R (Maughan) v HM Senior Coroner for Oxfordshire

Supreme Court confirms that Coroners' Inquests shall apply the lower civil standard of proof to all forms of Inquest conclusions of suicide and unlawful killing

In this long-running Judicial Review challenge, the Supreme Court has confirmed that the civil standard of proof applies to all Coroners' Inquest suicide conclusions (whether short-form or narrative form), and went further by stating that the civil standard of proof shall also apply to all forms of unlawful killing conclusions.

Unlawful killing includes murder, manslaughter and infanticide, so the lower standard of proof for unlawful killing will be of interest to those considering corporate manslaughter issues. This decision is also relevant to insurers handling life policy claims (where there is often a suicide exclusion for the first year of insurance cover) and accidental death benefit claims under PA policies.

It is hoped that the outcome in ***Maughan*** will assist with more accurate statistics and promote the modern purpose of Inquests that includes - through a fact-finding exercise - learning lessons from a person's untimely death, in order to seek to reduce the risk of those types of deaths in the future. Unlike the Court of Appeal in May 2019, the Supreme Court was not bound by previous Court decisions. Therefore, in a 3-2 majority decision of 13 November 2020 in ***R (on the application of Maughan) v HM Senior Coroner for Oxfordshire*** [2020] UKSC 46, the Supreme Court also took the bold step of lowering the standard of proof for unlawful killing conclusions.

This Judgment represents a change to the law, which was stated in the footnote - **"Note (iii)"** - of the mandatory **Form 2** that is used to record the result of an Inquest in England & Wales. The lower standard of proof may lead to an increase in the number of recorded suicide and unlawful killing conclusions, and less open conclusions.

A key issue in this case was the status of **Note (iii)** of **Form 2** - did it simply set out the understanding of the law from Court Judgments (referred to as 'common law') at that time so that the Courts

remained free to change it or did it codify the law in legislation, so that new legislation was needed to change it?

Due to the wide-ranging and important implications of the issues being considered, the Chief Coroner of England and Wales and INQUEST (a charity with expertise in state-related deaths and their investigation) were given permission to make representations in the May 2019 Court of Appeal case, as well as the Supreme Court case.

The Purpose of a Coroner's Investigation

A Coroner is involved when there is reason for him/her to suspect that the deceased died a violent or unnatural death; the cause of death is unknown or the deceased died while in custody or otherwise in state detention (Section 1 (2) Coroners and Justice Act 2009) (the **"2009 Act"**).

The purpose of a Coroner's investigation is to establish the 'who, how, when and where' the deceased came by his or her death, so that the Record of Inquest (mandatory **Form 2** which is contained in the Schedule to the Coroners (Inquests) Rules 2013 (the **"2013 Rules"**) can be completed for registration of death purposes.

Sometimes the Coroner's role covers 'in what circumstances' the deceased came by his or her death in order to comply with the state's obligations under the European Convention on Human Rights (**Article 2** - which concerns protection of the right to life), for example, when a person dies while in state custody, as was the case in **Maughan** which concerned a death while in prison.

Inquests are not criminal proceedings. As stated in ***R v South London Coroner, ex parte Thompson*** (1982):

> *"An inquest is a fact-finding exercise and not a method of apportioning guilt … In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation".*

Short-form and Narrative Conclusions

Coroners' Inquests can be concluded by way of a short-form conclusion and/or narrative conclusion. **Form 2** in the Schedule to the **2013 Rules** lists nine options for a short-form conclusion e.g. 'natural

causes', 'accident or misadventure', 'open', 'suicide' and so on. Where a narrative conclusion is used on its own or in addition to a short-form conclusion, the narrative conclusion will typically be factual and neutral. However, when **Article 2** convention issues arise (such as when the person has died while in prison) then the narrative conclusion can be judgmental in nature. This is consistent with one of the modern purposes of Inquests being to learn lessons from the person's death.

Note (iii) of Form 2 – Record of Inquest

On 25 July 2013, rules on the practice and procedure for Inquests carried out as part of an investigation into a death came into force. These are described here as the **2013 Rules**, and were made due to the power in Section 45 of the Coroners and Justice Act 2009 – the primary legislation on Coroners' Inquests.

Schedule 1 contains a mandatory form (**Form 2**) for recording the Inquest findings and conclusion (previously known as the verdict).

