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Case No: AC-2023-LON-000953

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 12 January 2024

Before:

LORD JUSTICE STUART-SMITH
and
MR JUSTICE DOVE

- -

Between:

THE KING
(on the application of NATASHA MIRANDA BRYAN)

Claimant

-and-

HIS MAJESTY'S ASSISTANT CORONER FOR BUCKINGHAMSHIRE

Defendant

-and-

YVETTE REDMOND

First Interested Party

-and-

CHIEF CORONER FOR ENGLAND AND WALES

Second Interested Party

- -

Kelvin Rutledge KC and **Alex Littlefair** (instructed by **Hudgells Solicitors**) for the **Claimant**
Bernard Richmond KC (instructed by **Bevan Brittan LLP**) for the **Defendant**
Caoilfhionn Gallagher KC and **Nicholas Ostrowski** (instructed by **Leigh Day Solicitors**) for the First Interested Party
Scarlett Milligan (instructed by **Government Legal Department**) for the **Second Interested Party**

Hearing date: 29 November 2023

Approved Judgment

This judgment was handed down remotely at 10.30am on 12 January 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

Lord Justice Stuart-Smith:

Introduction

1. This is the judgment of the Court.

2. These Judicial Review proceedings arise out of an awful tragedy that occurred on 18 February 2019. In the early evening Leighane Redmond ["Leighane"] went with her three-year old daughter ["Melsadie"] to Taplow Station, which was un-manned. Over the course of approximately two hours, she wandered up and down different platforms, on one occasion leaving the station before returning some minutes later. There was a fence preventing access to the track from Platform 1. On two separate occasions Leighane lifted Melsadie over the fence. After the second occasion, Leighane stood on the platform, giving the appearance of waiting. At 9.35pm, while holding Melsadie in her arms, Leighane jumped down onto the track and directly into the path of an Oxford-bound train that was approaching at a speed of about 110 mph. The train struck Leighane and Melsadie, killing them instantly.

3. The inquest into the deaths of Leighane and Melsadie was opened on 1 March 2019 and had a protracted history even before the final hearing, which took place between 14 and 30 November 2022 before HM Assistant Coroner Wade KC ["the Coroner"] sitting alone. It was treated as an Article 2 "Middleton" inquest and ranged far and wide, including very detailed analysis of Leighane's movements and state of mind and the investigation of other concerns surrounding the circumstances of Leighane and Melsadie's death about which the Coroner reached conclusions but which have not been the subject of this application for Judicial Review. At the conclusion of the hearing the Coroner returned a short-form conclusion of suicide in relation to Leighane and a narrative only conclusion in relation to Melsadie.

4. These proceedings are brought by Melsadie's grieving paternal aunt ["Ms Bryan"], who may be said to represent the views of Melsadie's father's side of the family. They challenge the form and substance of the Coroner's conclusion in respect of Melsadie's death. The first interested party is Melsadie's grieving maternal grandmother ["Ms Redmond"], who may in the same way be said to represent the views of Leighane's side of the family. The maternal and paternal sides of Melsadie's family were separately represented as interested persons at the inquest. The defendant is the Coroner, who has taken no active part in these proceedings. The second interested party is HM Chief Coroner for England and Wales who, while scrupulously maintaining neutrality as between the various different interests, has made helpful submissions about the relevant and applicable principles with which we are concerned.

5. As we shall explain in greater detail below, there are two main challenges to the Coroner's narrative conclusion in respect of Melsadie's death. The first is that the Coroner erred in law in his approach to the issue of Leighane's sanity or insanity at the time of the deaths: in briefest outline, it is said that the Coroner mistakenly adopted a presumption of insanity when he should in fact have adopted a presumption of sanity. Second, it is alleged that any conclusion other than a short form conclusion that Melsadie was unlawfully killed was irrational. It is accepted on behalf of Ms Bryan that the state of Leighane's mind was raised and the subject of evidence during the inquest and, furthermore, that there was evidence of episodic mental disturbance that may properly have led to a finding of insanity if the act had happened at some other

(unspecified) time. Her submission is that there was no evidence to justify a rational conclusion that Leighane was or may have been insane at the time of and immediately before the act that caused her and Melsadie's death.

6. In order to resolve these main challenges and the associated points that are made in support of them, it is convenient first to set out some of the principles that determine the approach to be adopted by a coroner in a case such as the present; then to describe in more detail the proceedings during the inquest and how the Coroner addressed the issue of Leighane's sanity or insanity; and then to address the criticisms that are made of the Coroner's approach and conclusions.

7. In adopting this approach, we must address issues that may seem legalistic and tangential or irrelevant to the grief suffered by both sides of the family; and we will reach conclusions that one side of the family or the other will find hard or impossible to accept. As we explained during the hearing, we do so without forgetting for a moment that what lies at the heart of these proceedings is the tragedy that befell Leighane, Melsadie and all those who loved them, whatever their perspective on what happened. We start, therefore, by offering the Court's condolences to all those who grieve for the loss of two precious and irreplaceable lives.

