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Case No: CO/1325/2020

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 24/12/2020

Before:

Mr Justice Garnham

- -

Between :

The Queen (on the application of Sharon Grice)	**Claimant**
- and -	
Her Majesty's Senior Coroner of Brighton and Hove	**Defendant**
- and -	**Interested**
(1) The Chief Constable of Sussex Police	**Party**
- and -	**Interested**
(2) Sussex Partnership NHS Foundation Trust	**Party**

- -

Kirsty Brimelow QC and Harriet Johnson (instructed by **Hudgell Solicitors**) for the **Claimant**
Jonathan Hough QC (instructed by **Brighton and Hove City Council Legal Services**) for the **Defendant**
George Thomas (instructed by **Weightmans LLP**) for the **First Interested Party**
Gwen Goring (instructed by **Trust Legal Services Team**) for the **Second Interested Party**

Hearing dates: 10th December 2020

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Covid-19 Protocol: This judgment was handed down remotely by circulation to the parties' representatives by email, release to BAILII and others, and publication on the Courts and Tribunals Judiciary website. The date and time for hand-down is deemed to be 09:30am on 24 December 2020.

Mr Justice Garnham:

Introduction

1. On 25 August 2016, Shana Grice ("Ms Grice") was murdered by her former boyfriend, Michael Lane, at her home in Brighton. That dreadful act, which has left Ms Grice's family devastated, has been the subject of a number of enquiries. The primary issue before the Court is whether the European Convention of Human Rights ("ECHR") requires that, in addition, the inquest into her death should be resumed.

2. On 3 January 2020, Her Majesty's Senior Coroner of Brighton and Hove, Ms Veronica Hamilton-Deeley ("the Coroner"), decided not to re-open the inquest into the killing of Ms Grice. By these judicial review proceedings, Shana's mother, Sharon Grice, seeks to challenge that decision. Cheema-Grubb J granted the Claimant leave to apply for judicial review on two grounds:

    (i) The Defendant's decision not to resume the inquest and hold a full inquest into Ms Grice's death is a breach of the Investigative duty under Article 2 of the European Convention on Human Rights;
    (ii) The decision not to resume the inquest was irrational.

3. The Claimant, Mrs Grice, was represented by Kirsty Brimelow QC and Harriet Johnson. In both their written and oral submissions, they concentrated almost entirely on Ground 1. At the end of the hearing, I suggested to Ms Brimelow that if she succeeded on Ground 1 she would not need Ground 2 and that if she failed on Ground 1 it would be difficult to succeed on Ground 2. She agreed. Nonetheless, both grounds are maintained and will be addressed below, the latter very briefly.

4. The relief sought includes an order quashing the Defendant's decision of January 2020 and a mandatory order requiring the Defendant to resume the inquest.

5. By her counsel, Mr Jonathan Hough QC, the Coroner made written and oral submissions with a view to assisting the Court on matters of background and coronial law, and explaining the context for, and reasoning behind, her ruling. The First Interested Party, the Chief Constable of Sussex Police, has adopted a similar course. The Second Interested Party's submissions were somewhat more equivocal. Nonetheless, I am grateful to all counsel for their assistance both in writing and orally at the hearing.

The History

6. The essential factual background to this claim is not in dispute.

7. In the summer of 2015, Ms Grice began working at Brighton Fire Alarms where she met Mr Lane. By the autumn of 2015, they had started a relationship, which apparently broke up later that year. Ms Grice then resumed a relationship with her long-term boyfriend, Mr Ashley Cooke.

8. On 31 December 2015, Mr Cooke found a note on his windscreen saying that Ms Grice had cheated on him. In mid-January 2016, Ms Grice received flowers and an unsigned

love note at work, later found to have been sent by Mr Lane. Shortly afterwards, she discovered the tyres of her car had been slashed. Mr Cooke's car, also, was vandalised.

9. On 8 February 2016, Ms Grice made her first report to Sussex Police. She complained she was being stalked by Mr Lane. She said that in recent months he had been waiting outside her house some mornings; that at one point he had thrown his keys at her; and that her tyres had been let down. She also mentioned the flowers. Her account at that point was that Mr Lane was just a work colleague who had misconstrued their relationship. She wanted the police to speak to him.