Note (iii) to **Form 2** states:

> *"The standard of proof required for the short form conclusions of 'unlawful killing' and 'suicide' is the criminal standard of proof. For all other short-form conclusions and a narrative statement the standard of proof is the civil standard of proof".*

The status of **Note (iii)** came under scrutiny in this case, as referred to below.

Facts of Maughan

Mr Maughan's brother died whilst in prison in July 2016. Early one morning, he was found hanged in his cell. Therefore, Article 2 Convention considerations arose during the Inquest.

Two elements must be established before reaching a conclusion of suicide: first it must be shown that the deceased took his own life and secondly that he intended to kill himself.

At the Inquest, the Coroner was of the view that there was insufficient evidence to enable a jury to be sure, beyond reasonable doubt, that he had intended to take his own life. Therefore, the Senior Coroner for Oxfordshire directed the jury to address five questions and to respond in a narrative conclusion, applying the civil 'on the balance of probabilities' standard of proof.

The five questions were closely modelled on the approach in the Chief Coroner's Guidance and the Coroner Bench Book, at that time, which provide guidance on the use of words in an Inquest. These questions included:

- Whether it is more likely than not that he intended the outcome to be fatal, or, for example, if it was likely that he intended to be found and rescued? And whether the deceased was unable to form a specific intent to take his own life through mental illness?

- Whether there were errors or omissions on the 10-11 July 2016 in the provision of care on the part of prison staff which caused or contributed to his death? If so, what those errors/omissions were and how they contributed to his death.

The jury's conclusion was that it was more likely than not that he intended the fatal outcome and that increased vigilance would not have prevented his death.

The deceased's brother regarded the Inquest conclusion as unlawful because the civil standard (rather than the criminal standard) was used to reach the view that the deceased had intended to kill himself. The deceased's brother therefore started a Judicial Review Court case seeking to quash the jury's conclusion that his brother intended to kill himself, and challenging the direction that the Coroner gave to the jury to apply the civil standard of proof.

It appears that the Coroner regarded himself as having followed **Note (iii)** of **Form 2** and the guidance at that time.

Earlier Court Judgments

The first Judgment (of the Divisional Court) of July 2018 dismissed the brother's claim, stating that the standard of proof to be applied in cases of suicide, for narrative conclusions as well as short-form conclusions, was the civil standard of 'on the balance of probabilities', and that earlier Court cases had not correctly stated the law.

The brother appealed, and at this point the Chief Coroner and the charity, INQUEST, were given permission to take part in the Court case, given the potentially wide ramifications. The Chief Coroner's role was a neutral one, in which he assisted by providing information on the pros and cons.

The charity, INQUEST, submitted views to the Court of Appeal that the standard of proof at an Inquest should be the same for unlawful killing and suicide, and that a higher criminal standard of proof for issues of unlawful killing at Inquests was not justified. One aim of the charity is to ensure Inquests hold state agents to account and better identify wrongdoing.

In May 2019, the Court of Appeal dismissed the brother's appeal. The three Court of Appeal Judges were unanimous in confirming that the civil standard of proof should apply to both short-form and narrative conclusions on suicide.

The Court of Appeal also considered the ***McCurbin*** case which involved an unlawful killing Inquest conclusion following death in the course of police arrest that had not been discussed in the July 2018 Judgment. In ***McCurbin*** [1990] 1 WLR 719, the applicable standard of proof for unlawful killing was regarded as the criminal standard of 'beyond all reasonable doubt'.

Overall, the Court of Appeal commented that unlawful killing should remain on the criminal standard of proof. However, it did not necessarily agree that that ought to be the outcome, as it could see a powerful argument that the same civil standard of proof should apply to both suicide and unlawful killing conclusions, and considered that a statutory review of the **2013 Rules** would be preferable to avoid future debate on unlawful killing Inquest cases.

Supreme Court Judgment

However, the deceased's brother made a further appeal and on 13 November 2020, the Supreme Court reached a majority 3-2 Judgment, dismissing the appeal and going further in relation to unlawful killing.

In summary, the overall outcome was that the lower civil standard of proof applies to all forms of Coroners' Inquest conclusions (regardless of whether it is short-form and/or narrative form) and the civil standard applies in respect of all outcomes including suicide and now unlawful killing.

This decision was possible because the Supreme Court was not bound by the earlier Court of Appeal Judgment of ***McCurbin***, which is now overruled.

The leading Judgment was given by Lady Arden (with whom Lord Wilson agreed) and Lord Carnworth provided some additional comments of his own on the effect of the **2009 Act**, the purpose of Coroners' Inquests and the status of **Note (iii)**.