Applicable principles

The Coroners and Justice Act 2009 ["the Act"]

8. The Act lays down the parameters for an inquest such as the one in the present case. The purpose of the investigation into a person's death is to ascertain who the deceased was and how, when and where the deceased came by their death: section 5(1). Where, as here, an Article 2 "Middleton" inquest is held, the purpose shall be read as including the purpose of ascertaining in what circumstances the deceased came by their death: section 5(2). After considering the evidence given to the inquest, the coroner (or jury if there is one) must make a determination as to those questions, and must do so without framing their determination in such a way as to appear to determine any question of criminal liability on the part of a named person or civil liability: section 10(1) and (2). The Coroners (Inquests) Rules 2013 provide that the required determinations and any findings shall be made using a prescribed form, the notes to which record the short-form conclusions that may be adopted, which include "lawful/unlawful killing".

The test for insanity

9. It is common ground before us that, subject to the question of presumptions of sanity/insanity, the relevant criteria for the determination of an issue of sanity/insanity are to be found in the *M'Naghten* rules, the relevant parts of which are summarised in *Archbold 2024 Edn* at 17B-79 as follows:

> "(1) Every man is presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary is proved.
>
> (2) In order to establish the defence of insanity, it must be clearly proved that, at the time of committing the act, the party accused was labouring under such a defect of reason, from

> disease of the mind, as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know that what he was doing was wrong."

10. The Rules were delivered and are typically applied in the context of criminal cases where a defendant wishes to raise the state of their mental health as providing a defence to the criminal charge they face. It is common ground before us (and we agree) that in that context, the presumption of sanity set out in rule 1 is the starting point; and the burden of proof lies upon the accused to establish on the balance of probabilities that he was labouring under the requisite defect of reasoning to bring himself within rule 2. If the accused fails to raise evidence sufficient to go to the jury, it is the duty of the Judge to withdraw the issue of insanity from them: see *R v Windle* [1952] 2 QB 826, 831. There is an unresolved divergence of academic opinion about the burden and standard of proof that rests on the prosecution in a criminal trial once the accused has satisfied the evidential burden required to raise the issue: see *Smith, Hogan and Ormerod's Criminal Law*, 16th Edn at [9.2.2.3]. It is not necessary for us to enter that debate, since the position in a coronial context is materially different: see below at [14].

11. Ms Redmond submits that it would not be right simply to transplant the presumption in Rule 1 into the different field of coronial proceedings. She submits that the question of presumptions of sanity or insanity simply do not arise in the coronial context and would in any event only be relevant if a coroner found themselves unable on all the evidence to decide on the balance of probabilities one way or another. She points to decisions in other fields where the applicability of the Rule 1 presumption has been either doubted or disclaimed. Specifically, she relies upon *Williams v Williams* [1964] AC 699, 719, 740-741, 748 where the House of Lords held that the *M'Naghten* rules did not apply in the same way in divorce cases involving allegations of cruelty where insanity was raised as a defence as they would if insanity were raised by an accused in a criminal case.

12. In our judgment the answer to the question of the applicability of presumptions in the context of inquests is to be found in the nature of coronial proceedings. As pointed out by Sir Thomas Bingham MR in his seminal judgment in *R v HM Coroner for North Humberside and Scunthorpe, Ex p. Jamieson* [1995] QB 1, 23-25:

> "(1) An inquest is a fact-finding inquiry conducted by a coroner, with or without a jury, to establish reliable answers to four important but limited factual questions. The first of these relates to the identity of the deceased, the second to the place of his death, the third to the time of death. In most cases these questions are not hard to answer but in a minority of cases the answer may be problematical. The fourth question, and that to which evidence and inquiry are most often and most closely directed, relates to how the deceased came by his death. Rule 36 requires that the proceedings and evidence shall be directed solely to ascertaining these matters and forbids any expression of opinion on any other matter.
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> …
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> (3) It is not the function of a coroner or his jury to determine, or appear to determine, any question of criminal or civil liability, to

> apportion guilt or attribute blame. This principle is expressed in rule 42 of the Rules of 1984. The rule does, however, treat criminal and civil liability differently: whereas a verdict must not be framed so as to appear to determine any question of criminal liability on the part of a named person, thereby legitimating a verdict of unlawful killing provided no one is named, the prohibition on returning a verdict so as to appear to determine any question of civil liability is unqualified, applying whether anyone is named or not.
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> (4) This prohibition in the Rules is fortified by considerations of fairness. Our law accords a defendant accused of crime or a party alleged to have committed a civil wrong certain safeguards rightly regarded as essential to the fairness of the proceedings, among them a clear statement in writing of the alleged wrongdoing, a right to call any relevant and admissible evidence and a right to address factual submissions to the tribunal of fact. These rights are not granted, and the last is expressly denied by the Rules, to a party whose conduct may be impugned by evidence given at an inquest.
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> (5) It may be accepted that in case of conflict the statutory duty to ascertain how the deceased came by his death must prevail over the prohibition in rule 42. But the scope for conflict is small. Rule 42 applies, and applies only, to the verdict. Plainly the coroner and the jury may explore facts bearing on criminal and civil liability. But the verdict may not appear to determine any question of criminal liability on the part of a named person nor any question of civil liability.
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> …
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> (14) It is the duty of the coroner as the public official responsible for the conduct of inquests, whether he is sitting with a jury or without, to ensure that the relevant facts are fully, fairly and fearlessly investigated. He is bound to recognise the acute public concern rightly aroused where deaths occur in custody. He must ensure that the relevant facts are exposed to public scrutiny, particularly if there is evidence of foul play, abuse or inhumanity. He fails in his duty if his investigation is superficial, slipshod or perfunctory. But the responsibility is his. He must set the bounds of the inquiry. He must rule on the procedure to be followed. His decisions, like those of any other judicial officer, must be respected unless and until they are varied or overruled."

