purpose of section 13(1)(b). Other than that, Ms McNeill said that the respondent adopted a neutral approach.

Discussion

24. The original decision to hold an inquest in writing was procedurally flawed because it failed to take into consideration the family’s view that Marc died not as a consequence of suicide but by accidental overdose. The respondent had not invited representations from the family who were plainly interested persons and, in light of the correspondence setting out the family’s view, it could not reasonably have

appeared to the coroner that there was no real prospect of disagreement among interested persons as to the determinations or findings that the inquest could or should make. I agree with Mr Naughton that the respondent breached both section 9C(2)(a) and (c) of the 2009 Act and also the relevant provisions of the Guidance.

25. The irregularity of proceedings was then compounded by the respondent's decision to hold an inquest hearing, albeit on the documents, because of a fault in the IT system in her Office. It was not open to her to hold a hearing without following the provisions of rule 9 to give notice to the applicant. That Ms Haggar had informed her that the family did not want an inquest did not mean that the respondent was free to bypass the mandatory terms of rule 9. That there was no "background statement" from a family member or friend made no difference: rule 9 still applied.
26. Ms McNeill was in my judgment correct to concede both the breach of rule 9 and that it amounted to a procedural irregularity. The importance of giving notice of a hearing, as reflected by the mandatory nature of rule 9, makes it necessary in the interests of justice for this court to grant relief.
27. It is possible that a different conclusion about Marc's death may be reached at a fresh investigation and inquest. There is some evidence which a coroner may find amounts to evidence of accidental overdose. The positioning of staining consistent with blood staining close to Marc's sitting room window may suggest that he went towards the window to seek help from someone outside. A line of cannabis on a table may suggest that he was planning some form of activity after he had consumed his prescribed medication. There was a blood stained cushion cover in the washing basket in the utility room which may suggest that he planned to do his washing. Marc's GP had recorded in mid-July 2022 that he had no thoughts of self-harm or suicide. I emphasise that it is not for this court to reach any conclusions about these strands of the evidence. The coroner will wish to consider these factors and the evidence that the applicant has now provided about Marc's personality and situation prior to his death.

Costs

28. As to costs, the respondent has appeared today in a neutral capacity. Ms McNeill reminded us of the established approach that this court will not generally make a costs order against a coroner who appears before the court in a neutral capacity and submits that there is no good reason to depart from that general rule. There was in the present case no new evidence and no indication that the evidence previously read under rule 23 is now disputed. She submits that it was reasonable for the respondent to allow the court to determine whether the test in section 13 is met.
29. The question of the award of costs against coroners was considered in *R (Davies (No 2)) v HM Coroner for Birmingham* [2004] EWCA Civ 207, [2004] 1 WLR 2739. Brooke LJ reviewed the case law and summarised the approach to be taken at para 47 of his judgment:

“... (1) the established practice of the courts was to make no order for costs against an inferior court or tribunal which did not appear before it except when there was a flagrant instance of improper behaviour or when the inferior court or tribunal

unreasonably declined or neglected to sign a consent order disposing of the proceedings; (2) the established practice of the courts was to treat an inferior court or tribunal which resisted an application actively by way of argument in such a way that it made itself an active party to the litigation, as if it was such a party, so that in the normal course of things costs would follow the event; (3) if, however, an inferior court or tribunal appeared in the proceedings in order to assist the court neutrally on questions of jurisdiction, procedure, specialist case law and such like, the established practice of the courts was to treat it as a neutral party, so that it would not make an order for costs in its favour or an order for costs against it whatever the outcome of the application; (4) there are, however, a number of important considerations which might tend to make the courts exercise their discretion in a different way today in cases in category (3) above, so that a successful applicant ... who has to finance his own litigation without external funding, may be fairly compensated out of a source of public funds and not be put to irrecoverable expense in asserting his rights after a coroner, or other inferior tribunal, has gone wrong in law, and where there is no other very obvious candidate available to pay his costs.”

30. The now familiar *Davies* approach does not lay down cast iron rules. It recognises that a successful applicant may recover costs if the coroner has gone wrong in law and if the applicant has had to fund the proceedings from his own resources.
31. In the present case, there has been an admitted breach of a mandatory provision of the Rules. There has been a breach of section 9C of the 2009 Act and a failure to follow the Chief Coroner’s Guidance. While I appreciate the pressure of work on coroners, all of this ought to have been obvious to the respondent. It would, in the particular circumstances of this case, be unjust for the financial burden to fall entirely on the applicant.

Conclusion

32. For these reasons, I would allow the application. If My Lady agrees, I would quash the Record of Inquest and would quash the findings and conclusions at the inquest. I would order a fresh investigation and a fresh inquest before a different coroner.
33. I would order the respondent to pay a contribution towards the costs of the application in the sum of £20,000 which, in the absence of a comprehensive costs schedule from the applicant, is in my judgment the just course under section 13(2)(b).

LADY JUSTICE ANDREWS:

34. I agree.