The main reasoning provided by Lady Arden was as follows:

The change in the nature of Inquests and the recent use of narrative conclusions

Lady Arden acknowledged that the nature of Inquests had changed. Longer, more judgemental narrative conclusions were relatively new, and arose from the transformation from being a traditional inquiry into a suspicious death to a modern investigation, which was to elicit facts about what happened and in appropriate cases (such as **Article 2** convention cases e.g. where a death has occurred while in state care) to identify lessons to be learnt for the future.

Lady Arden noted that one of the Chief Coroner's roles was to provide guidance to Coroners by issuing Guidance and the Coroner Bench Book, but the **2009 Act** did not attribute any particular status to these. Lady Arden referred to the Chief Coroner's **Guidance No. 17 on conclusions** dated 14 January 2016 and, in particular, paragraph 62, which addresses a possible explanation a Coroner sitting without a jury might give where the Coroner considers that suicide is not established to the criminal standard of proof:

> *"Looking at the two elements which must be proved to the higher standard of proof before a conclusion of suicide can be recorded, I am satisfied that [the deceased] took his own life, but I am not satisfied that he intended to do so. I cannot be sure about it. It is in my judgment more likely than not that he had that intention, but on the evidence looked at as a whole I cannot rule out that this was a terrible accident. For those reasons my conclusion is not suicide or accident but an open conclusion".*

Standard of proof and status of **Note (iii)** to **Form 2**

The **2009 Act** did not stipulate the standard of proof for Inquest conclusions (and neither did the Convention require any particular standard of proof). Whilst there were previous Court cases to the effect that conclusions of suicide and unlawful killing should be reached on the criminal standard, Lady Arden stressed that Inquests are not criminal proceedings. She noted that the **2013 Rules** were

made using the Section 45 power in the **2009 Act**, and for the first time these Rules prescribed a particular form to use for the Record of Inquest (**Form 2** which is in the Schedule to the **2013 Rules**). This form contained a footnote – **Note (iii) -** which is set out above.

Lady Arden considered whether **Note (iii)** *"simply declares the common law position in a convenient form or whether it goes further and codifies the common law rules and makes them mandatory in this form so as to remove them from the reach of the courts when considering the true state of the common law"*.

Lady Arden then referred to the fact that the Ministry of Justice ("**MOJ**") conducted a public consultation on the draft **2013 Rules**, and in the **MOJ** response dated 4 July 2013 it recorded:

> *"As the requirement to use the criminal standard of proof when returning a suicide verdict is established under case law rather than coroner legislation we cannot take forward a change in the law through secondary legislation flowing from the **2009 Act**. However the Chief Coroner and the **MOJ** are considering the views expressed on this issue."*

It had earlier been established as at 2019 that there was no active review on the standard of proof to be used. Lady Arden regarded the contents of the **MOJ** consultation paper and response as capable of being referred to when the Supreme Court Judges were interpreting the meaning of the words in the **2013 Rules**, and she commented that this pointed to case law determining the law in this area.

Whilst acknowledging that a footnote to a schedule in legislation could be the means by which Parliament could change the law, Lady Arden distinguished the facts of a case in 1990, where this had occurred, from the circumstances in ***Maughan***. Therefore, overall Lady Arden reached the conclusion that **Note (iii)** *"set out the common law {arising from Court Judgments} as at the date of the **2013 Rules** and did not exclude the power of the courts to develop the common law".* The Courts had not had the opportunity of considering the standard of proof for narrative conclusions at that point, and therefore in her view, the drafter of **Note (iii)** simply deduced that the general principle was that, in civil proceedings, the civil standard of proof applies.

As **Note (iii)** was written in the present tense, this also supported the interpretation that it simply set out the 'common law' position at that time.

Finally, Lady Arden referred to the presumption in statutory interpretation that:

> *"… it is a principle of legal policy that law should be altered deliberately rather than casually, and that Parliament should not change either common law or statute law by a sidewind, but only be measured and considered provisions"* (Bennion on Statutory Interpretation)

and commented that *"to hold that Parliament had set down the standard of proof in note (iii) would in my judgment be inconsistent with this presumption".*

On the key issue as to what is the correct standard of proof for a short-form conclusion of suicide, Lady Arden referred to four points:

- <u>The decision needs to be decided on the basis of legal principle</u>

  Lady Arden stated that *"the principle is clear and it is that in civil proceedings the civil standard of proof shall apply"*.