13. These observations are not limited to deaths in custody and are of general application. Three strands are of particular importance because they bear on the differences between criminal and coronial proceedings. First, an inquest is a fact-finding inquiry conducted by the coroner. It is therefore inquisitorial and not adversarial. It is the duty of the coroner as the public official responsible for the conduct of inquests to ensure that the relevant facts are fully, fairly and fearlessly investigated. Interested persons have an

important but strictly limited role. Second, it is for the coroner to determine the bounds of the inquiry and the procedure to be followed. It is clear beyond argument that the coroner has a broad discretion both in determining the bounds of the inquiry and the procedure to be followed. That is not to say that their discretion is either entirely unfettered or immune from challenge for *Wednesbury* unreasonableness or breach of the coroner's *Tameside* duty. Third, the rights and protections afforded to a person accused of a crime in criminal proceedings are lacking in the context of an inquest where the same person is suggested to have acted unlawfully.

14. These three strands, singly and cumulatively, strongly suggest that the concepts of presumptions and burdens of proof are inapposite to be applied to the deceased person or to interested parties involved in an inquest, for basic reasons of fairness. That is perhaps most particularly so where the person whose conduct is at issue is themself (a) deceased and (b) a subject of the inquest.

15. *Jamieson* was decided before the Supreme Court decided in *R (Maughan) v Coroner for Oxfordshire* [2020] UKSC 46 [2021] AC 454 that short form conclusions in inquests (including suicide and unlawful killing) should be decided on the basis of the civil standard of proof. However, the change effected by *Maughan* does not affect the essential reasoning in *Jamieson*. Considerations of fairness similar to those in *Jamieson* were at play before *Maughan* in *R (O'Connor) v Avon Coroner* [2011] QB 106, another case decided before *Maughan*, though here it may be said that the reasoning is affected to some extent.

16. In *O'Connor* the father of two children, after an argument with his wife during a holiday in Crete, pushed the two children off a hotel balcony and then threw himself after them. One of the children died from his injuries. His father was charged with manslaughter in Greece and acquitted on the basis of psychiatric reports evidencing that he had been suffering from a temporary psychosis. At an inquest in the United Kingdom the coroner returned a verdict of unlawful killing. A challenge to his verdict was not contested by the coroner because he accepted that he had erroneously treated as irrelevant the mental state of the father and his capacity to understand his acts. The issue in the judicial review proceedings concerned the approach that should have been adopted with regard to the issue of insanity and what other verdict, if any should be substituted by the Divisional Court.

17. Giving the judgment of the court Sir Anthony May P said at [19]:

> "19. A coroner's inquest is not, however, a criminal trial. As Lord Lane CJ said, giving the judgment of the court in *R v South London Coroner, Ex p Thompson* (1982) 126 SJ 625:
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> > "Once again it should not be forgotten that an inquest is a fact-finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. 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 quite unlike a criminal trial where the prosecutor accuses and the accused defends, the judge holding

> the balance or the ring, whichever metaphor one chooses to use."

> This passage was cited by Sir Thomas Bingham MR in *R v Coroner for North Humberside and Scunthorpe, Ex p Jamieson* …, after which he added that Lord Lane CJ went on to say that the function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires. Sir Thomas Bingham MR himself said, as one of his general conclusions in *Ex p Jamieson* …, that the prohibition in rule 42 on a coroner's inquest determining or appearing to determine any question of criminal or civil liability is fortified by considerations of fairness. Our law affords a defendant accused of crime certain safeguards rightly regarded as essential to the fairness of the proceedings. Among these are a clear statement in writing of the alleged wrongdoing, a right to call any relevant and admissible evidence, and a right to address factual submissions to the tribunal of fact. These rights are not granted, and the last is expressly denied by the rules, to a party whose conduct may be impugned by evidence given at an inquest."

18. The judge then addressed the question: how should a coroner direct a jury as to the standard of proof in a case where, insanity apart, a verdict of unlawful killing is obviously correct on the facts? The submission by Mr Badenoch QC, which the Court ultimately accepted, was outlined at [22]:

> "… a standard of proof predicates a party upon whom the burden of proof to that standard rests. In an inquest, there are no parties, indictments, prosecution, defence or trial; simply an inquisitorial attempt to establish facts. There are none of the safeguards of a criminal process to which Sir Thomas Bingham MR referred in *R v Coroner for North Humberside and Scunthorpe, Ex p Jamieson* [1995] QB 1 . It would be unfair in these circumstances if a person were to face the stigma of a verdict of unlawful killing … if temporary insanity is not established on the balance of probabilities, when that person or those representing him do not have proper formal entitlement to set about establishing his insanity to that standard. The submission is that the coroner should direct the jury that they must be sure, not only of the ingredients of unlawful killing, but also that the person was not legally insane at the time of the killing. They must in short be sure that unlawful killing is proved in every material respect, including that element of disproof."