10. A police Resolution Centre investigator spoke to the human resources manager at Brighton Fire Alarms, who expressed concern for Ms Grice's safety. There had been a meeting at work at which Mr Lane had been told of Ms Grice's concerns. The police investigator considered issuing a Police Information Notice ("PIN") but did not do so for lack of evidence. He telephoned Mr Lane and gave him a warning. He denied the allegations of harassment.

11. In the evening of 24 March 2016, Ms Grice returned home. Later, her housemates came in, accompanied by Mr Lane. There was an argument in which he followed her out of the house, grabbed her phone and pulled her hair. A passing motorist stopped and asked her if she was alright and then took her to her boyfriend's house. The incident was reported to the police by Ms. Grice's boyfriend's mother and Mr Lane was arrested on suspicion of assault.

12. The next day, PC Godfrey of Sussex Police took a statement from Ms Grice, in the presence of her boyfriend and his family, in which she claimed to have become friends with Mr Lane, but to have declined his invitations for drinks because she was not interested in a relationship with him. She recounted incidents of him following her home, the damage to her car and the unwanted flowers. PC Godfrey then interviewed Mr Lane, who said that he had had an "on and off" intimate relationship with Ms Grice since autumn 2015. He admitted having followed Ms Grice to speak to her but claimed to have ceased contact following the police warning. He said that she had contacted him, and the relationship had begun again. To support his claim of a continuing relationship, he showed PC Godfrey various text messages.

13. PC Godfrey then spoke to Ms Grice, who admitted that she had been in a relationship with Mr Lane. The officer decided that there was to be no further action on any of the allegations. Mr Lane was released without charge. Another officer issued Ms Grice with a Fixed Penalty Notice ("FPN") for wasting police time by lying about the relationship.

14. Shortly after this incident, Ms Grice left her job (citing Mr Lane as the reason). She was then out of work for a few weeks, during which time Mr. Lane carried out unsolicited visits to Ms. Grice's home Mr Lane also resigned from his work before a meeting, at which he was to be challenged about his visits to Ms Grice's home, was held.

15. It is understood that, at some point, he placed a tracker on Ms Grice's car and continued to follow her. From this time onwards, different people described how Mr. Lane regularly seemed to be "lurking around" Ms Grice. However, it appears that Ms Grice and Mr Lane were still continuing a secret, periodic relationship.

16. In May 2016, Ms Grice found her tyres slashed again. Subsequently, Mr Lane forced his way into a house where she was in the company of another man.

17. In early June 2016, Ms Grice and Mr Lane began an overt relationship, which ended in early July 2016. Ms Grice began seeing Mr Cooke again, while continuing to see Mr Lane in secret.

18. On 8 July 2016, Mr Lane left Ms Grice's house, taking a back-door key. At 6am the next morning, he used the key to enter her home. He entered her bedroom, where Ms Grice hid beneath the bed covers until he left. She described her fear at hearing a man "breathing in her bedroom". She identified Mr. Lane by looking out of the window and seeing him as he left the house. Ms Grice reported this event to Sussex Police, and an officer visited and took a statement from her in which she described her shock and fear. While the officer was at her house, Mr Lane arrived and was arrested on suspicion of theft of the key. PC Mills investigated the matter and he interviewed Mr Lane, who admitted to taking the key "stupidly". Mr Lane was given a police caution for the theft and issued with a PIN for harassment.

19. On 10 July 2016, Ms Grice called Sussex Police, reporting a series of calls, one of which she had answered and heard heavy breathing on the line. She described herself as worried and scared. A police call handler told her that one of the numbers used to call her had been shown by a "Google" search to be that of a travel insurance company. In fact, it was Mr Lane's landline number. Eight days later, the police identified the landline as originating from Mr. Lane's address. No action was taken.

20. On 12 July 2016, Ms Grice called Sussex Police again, reporting that Mr Lane had been following her to work. A call handler assessed the risk of harm as "low" because of a lack of threatening behaviour and Ms Grice's presentation. Later that day, Ms Grice made a final call to the police, asking for an update. Although the calls were referred to the responsible officers, she received no response. Referrals were made to Victim Support and to RISE (a domestic abuse charity). Because calls from those organisations were made to Ms. Grice from withheld numbers, Ms Grice did not respond to their messages.

21. Over the following weeks, Mr Lane continued to be seen near Ms Grice's home. In early August 2016, a friend urged her to call the police. She said she was reluctant to do so because the police would think she was "blowing it out of proportion". In mid-August 2016, she and Mr Lane arranged to meet at a local hotel. They spent a few hours together and apparently agreed that their relationship was over.