- <u>Use of the higher criminal standard of proof may lead to suicides being under-recorded and to lessons not being learnt</u>

  The comments in this part of the Judgment are particularly relevant to life insurers. Acknowledging that the reasons for suicide are often complex, Lady Arden stressed that *"Society needs to understand the causes and to try to prevent suicides occurring. Statistics are the means whereby this can be done. If a criminal burden of proof is required, suicide is likely to be under-recorded. This is especially worrying in the case of state-related deaths. If there is an open verdict because the criminal standard of proof cannot be achieved, the circumstances of the case have to be analysed before it can be included in any statistics to show the true number of suicides. There is considerable public interest in accurate suicide statistics as they may reveal a need for social and medical care in areas not previously regarded as significant. Each suicide determination can help others by revealing how suicide risks may be managed in future"*. While Lady Arden acknowledged that to some extent policymakers and researchers can seek to mitigate the under-recording of cases by examining cases of open conclusions, they may not be

able to do so accurately and she concluded that *"lowering the standard of proof would be a more satisfactory way of getting accurate figures"*.

- <u>The changing role of Inquests and changing societal attitudes and expectations confirmed the need to review the standard of proof in cases of suicide</u>

  Inquests are concerned with the investigation of deaths, and not with criminal justice. Lady Arden considered that the time was right for accepting the lower standard of proof. She noted that there had been significant changes both in legislation and in society's understanding and attitude towards suicide. Suicide was considered a crime up until 1961, when this was abolished by the Suicide Act 1961; although, it remains a crime for a person to encourage or assist another person to commit suicide (Section 2 of the Suicide Act 1961).

  It has long been recognised in negligence cases against hospitals that it is not contrary to public policy to award compensation to bereaved family members of the deceased in cases of suicide.

- <u>Leading Commonwealth jurisdictions have applied the civil standard to suicide conclusions</u>

  Finally, looking to the approach taken in other jurisdictions, it was pointed out that Courts in Canada, New Zealand and Australia have sought to align the evidential standard in Inquests to that which applies to Civil Court cases. Academic discussion about this trend in Commonwealth jurisdictions dated back to the early 1990's.

On the final issue as to whether the criminal standard of proof should be retained for unlawful killing, the Supreme Court, in its majority Judgment, regarded it as beneficial for the standard of proof for all short-form conclusions at an Inquest (i.e. including unlawful killing and suicide) to be 'on the balance of probabilities' (the civil standard of proof). Lady Arden stated that "*the short form conclusions of unlawful killing and suicide cannot satisfactorily be distinguished with respect to the standard of proof*."

Whereas it used to be the duty of the Coroner's jury where they found that the death was murder, manslaughter or infanticide, to state the name of the person considered to have committed the offence or of being an accessory, this was prevented by Section 56(1) of the Criminal Law Act 1977. Therefore, the nature of Inquests has changed over time and their objective is to be investigative.

There is also a specific requirement in Section 10(2) of the **2009 Act** that *"a determination … 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 ..."* and Rule 25 (4) of the **2013 Rules** states that *"a Coroner **must** adjourn an Inquest and notify the Director of Public Prosecutions, if during the course of the Inquest, it appears to the Coroner that the death of the deceased is likely to have been due to a homicide offence and that a person may be charged in relation to the offence"*.

The minority dissenting views of the Supreme Court

The main Judgment against this outcome was given by Lord Kerr (with Lord Reed agreeing with him). Lord Kerr was of the view that **Note (iii)** was deliberately drafted so as to mean that, to reach a short-form conclusion for either suicide or unlawful killing, the criminal standard of proof must be applied and that each of these short-form conclusions *"denote a solemn pronouncement and they have clear resonances beyond those of other short form conclusions"*.

In his dissenting Judgment, Lord Kerr, also stated that a narrative form conclusion of unlawful killing or suicide should be regarded as recounting *"the salient evidence and circumstances … it should not purport to constitute a final conclusion on that evidence unless the coroner or the jury has become convinced beyond reasonable doubt that it is justified"* (our emphasis).

He regarded Lady Arden's interpretation of the word *"required"* in **Note (iii)** as *"logically referring to a source of law which pre-existed the **2013 Rules"*** as being contrived, compared with the straightforward interpretation, in his view, that the criminal standard applied to short-form conclusions for suicide and unlawful killing, as long as **Note (iii)** of **Form 2** remained in force.

As regards the nature of Inquests, he regarded them as neither civil nor criminal proceedings – they were unique, with procedural rules of their own.