19. In accepting this submission, Sir Anthony May said at [26]:

> "The procedure at an inquest does not accord a would-be defendant the safeguards that he would have in a criminal trial. There is no defendant and therefore no one upon whom the relevant burden of proof might lie. It is not fair that a person should risk the stigma of a finding of unlawful killing—even if

> the verdict technically conceals identity—without those safeguards and without the right to have deployed on his behalf the case that he was legally insane when he perpetrated the otherwise unlawful act. Crucially, we consider that the relevant direction which the coroner would have to give to a jury would be contorted and unsatisfactory. In a criminal trial, the heart of the direction is that it is for the defendant to prove insanity on the evidence taken as a whole, not beyond reasonable doubt, but upon the balance of probabilities. At an inquest, the coroner would have to direct the jury along the lines that it is for them to decide whether they are sure that the killing was unlawful, except that the killing would not be unlawful if they concluded on the balance of probabilities on the evidence which the coroner had decided to adduce or had admitted that the person who perpetrated the killing was legally insane. If this formulation is somewhat contrived to make a point, the concept of applying a hybrid standard of proof, derived from a structure where a burden is on the defendant, to circumstances where there is no defendant is not satisfactory. The differences between a coroner's inquest and a criminal trial necessitate a different standard of proof."

20. The issue of the standard of proof was resolved authoritatively in *Maughan*. What seems to us to be of lasting importance in this passage is the observation that "there is no defendant and therefore no one upon whom the relevant burden of proof might lie." In our judgment, that is plainly correct and indicates that the concept of presumptions as applied in the criminal law relating to insanity are inapposite.

21. *O'Connor* referred to insanity being "properly raised on the evidence": see [20], [27]. In our judgment the reference to it being "properly" raised is not a reference to the motivation of persons adducing evidence, though that could be a material consideration. Rather it is a reference to the issue being sufficiently raised on the evidence to make it one that should be considered by the coroner or, if there is a jury, should be left to them to consider. This approach reflects the fact that, together with their responsibility and duty to investigate the relevant facts fully, fairly and fearlessly, it is for the coroner to determine what evidence should be adduced as part of their inquisitorial investigation of the facts: they have a broad discretion about what evidence to call, what procedure to follow, the scope of the inquiry and what issues to consider or leave to a jury: see [13] above and *R (Sreedharan) v HM Coroner for Greater Manchester* [2013] EWCA Civ 181 at [71]. This position is also reflected in the advice given by the Chief Coroner's Law Sheet No. 5 on the discretion of the coroner at paragraphs 3, 22, 25 and 30, which it is not necessary to set out in detail here but which we would endorse.

22. In her submissions on behalf of the Chief Coroner, Ms Milligan raised the question of the type of evidence that may be relevant to the issue of insanity in a coronial context. We do not think it appropriate to be prescriptive or to attempt a definitive reply to this question. We would agree that, since the issue of insanity is dependent upon the working of the person's mind at the time of committing the relevant act, it is likely that psychiatric and/or other medical evidence will have a significant part to play. However, other evidence (such as direct evidence of the person's behaviour either when, before

or after committing the act) may be relevant to be brought into account. What is important is that the coroner should, as appropriate, exercise their discretion rationally and in accordance with the *Tameside* duty when deciding whether and to what extent to follow lines of enquiry that are or may be relevant to the issue.

23. In the light of this review, we consider that it would be inappropriate to attempt to transpose directly the concepts of presumption of sanity and burdens of proof as they apply in the context of criminal proceedings to the very different context of coronial proceedings. The coronial process starts with the coroner being notified of the death and deciding to conduct an inquest. In the discharge of their duty to investigate the death fully, fairly and fearlessly, the coroner will exercise their discretion about what evidence to call for and, if appropriate, introduce in the proceedings. It is also possible that evidence will emerge and be introduced from other sources. The question for the coroner will be whether, on all the available evidence, the issue of insanity is properly raised in the sense that we have explained above. If there is sufficient evidence of insanity for it not to be withdrawn from consideration (either by the coroner or, if there is one, the jury) then the question will be whether, on all of the relevant evidence, the correct conclusion on the balance of probabilities is that the person in question was not insane. In our judgment, this approach preserves the protections required by the considerations of fairness to which we have referred above. If it is more likely than not that the person was insane at the time of committing the act that led to the death in question, a conclusion of unlawful killing would be unsafe and should not be reached.

24. It is, in our judgment, clear that this approach also underpins the approach as set out in paragraph 32 of the Chief Coroner's Law Sheet No. 1 on Unlawful Killing. It is evident from paragraph 1 that it has been modified in the light of the decision in *Maughan*. Paragraph 2 states:

> "[*Maughan*] means that a conclusion of unlawful killing may only be reached, following an inquest, when the Coroner or jury is satisfied on the balance of probabilities (so that it is more likely than not) that a death was caused by one of the following criminal offences: (1) murder, (2) manslaughter … and (3) infanticide."