22. On 25 August 2016, Ms Grice was not at work and her manager called Mr Cooke. His sister went to Ms Grice's home, where she found a bloody footprint on the doorstep. She called her father and together they entered the house. They found Ms Grice's body on the bed, with her throat slit. In the criminal trial that followed in 2017, it was established that Mr Lane had killed her that morning; that he had moved Ms Grice's body to the bed before dousing the room with petrol and setting a fire (which had not spread), and that he had then taken her bank card and withdrawn money from her account.

23. Mr Lane was arrested, interviewed and charged with Ms Grice's murder, an offence he denied. The Coroner opened an inquest into Ms Grice's death and adjourned it pending the criminal investigation and trial.

24. After the killing of Ms Grice, 12 other young women came forward reporting incidents of harassment by Mr Lane, most with a sexual connotation. With one exception, none had made a report to police before Ms Grice's death. The exception was that, in 2010, Mr Lane had been a scout volunteer and had been arrested for sending inappropriate text messages to a girl attending the scout group. The incident had been investigated and closed because an offence could not be proven.

25. The trial took place in February and March 2017 at Lewes Crown Court before Green J (as he then was) and a jury. Mr Lane pleaded not guilty, but on 22 March 2017 was convicted of murder.

26. Four further investigations or reviews followed:

    (i) a statutory Domestic Homicide Review ("DHR") of the case, which reported in September 2017**;**

    (ii) an investigation into the case by the Independent Office for Police Conduct ("IOPC"), which reported in June 2018;

    (iii) an inspection by HM Inspectorate of Constabulary and Fire & Rescue Services ("HMICFRS") concerning Sussex Police and its response to cases of stalking and harassment, which reported in April 2019; and

    (iv) police disciplinary proceedings, which concluded in July 2019 with findings of gross misconduct against one officer and misconduct against two others.

The decision under challenge

27. On 4 March 2019, Solicitors for the Grice family wrote to the Coroner asking about the suspended inquest. The Coroner responded on the 7 March in the following terms:

> "A year has now passed since the conviction of Michael Lane after a full airing of the circumstances. I do not propose to resume the trial."

28. Solicitors wrote again, on 11 June, inviting the Coroner to resume the inquest. That letter attached submissions drafted by counsel in support of that request. Those submissions contended that the criminal trial did not obviate the need for an inquest because it focused on the facts of the killing rather than on police conduct. It was argued that the IOPC investigation had not explored institutional or cultural failings within Sussex Police.

29. On 3 January 2020, having obtained copies of the IOPC report, the Coroner produced her ruling. She summarised the facts of the case. She acknowledged that the State's investigative obligation under Article 2 ECHR was engaged on the basis of potential breach by the police of their operational duty to safeguard the life of Ms Grice. The Coroner summarised the relevant legal principles. She referred to the other

investigations that had taken place including the trial, the IOPC investigation, the DHR and HMICFRS inspections. She then set out her ruling by answering four questions.

30. First, in response to the question 'Have other investigations adequately covered the ground an inquest would cover?', she replied "Yes they have and indeed have gone beyond the remit of the Inquest even an Article 2 Inquest."

31. In answer to the question 'Whether the Inquest could provide valuable conclusions (whether by conclusion or Regulation 28 report) going beyond those reached by other investigations?', she answered:

> "The conclusions cannot be inconsistent with the criminal proceedings therefore could only be "Unlawful Killing".
>
> The regulation 28 report is just a report. It cannot require action.
>
> Other inquiries into Shana's death have been able to make recommendations and require action.
>
> If this Inquest was resumed, any regulation 28 report would not/could not provide anymore information regarding Shana's death and the broad circumstances thereof then had already been provided by the several independent inquiries which have taken place as described above.".

32. In answer to the question 'Whether the request to resume the inquest is an attempt to relitigate a criminal trial or otherwise go behind its result?', she answered "I am satisfied it is not".

33. In answer to the fourth question 'What are the wishes of the family?', she answered:

> "That is hard to discern. They have not made their wishes clear in their submission to me. It is simply argued that the investigations do not satisfy the requirements of Middleton.
>
> I do not agree. In my view they do.
>
> This family are understandably traumatised/outraged and angry about Shana's death. However, they appear to have rejected opportunities offered by all the independent investigations to engage save through "family friends" who have apparently only been able to make little or no impact
>
> No further enquiry whether it be resumption of the Inquest or any further enquiry can undo the tragedy (arguably potentially avoidable) of Shana's death. Having given serious and careful consideration to this application I refuse it. There is not sufficient reason for resuming this Inquest."