The response to the Supreme Court decision

On 13 January 2021, the Chief Coroner, published Law Sheet No. 6 which provides specific guidance to Coroners and those involved in Inquests on the practical implications of the Supreme Court Judgment in ***Maughan***.

https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/coroners-guidance/law-sheet-no-6-maughan/

The Chief Coroner's **Guidance** (including Guidance No. 17 on conclusions) is also likely to be updated.

Changes to the footnote - **Note (iii**) - to **Form 2** have not yet been made to reflect this change in law, but would be published at https://www.legislation.gov.uk/uksi/2013/1616.

CPB Comment

Although as a result of this case both the Coroner's Inquest and the Life and PA insurer will be considering matters using the civil standard of proof, their respective remits are not the same, and it could be helpful to engage more in the hearing, rather than simply reading the Inquest conclusion and Notes of Evidence after the event.

Life and PA insurers can ask the Coroner's Office to notify them of the Inquest hearing so that they can attend to observe or arrange legal representation to ask questions at the hearing as an 'interested person'. The considerations of the insurer in relation to a potential insurance policy claim are likely to be wider than those of the Coroner, as the Coroner's role is to consider the 'who, how, when and where' the deceased came by his or her death (and sometimes, in what circumstances), so that the Record of Inquest can be completed in respect of registration of death. However, the insurer will also need to consider the insurance contract.

Any investigations by the police will also focus on the task in hand by the Coroner (rather than the insurance context), so there could be information which is available to the police, but not passed to the Coroner and in turn not revealed in the Notes of Evidence.

A conclusion of unlawful killing, at an Inquest, is restricted to the offences of murder, manslaughter (which includes corporate manslaughter) and infanticide, and the Coroner will need to direct himself/herself or the jury (where there is one) that each element of the relevant offence must now be established to the civil standard of proof, in order to reach an unlawful killing conclusion.

On 7 October 2019, the Chief Coroner issued Guidance No. 33 on 'Suspension, adjournment and resumption of Investigations and Inquests'. As stated above, Rule 25(4) of the **2013 Rules** requires a

Coroner to adjourn the Inquest so that a criminal case can proceed. Once the outcome of the criminal case is available, which could include conviction or acquittal, the Coroner has discretion to resume the Inquest if there is sufficient reason to do so, but the outcome of any resumed Inquest cannot be inconsistent with the result of the criminal proceedings.

Due to COVID-19 restrictions, there is a backlog of criminal cases, so Life and PA insurers may notice delays in the provisions of Inquest conclusions in cases where criminal proceedings are involved. During the pandemic, an increase in the risk of domestic violence and economic abuse has been seen; this is relevant to insurers as just over 30% of women who have been killed, are killed by their partner.

Another potential impact of COVID-19 is the detrimental effect on mental health. The outcome of this Court case will help in the process of more effectively dealing with the psychological aftermath of the pandemic, as it should lead to more accurate statistics of suicide. Those statistics can potentially help to identify areas where social and medical care are needed.

The rate of suicides is generally in the region of 11 deaths per 100,000 people in this country, with the majority being men. The highest age-specific suicide rate is in respect of men aged 45-49 years at just over 25 deaths per 100,000. To put this in context, in Lithuania the suicide rate is almost 32 per 100,000; perhaps a factor in relation to the higher rate is the absence of a national suicide prevention programme. This reinforces that it is important that there is a proactive approach to promoting mental health and reducing the risk of suicide.

What is concerning is the rising rate of suicides in under 25s, even before the pandemic. This is the age range which has been particularly affected by the pandemic due to reduced opportunities in areas such as work and education. Also, the majority of mental health issues are understood to first originate in that age range. This highlights the importance in increasing access to suitably trained psychological support for the younger generation. When events such as taking out a mortgage and having a family arise, which should prompt taking out insurance, this group needs to have access to appropriate insurance.

The insurance industry can further support increasing awareness of suicide risk and mental health issues. An important step has been the formation of the voluntary industry group Action for Suicide

Prevention in Insurance (**"ASPiiN"**) which has produced a guidance document for insurers and more recently, in 2020, it produced a directory of suicide prevention training.

Helen Tilley
Partner

T: 0203 697 1910
M: 0771 773 3865
E: helen.tilley@cpblaw.com

Lisbeth Poulsen
European Qualified Lawyer

T: 0203 697 1905
M: 0783 246 7563
E: lisbeth.poulsen@cpblaw.com