25. Guidance on insanity is given by paragraph 32, which states:

> "The conclusion of unlawful killing may not, however, be available if there is evidence that the person who carried out the act which led to death was insane at the time and therefore lacked the necessary *mens rea* for the offence. The test is as follows: Is the coroner (or the jury) satisfied that the person was not legally insane at the time of the killing?"

26. None of the parties before us submits that this advice is incorrect; and it is in accordance with the approach that we have indicated above. In our judgment the guidance in paragraph 32 does not seek to introduce a presumption of sanity. Rather, it addresses the approach to be adopted where there is evidence that the person who carried out the act which led to death lacked the necessary *mens rea* for an offence of murder, manslaughter or infanticide. In our judgment it is implicit that this approach is to be adopted having regard to the evidence as a whole. It is unlikely to be helpful to parse

the evidence into discrete sections relating to the *actus reus* and *mens rea* of the offence in question, though it would not necessarily be wrong to do so if the facts of a given case justified it.

The inquest

27. By any standards, this inquest was protracted and complicated. The scope was widened to include Leighane's behaviour over the months before the deaths and her interaction with various social and medical services. In total there were ten interested persons with multiple legal representation. The Coroner heard from 24 oral witnesses, with the evidence of another 44 witnesses being read. We are told that the inquest bundles ran to 2,000 pages.

28. Leighane's mental state was the focus of intense attention and submissions. By September 2021 Senior Coroner Butler had commissioned a report from a consultant psychiatrist, Dr Mynors-Wallis. From early in his appointment, the Coroner made clear that he was gathering additional evidence about Leighane's mental health history in order to explore with Dr Mynors-Wallis whether it shed any different or clearer light on her likely or perceived psychiatric illness. Ms Redmond, who had been closely involved with Leighane in the months leading to her death, gave evidence about Leighane's state as she perceived it to be from watching the CCTV footage of her behaviour at Taplow Station and about Leighane's behaviour in the months before the deaths. She was cross-examined by leading counsel then representing Melsadie's father, who now represents Ms Bryan. We return to the evidence when considering Ms Bryan's rationality challenge later in this judgment.

29. Having received submissions on the appropriate outcome of the inquest, the Coroner gave his conclusions in Court on 30 November 2022. In respect of Leighane, the Coroner returned the short-form conclusion of suicide. In respect of Melsadie, the Coroner made findings of fact and then, having recorded the medical cause of death as multiple injuries, returned a detailed narrative conclusion, which gives some indication of the complexity of the inquest as a whole in addition to being specifically relevant to Leighane's state of mind. The narrative conclusion as recorded in Box 4 of the Record of Inquest into Melsadie's death was as follows:

> "Conclusion of the Coroner as to the death
>
> Narrative conclusion: Melsadie was three years old and in the custody care and control of a responsible adult. She was well cared for and loved by that adult. She was equally well cared for and loved by all her relatives. On 23rd October 2018 an alert was raised by her carer that Melsadie had been assaulted, which was investigated appropriately by police and local childrens social services under the provisions of the Children Act 1989, and was discounted. Melsadie remained in the custody of her carer. The social services investigation file remained open and ongoing. During the subsequent period, of not less than four months before Melsadie's death, her carer suffered an overt breakdown in mental health such that an episodic psychosis was occasionally manifest, and intentionally concealed, and mild to moderate depression was diagnosed. On 23rd December 2018

> her carer exhibited symptoms of acute mental illness which was brought to the attention of the social worker team who took appropriate urgent steps to remove Melsadie from her carer and arrange a mental health assessment for the carer by qualified mental health professionals. On 29th December 2018 Melsadie's carer was appropriately assessed by healthcare professionals and deemed not to be psychotic and to have depression. The carer was discharged from the mental health team on reasonable grounds.
>
> Melsadie was restored to that adult's care. Thereafter her carer suffered another deterioration in mental health, the full extent of which was not known to childrens social services who closed their ongoing investigation. In the course of reviewing that decision the childrens social service staff undertaking the investigation were informed of an additional concern about the carer which prompted a review of Melsadie's safety but which was considered not to justify further gathering of evidence or reference of the matter to the mental health service. An opportunity to inspect the carer's home, and to seek evidence from the carer's family of other signs of the carer's developing mental illness, and to liaise with mental health services, was missed. It cannot be concluded that such an opportunity if taken would have made any difference to the outcome.
>
> The carer continued to demonstrate capacity and normal function and also provided good care to Melsadie. On 18th February 2019 the carer looked after Melsadie throughout the day with evident good intention. In the evening Melsadie went willingly with the carer to Taplow Train Station where the carer deliberately entered a prohibited area within the station by climbing over a fixed barrier and entering a disused platform through which non-stop trains passed. On the balance of probabilities the carer's intention was to end their own life by the act of jumping into the path of a moving train, which did occur, while at the same time intentionally holding Melsadie and thereby exposing her to the same catastrophic collision with the train, which occurred simultaneously. When this happened it is not possible to determine that the carer was not suffering from such a disease of the mind as to be capable of action but incapable of distinguishing between right and wrong and was therefore likely to be legally insane."