The Statutory Scheme

34. Section 1 of the Coroners and Justice Act 2009 ("CJA") provides, as is material:

> "(1) A senior coroner who is made aware that the body of a deceased person is within that coroner's area must as soon as practicable conduct an investigation into the person's death if subsection (2) applies.
>
> (2) This subsection applies if the coroner has reason to suspect that—
>
> (a) the deceased died a violent or unnatural death,
>
> (b) the cause of death is unknown, or
>
> (c) the deceased died while in custody or otherwise in state detention."

35. The purpose of an inquest, and the matters to be ascertained, are set out in section 5:

> "(1) The purpose of an investigation under this Part into a person's death is to ascertain—
>
> (a) who the deceased was;
>
> (b) how, when and where the deceased came by his or her death;
>
> (c) the particulars (if any) required by the 1953 Act to be registered concerning the death.
>
> (2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.
>
> (3) Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than—
>
> (a) the questions mentioned in subsection (1)(a) and (b) (read with subsection (2) where applicable);
>
> (b) the particulars mentioned in subsection (1)(c).
>
> This is subject to paragraph 7 of Schedule 5."

36. Paragraph 7 of Schedule 5 provides that:

> "(1) Where—

> (a) a senior coroner has been conducting an investigation under this Part into a person's death,
>
> (b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and
>
> (c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,
>
> the coroner must report the matter to a person who the coroner believes may have power to take such action.
>
> (2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.
>
> (3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner."

37. Section 10 provides:

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

38. Paragraph 2 of Schedule 1 provides:

> "(1) Subject to sub-paragraph (6), a senior coroner must suspend an investigation under this Part of this Act into a person's death in the following cases.
>
> (2) The first case is where the coroner—

> (a) becomes aware that a person has appeared or been brought before a magistrates' court charged with a homicide offence involving the death of the deceased…
>
> (6) The coroner need not suspend the investigation—
>
> (a) in the first case, if a prosecuting authority informs the coroner that it has no objection to the investigation continuing…
>
> (c) in any case, if the coroner thinks that there is an exceptional reason for not suspending the investigation."

39. Paragraph 8(1) of Schedule 1 provides:

> "(1) An investigation that is suspended under paragraph 2 may not be resumed unless, but must be resumed if, the senior coroner thinks that there is sufficient reason for resuming it…"

40. Article 2 ECHR provides:

> "1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
>
> 2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary: (a) in defence of any person from unlawful violence; (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; (c) in action lawfully taken for the purpose of quelling a riot or insurrection."

The competing contentions and the issue in the case

41. As is apparent from the Coroner's decision, it is common ground that the investigative obligation under Article 2 ECHR was engaged on the basis of potential breach by the police of their operational duty to safeguard the life of Ms Grice. The central issue for me is whether the Coroner was right to hold that the criminal trial and the other investigations which followed were sufficient to meet that obligation.

42. On behalf of Mrs Grice, Ms Brimelow argued that the Coroner was in error in finding that the investigations to date were sufficient. Relying on the House of Lords decision in *Amin v Secretary of State for the Home Department* [2004] 1 AC 653, she submitted that the reviews were inadequate because they were not sufficiently independent, were ineffective, provided insufficient scrutiny and permitted insufficient involvement of Ms. Grice's family.

43. She submitted that the criminal trial was focused upon Mr. Lane and "evidence to identify his actions". There was no focus upon the conduct of the police in relation to how they treated Ms. Grice or upon their breaches of duty towards her. There was no

consideration of the failure by the Second Interested Party, the NHS Trust or the potential missed opportunity to intervene when Mr. Lane was arrested in March 2016. She argues that the criminal trial "involved almost no exploration of the circumstances surrounding Ms. Grice's murder – merely an examination of whether a jury could be sure to the criminal standard that Lane had killed her".

44. As to the DHR and IOPC proceedings, she argued that the Claimant attempted to participate in the processes. But the participation allowed was limited in any event. She pointed out that both of these enquiries were conducted in private and the Claimant had no opportunity to be present whilst the reviews were ongoing.