30. At the conclusion of the Coroner's oral announcement of his findings of fact and conclusions, it became apparent that some interested persons who were attending via video link had not been able to hear his findings of fact. He therefore typed up his notes and delivered them to interested persons as a separate 18-page document on 2 December 2022. He identified the purpose of the document at its commencement:

> "I have been asked to provide a copy of the notes I referred to in court when announcing my findings and conclusions. This

> document represents the various sources I used, either verbatim or by summarising. It is created after the event in order to assist the Interested Persons."

31. There was some discussion before us about the status of this note, to which we will refer as "the Note". In the absence of transcripts (which is proportionate and sensible) the pragmatic position was reached that, while not forming part of the Record of Inquest as such, the Note provides the best evidence of the Coroner's findings of fact and other matters recorded in it. We endorse this approach, not least because of the high level of detail contained in the Note. That said, as appears later, the Note is not a full or verbatim account of the evidence that was given and has to be treated with a degree of caution for that reason.

Ground 1: misdirection in law

32. As explained by Mr Rutledge KC in his written and oral submissions, this ground raises a very narrow point. No issue is taken with any part of the narrative conclusion other than the last sentence which, it is submitted, impermissibly reverses the presumption of sanity that the Coroner should have adopted and, in its place, substitutes a presumption of insanity. It is submitted that, rather than asking himself whether there was evidence before the court to show that Leighane was at the time of her act insane within the meaning of *M'Naghten* Rule 2, or whether evidence of insanity had been "properly raised" (in the sense used in *O'Conner* and explained above), the Coroner began his conclusion on the erroneous premise of a presumption that she was insane, treating the second sentence of paragraph 32 of Law Sheet No. 1 as if it were the single test for insanity.

33. We would accept (as would the Chief Coroner) that, if the Coroner had started with an assumption that Leighane was insane at the time of her act and treated the second sentence of paragraph 32 of Law Note No. 1 as the only matter to be considered, he would have been wrong to do so and would have materially misdirected himself on the law. As we have explained above, the question of insanity falls to be considered if there is evidence that properly raises it; and paragraph 32 of Law Note No. 1 reflects that principle.

34. We are, however, quite unable to accept that the Coroner misdirected himself in the manner alleged. On a fair reading of his narrative conclusion, even taken on its own, it is clear that the Coroner considered that there was evidence that Leighane was insane at the time she carried out the act. Whether that was a rational conclusion falls to be decided under Ground 2; but that he considered there to be evidence that properly raised the issue (as set out in his narrative conclusion and as summarised in the Note of his findings) is clear beyond argument to the contrary.

35. Mr Rutledge is right when he points out that the Coroner only referred expressly to the second sentence of paragraph 32. But that does not mean that he started with a presumption of insanity. What it shows is that he had paragraph 32 in mind. Paragraph 32, while very concisely expressed, must be read as a whole because the second sentence does not become relevant unless application of the first sentence means that the issue of insanity is raised. The absence of express reference to the first sentence therefore does not mean or even imply that it was ignored.

36. At the hearing it was accepted that the court should adopt the same approach to the consideration of the reasons proved in a narrative conclusion of the kind returned by the Coroner as it would, conventionally, to other forms of public law decision. That is to say, as exemplified by the observations of Lord Brown in [35] and [36] of his opinion in *South Bucks District Council v Porter* [2004] 1 WLR 1953; [2004] UKHL 33. Lord Brown quoted with approval the observations of Sir Thomas Bingham MR (as he then was) in *Clarke Homes v Secretary of State for the Environment* (1993) 66 P&CR 263 that a decision should be subject to "a straightforward and down-to-earth reading…without excessive legalism or exegetical sophistication". Applying this approach to this decision the express reference to the second sentence implies that the first sentence has also been considered and found to be satisfied so as to open the way to the second.

37. For these reasons, which are almost as short as the point is narrow, the challenge on Ground 1 fails.

Ground 2: the rationality challenge

38. We start by accepting that the Coroner's conclusion is less than immaculately expressed. Specifically, in seeking to follow the advice of paragraph 32, the Coroner has introduced a "clunky" double negative; and the sense of his conclusion could have been more clearly expressed to show that he was not finding that it was impossible to make a finding that Leighane was legally insane. However, applying the approach which is appropriate to the reading of decisions of this kind which is set out above, we consider that it is reasonably clear that his findings were that (a) he was not satisfied that Leighane was not insane at the time of the act, and (b) he was satisfied that she was likely to have been insane at the time of the act.

39. In advancing the submission that these findings were irrational, Mr Rutledge understandably concentrates upon findings by the Coroner that Leighane's actions at Taplow Station were deliberate. Specifically, he found, referring to Leighane lifting Melsadie over the barrier on Platform 1:

> "This was a controlled directed act. It was efficient and effective. It was determined and deliberate. It was calm. *It is however not possible to know exactly what was in her mind.* Nevertheless her actions appear to be considered and pre-planned."

And, elsewhere, when considering the construction of the fence:

> "What occurred was the deliberate and intended exposure to risk, by an act of trespass, into an area which attracted Leighane precisely because it was dangerous once she had breached the prohibition against unauthorised access. She was not there by accident or inadvertence; she was not there because a barrier had been opened or not created; she was not there to do something which required the persistence of life (for example, thrill-seeking or shooting a YouTube video, or theft)."

40. We note in passing that the highlighted passage in the first citation is not included in the references as they appear in Ms Bryan's skeleton argument. That in turn highlights a broader problem which serves to identify the kernel of the issue on this ground: a person's continuing capacity to act deliberately is not necessarily removed when they are in the grip of a psychosis and so is not determinative of the issue of insanity.

41. Once the available information is reviewed more broadly, it becomes clear that the issue was much more nuanced than Mr Rutledge's persuasive submissions would suggest. Without conducting a comprehensive review, we note the following aspects of the evidence that was before the Coroner:

    i) Despite the difficulties that were evidenced during the inquest, Leighane was described as a loving and good mother, even a "great" one. The consistency of that evidence alone would be sufficient to raise the question of her motivation when she came to her fatal action. As the Coroner said in the note, it made Melsadie's death utterly unpredictable. There was significant evidence touching on that question.

    ii) On 23 December 2018 Ms Redmond received a telephone call from Leighane around lunchtime. She was incoherent and crying and all her mother could make out was "they are going to kill me" and "you have to come and help me". She went on to say "they told me you are the only one I can trust". When she went to Leighane's flat she noticed that Leighane had drastically lost weight over the previous two months. She looked withdrawn and pale. Leighane was rambling about a hex being placed upon her by a female relative of Melsadie's father since Melsadie was born. She said her phone was sending messages into her brain and that her partner had been paid to give her HIV. Leighane also informed Yvette that she had been for an HIV test, but although the result was negative, the nurse was lying. Leighane said nonsense things like a sandwich fell out of the sky, whilst she was on the train. Melsadie's bed had been removed. Leighane said they had put cameras in it to monitor Melsadie. She had removed the heads of Melsadie's teddy bears looking for cameras. En route to hospital, Leighane said that if the HIV did not kill her by 29 December, then she would shoot the female relative of Melsadie's father and kill herself. Leighane said that she could see evil in Melsadie's eyes.

    iii) The following day, at an emergency appointment with Leighane's GP, Ms Redmond was advised that Leighane should not take any further HIV tests as people suffering from psychosis could not be convinced that they were not unwell.

    iv) When seen by the mental health team on 29 December 2018, they reached a coherent conclusion that Leighane was not psychotic, though she was suffering from mild to moderate depression. The team formed a favourable impression of the bond between Leighane and Melsadie.

    v) Throughout January and February Ms Redmond and others observed worrying symptoms of another deterioration in Leighane's mental health, such as her destruction of Melsadie's teddy bears for fear that they had hidden cameras which were spying on her; her destruction of Melsadie's bed; her wrapping up and putting the television away under the furniture; her swapping SIM cards;

her rambling allusions to others receiving payments or putting a hex on her; her staring into space; her seemingly incoherent or nonsensical notes; her obsession that she had HIV which extended to spending £160 on a needless repeat test; her failure to meet up with her aunt in London for a planned lunch.

vi) Leighane's behaviour on 18 February was complicated. She was meant to be starting a new job but rang her employer to say she was not coming as she could not get childcare, which was untrue. Over the next four hours or so her whereabouts were not always established, but she went to a retail park in the afternoon where some neighbours remarked on Leighane's "rather blank expression". Melsadie was skipping "as three year olds will do." She withdrew cash from an ATM where CCTV captured "an interaction between her and Melsadie which [was] poignant and warm and utterly normal." Leighane appeared to be aware of her surroundings and was conscious of Melsadie. She then had two phone conversations which appeared normal to the other people on the call. At about 7.30 she called her mother, Ms Redmond, but she did not answer. She then booked an Uber to take her to Ms Redmond's home, but did not show up at the agreed pickup point. It was not known why she did not make the meeting but, as the Coroner noted "it seems that from about this time something was going on in Leighane's mind which led to her wandering up and down from different platforms at Taplow station for some hours, coming and going".

vii) The Coroner described Leighane as going from platform to platform "somewhat aimlessly". Ms Redmond described her as looking "vacant and absent" which she said was how she had been on previous occasions when she had been acting oddly and did not recall afterwards where she was or what she was doing. The Coroner described her as looking "pensive" and "sadly thoughtful." Ms Redmond's witness statement for these proceedings records that she was cross-examined by Mr Rutledge about Leighane's state of mind. He put to her that Leighane knew what she was doing that evening: Ms Redmond disagreed because her behaviour mirrored what she had seen before. She strongly disagreed with the suggestion that Leighane had gone to Taplow Station with the intention of putting herself and Melsadie in front of a train.