45. As to the disciplinary proceedings, Ms Brimelow argues the Claimant had no faith in the independence of the misconduct panels. The Claimant objected to the fact that defendants in those proceedings were not subject to the same restrictions on referring to a complainant's private life, as would be the case in the criminal courts. As a result, she said, the process itself gave the appearance of bias against Ms. Grice. Ms Brimelow also argued that the family was not able to participate in the hearing.

46. She argued that the "Stalking Report" of HMICFRS found that Sussex police had made some improvements in its practice but still had much work to do. In April 2019, nearly three years after Ms. Grice's murder, there continued to be failures of safeguards for victims of stalking. These victims are predominantly young women and, Ms Brimelow argues, it "is significantly in the public interest that Sussex police's response to stalking complaints – which in Ms. Grice's case was gender based (sic) and apparently discriminatory - is examined in the Inquest". She says that 12 other women were subjected to stalking and harassment by Mr. Lane, and none had any engagement with State protection mechanisms. That speaks, she argues, to a systemic failure by Sussex police to protect young woman subject to stalking and that should be considered by the inquest.

47. She was critical of the effectiveness of the inquiries. She said that the response from Sussex police to events, revealed at the trial, revealed that the training of police officers and systems for responding to allegations of stalking were still poor long after Shana's death.

48. Referring to *R v Inner West Longdon Coroner ex p Dallaglio* [1994] 4 All ER 139, she argues that the proceedings and evidence at the inquest need to be sufficiently broad to serve the purpose of paragraph 7 of schedule 5, namely the prevention or reduction of the risk of future injuries in similar circumstances. Referring to *R (Lewis) v HM Coroner for the Mid and North Division of Shropshire* [2009] EWCA Civ 1403 she contends that the Coroner must investigate whether there are circumstances creating a risk of future deaths and that the scope for comment by a coroner on systemic failures in order to prevent similar deaths in the future is a wide one.

49. The underlying theme of much of Ms Brimelow's submissions, it seemed to me, was to the effect that all the investigations to date had failed to provide a means for the Grice family to challenge Sussex police, individually and as an institution, as to their admitted failures in the investigation of Shana's complaints, and that a much wider, deeper and more comprehensive inquiry was required to investigate the attitude or culture of Sussex police towards stalking allegations, in the lead up to Shana's death and ever since. I suggested to Ms Brimelow that what she was seeking in substance was a public

inquiry. She rejected that suggestion but maintained that the inquiries to date, whether viewed individually or collectively, were manifestly insufficient to meet the requirement of Article 2.

50. Neither Mr Hough nor Mr Thomas advanced positive cases in response, but both helpfully directed the Court to the relevant authorities. Ms Goring repeated submissions about the nature of the Article 2 duty.

Discussion

General provisions and principles governing inquests

51. There is no dispute about the legal regime governing inquests. The statutory scheme is set out above. Its effects were conveniently set out in Mr Hough's skeleton argument and the essential provisions can be summarised as follows:

52. A coroner must open an investigation into a death if he or she has reason to suspect that the deceased died a violent or unnatural death or a death of unknown cause, or that the deceased died while in state detention: CJA, section 1(1)-(2). After an investigation has been opened, there must be an inquest unless (i) the investigation can be discontinued under section 4 (not relevant here) or (ii) the investigation is suspended and not resumed.

53. The purpose of an inquest is to answer four factual questions: who the deceased was; and how, when and where the deceased came by his/her death (as well as providing formal particulars for death registration): see CJA, section 5(1). Subject to section 5(3), the inquest conclusion may not express opinions on any other matters. The determinations at the end of the inquest are required to answer the four questions: see section 10(1). They must not appear to determine any question of criminal liability of a named person or any question of civil liability at all: see section 10(2).

54. Before the incorporation of the ECHR into domestic law, the question "how" the deceased came to die was always read as meaning "by what means" the death occurred, a question focussing on the immediate cause of death. It was usually answered by short-form conclusions (e.g. accidental death), but could be answered by a short narrative account. (See: *R v HM Coroner for North Humberside, Ex Parte Jamieson* [1995] QB 1, 23-26).

55. Article 2 of the ECHR (the right to life) imposes negative obligations on the state not to take life without proper cause and carefully defined positive obligations to protect life. It also imposes procedural obligations, including both (i) a general obligation to have in place proper systems for investigating all deaths; and (ii) in respect of certain deaths, a specific obligation to establish one or more independent investigations which satisfy Convention standards.