viii) Dr Mynors Wallis assisted the Coroner with evidence about psychosis. In his opinion Leighane was exhibiting psychosis. He said that in January she likely had a psychotic disorder and was less well than had been thought. He said that psychosis does not prevent people from taking rational decisions. He said that on the CCTV, referring to her presentation on 18th February 2019, she had not lost control. But he could not express an opinion on what was going on in her mind at that time. He said she was making apparently sensible decisions in the weeks leading to her death. He said that if she had been assessed a second time it was likely she would have presented as normal, in the light of her known behaviour through January and February. He agreed that expressing the view that a child is evil is concerning but that context was everything.

ix) With the agreement of Mr Rutledge, we were shown the Senior Coroner for Buckinghamshire's pre-action protocol letter, which records that:

> "When asked questions by Leading Counsel for [Melsadie's father] Dr Mynors-Wallis agreed that from a review of the CCTV footage it appeared that Leighane had not "totally lost control"; but when asked whether she appeared to be making rational decisions, he stated that "it's difficult to say something that feels so irrational as the final outcome was the result of rational decision-making. What we don't know, and I don't know, is actually what's going on in Leighane's head at the time, how she's weighing up those decisions that she's making. That's what I don't know."
>
> When asked whether the condition of psychosis deprives people of the ability to make rational decisions, his evidence was that "it may do but not necessarily".
>
> He later agreed with Leading Counsel for [Ms] Redmond that a person may undertake behaviour which is physically deliberate but it may be because they are being told to do so by voices in their head."

x) A second consultant psychiatrist, Dr Bhatia, gave evidence. His primary role at the inquest was to give factual evidence about his own involvement in Leighane's case. However, he was asked to help more generally from his perspective as a consultant psychiatrist. As recorded in the same pre-action protocol response:

> "Dr Bhatia indicated to [the Coroner] that he agreed with the evidence of Dr Mynors-Wallace (which he had heard in full in Court). He also expressed his own view that it was not possible to say whether or not, when she went to Taplow Station, Leighane was in the grip of a psychosis. He stated (not specifically with reference to Leighane) that despite the presence of psychosis, some people can do some activities normally."

42. We note again the concession recorded at [5] above that there was evidence of episodic mental disturbance that may properly have led to a finding of insanity if the act had happened at some other (unspecified) time. That concession was properly and correctly made. Viewed in the light of that concession, the determinative issue is whether it was open to the Coroner rationally to conclude on the basis of all the evidence that, at the time of the act, (a) he was not satisfied that she was not insane and/or (b) she was likely to be insane. To state the questions points out the height of the hurdle which the claimant has to surmount in relation to this ground. The Coroner is an expert tribunal who heard extensive evidence, of which, as set out above, we have notes but no comprehensive record. The Coroner was, therefore, especially well placed if properly directed to make the necessary factual findings to reach his conclusion. For the reasons which follow we are satisfied that the Coroner's conclusions were well within the bounds of conclusions which were open to him on the available evidence.

43. In our judgment, the evidence (some of which we have rehearsed or summarised above) properly raised the issue of insanity for consideration by the Coroner. It is not disputed

that, on the available evidence, the Coroner could have concluded that Leighane was subject to an episodic psychosis. We would go further and say that, on the evidence, such a finding was virtually inevitable. For the most obvious and catastrophic reasons, direct evidence from Leighane herself about her state of mind at the time of her fatal act could not be available. So it was necessary to make an assessment on the basis of what was known or could be deduced from the evidence as a whole. On a fair reading of the Note, that is what the Coroner attempted to do. Once that assessment was undertaken, it led to the formulation of the question and the answer provided by the Coroner at the end of his narrative conclusion.

44. Three features stand out. First, the utter irrationality of Leighane's conduct calls into question the suggestion that she was acting rationally and any suggestion that she, a loving and good mother, knew at the time the nature and quality of the act she was doing or that what she was doing was wrong. Second, the fact that her actions may have been deliberate does not demonstrate that she was not in the grip of a psychotic episode. Third, even with the diagnosis of a mild to moderate depressive episode, no other persuasive explanation appears for why Leighane should have felt compelled to end both her life and the life of her much loved child. It may also be added that the doctors' statements that they did not know (or that it was impossible to know) what was going on in Leighane's head does not demand or even support a finding that Leighane was not insane at the time of her fatal act. It is merely a statement of uncertainty in the face of an irrational tragedy.

45. It has not been shown that the Coroner misunderstood the evidence or failed to take into account any information that he should have had in mind when reaching his conclusion. For the reasons we have given, all of which emerge from the evidence that was available to the Coroner, there was ample evidence on the basis of which he was entitled to answer the question he set himself as he did.

46. For these reasons, the challenge on Ground 2 fails.

Narrative conclusion and relief

47. As we have attempted to explain above, this was a detailed, complicated and sensitive case, particularly in relation to Leighane's state of mind. In our judgment the complexity and sensitivity of the case fully justified the Coroner's decision to give a narrative conclusion.

48. Had we reached other conclusions we would have had to address difficult issues on the question of relief. In the light of the conclusions we have reached, it is not necessary to address them and we do not do so.

Conclusion

49. While we do not doubt for a moment Ms Bryan's integrity or her belief in the challenge that she has brought, the challenge fails for the reasons we have given.