56. Where the Article 2 procedural obligation to establish a Convention-compliant investigation is engaged in relation to a death and has not been discharged by procedures other than an inquest, the statutory provisions governing inquest conclusions are modified so that the question "how" the deceased came by his/her death

is read as "by what means and in what circumstances" the deceased came to die. In practice, this can open up scope for conclusions addressing wider circumstances of death and underlying causes, and it may require a somewhat expanded form of narrative conclusion. See: *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182, [35]-[38]. As set out above, it has been given statutory force in such inquests by section 5(2) of the CJA.

57. The Article 2 procedural obligation is engaged automatically in some situations (such as suicides in prison or deliberate killings by state agents), none of which is relevant to the present case. Otherwise, it is engaged if there is an arguable case that the state or its agents breached one or more of the substantive Article 2 duties in relation to the death: see *R (Humberstone) v LSC* [2011] 1 WLR 1460, [52]-[68]; *R (Letts) v Lord Chancellor* [2015] 1 WLR 4497, [71]-[75]. That is the position here.

58. In all inquests, the coroner is accorded a broad range of judgment as to the scope of the inquiry: see *R (Hambleton) v Coroner for the Birmingham Inquests (1973)* [2019] 1 WLR 3417, [46]-[50]. A decision that the Article 2 procedural obligation is engaged will have little, if any, effect on the scope of inquiry or conduct of the hearing: *R (Sreedharan) v Manchester City Coroner* [2013] EWCA Civ 181, [18(vii)]. This is because any properly conducted inquest will consider the circumstances surrounding and events leading to death. The key effect of Article 2 engagement is upon conclusions at the inquest.

The central issue in the present case

59. If a coroner conducting an investigation is informed that a person has been charged with a homicide offence in relation to the death in question, as this Coroner was informed, she must suspend the investigation, unless the prosecuting authority indicates that it has no objection to the coronial investigation continuing or there is exceptional reason for not suspending the investigation (para. 2 of Schedule 1 to the CJA). There was no such indication and no such exceptional reason here. It follows that the Coroner here was obliged to suspend the inquest in 2017.

60. If an investigation has been suspended on that basis, then after the criminal proceedings, a coroner's investigation "may not be resumed unless, but must be resumed if, the senior coroner thinks that there is sufficient reason for resuming it" para. 8(1) of Schedule 1. It follows from that statutory language that the decision on whether or not to resume an inquest is one for the coroner's judgment and is one "of a highly discretionary character": see *R v Inner West London Coroner, Ex Parte Dallaglio* [1994] 1 All ER 139, 155e; *Re Howard's Application* [2011] NIQB, [23]-[27]. The question here therefore is whether the decision not to resume the inquest into Ms Grice's death was inconsistent with Article 2 ECHR or irrational. It is not, in those circumstances, surprising that the Coroner's initial decision of 7 March 2019 was to indicate a decision that the inquest should not be resumed. As the history makes clear, once reasons were advanced on behalf of Mrs Grice that it should be, the Coroner reconsidered. I see no grounds for any complaint thus far.

61. The central issue for the Coroner on that further consideration was whether other procedures had answered the statutory questions (including how the deceased came to die) in a manner which adequately served the public interest.

62. It is common ground that in answering that question in a case, like the present, which engages the State's procedural obligation under Article 2, ECHR, the Coroner should consider whether all the other investigative procedures of the state have collectively satisfied the requirements of the procedural obligation (see *Goodson v HM Coroner for Bedfordshire* [2004] EWHC 2931 (Admin) at paragraph 59 (iv) and (vi)). It is necessary for the Coroner to consider "the totality of available procedures", including public investigations and any potential for a civil claim: *R (AP) v HM Coroner for Worcestershire* [2011] EWHC 1453 (Admin), [95].

63. The precise requirements of an Article 2 investigation vary according to the circumstances of the case under consideration. But there are certain irreducible minima. As it was put in *R (D) v Secretary of State for the Home Department* [2006] EWCA Civ 143*:*

> "The Convention does not adopt a prescriptive approach to the form of the investigation. So long as minimum standards are met, it is for the state to decide the most effective method of investigating: see e.g. *Edwards v United Kingdom* (2002) 35 E.H.R.R. 487 at [69] and *Amin* per Lord Bingham at [31], Lord Slynn at [42] and Lord Hope at [63]."

64. The minimum requirements were set out in *Jordan v United Kingdom* (2001) E.H.R.R. 52 at [106] – [109], *Edwards* at [69] – [73] and in *Amin* at [25]. They are commonly referred to as the *Jordan* requirements:

> a) the authorities must act of their own motion;
>
> b) the investigation must be independent;
>
> c) the investigation must be effective in the sense that it must be conducted in a manner that does not undermine its ability to establish the relevant facts; this is, as it was described in *Jordan* "an obligation of means rather than results";
>
> d) the investigation must be reasonably prompt;
>
> e) there must be a ''sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory; the degree of public scrutiny required may well vary from case to case'': and
>
> f) there must be involvement of the next of kin ''to the extent necessary to safeguard his or her legitimate interests''

65. Citing *Goodson v HM Coroner for Bedfordshire* [2004] EWHC Admin 2931 at [68], it was accepted in *D* that "even the minimum requirements involve a degree of flexibility".

66. There is no complaint here that any of the relevant investigations were not instigated by the State or were not sufficiently prompt. The complaints concern independence, effectiveness, public scrutiny and next of kin involvement.

67. With those observations in mind, I turn to consider the investigations that took place in Ms Grice's case.

The Investigations and Proceedings arising out of the death of Ms Grice

68. As noted above, Mr Lane was convicted of murder on 22 March 2017. Green J sentenced Mr Lane to life imprisonment with a minimum tariff of 25 years in prison. At the end of the sentencing hearing, the Judge took the unusual step of making a statement about his concerns in respect of the handling of Ms Grice's complaints to Sussex Police. Those remarks were directed to the Independent Police Complaints Commission, representatives of which had attended the trial. Those remarks included the following:

> "2. Shana Grice was murdered by Michael Lane in August 2016. Between February and July 2016 Shana or persons on her behalf made five complaints to the Police about the behaviour of Michael Lane. On the second occasion in March a complaint was made about an alleged assault by Lane upon Shana. When questioned by Police Michael Lane showed them text messages passing between himself and Shana which indicated that he and she were in a sexual relationship. The Police then treated the complaint as being based upon the deliberate supply of false information. Shana was issued with a fixed penalty notice and a fine for wasting police time; in other words she was treated as the wrongdoer and having committed a criminal offence, and Michael Lane was treated as the victim.
>
> 3. There was seemingly no appreciation on the part of those investigating that a young woman in a sexual relationship with a man could at one and the same time be vulnerable and at risk of serious harm. The Police jumped to conclusions and Shana was stereotyped.
>
> 4. The position adopted by the Police had three potentially serious consequences.
>
> *5.* First, following this incident the Police treated all further complaints by Shana with scepticism. In particular three further complaints were made over the course of the short period between 9th and 12th July 2016. The first related to theft of a door key by Lane which he then used to enter Shana's bedroom to peer at her in her bed at 6.00am in the morning. The second concerned the sending of silent, heavy breathing, calls to Shana, believed to have been from Lane. The third concerned an incident when Lane was seen following Shana. In relation to the use of the stolen key to enter Shana's bedroom Lane received a caution for theft and a low level warning to terminate contact with Shana. In relation to the subsequent complaints Shana was told, in effect, that no further action would be taken. The incidents were classified as low risk. Shana was murdered six weeks later.
>
> 6. The second consequence was that when further incidents of stalking occurred Shana did not complain to the Police because

> she felt that her complaints would not be taken seriously. Evidence was given to this effect during this trial by those close to Shana.
>
> 7. The third consequence was that Michael Lane felt that if he continued with his obsessive stalking behaviour it was most unlikely that the Police would do anything to stop him. And he did continue even though he had been warned by Police to keep away from Shana.
>
> 8. I would emphasise that my concern lies with the way in which the complaints were handled. Following the murder the investigation and prosecution of this case has, in my view, been conducted by the Police professionally and efficiently.
>
> 9. I am aware that the Independent Police Complaints Commission (the IPCC) is investigating and indeed officials from the IPCC have been observing this trial. I am therefore directing that my concerns be brought to the attention of the lPCC so that they can be taken into consideration in the course of that investigation."

69. The IOPC had received a referral from Sussex Police after the killing. They decided to carry out "an independent investigation", the highest level of investigation in their calendar. The terms of reference were approved in October 2016 and the finalised report was produced on 10 June 2018.

70. The terms of reference for the IOPC investigation were:

> "To investigate the circumstances surrounding all police contact with both Shana Grice and Michael Lane from 8 February 2016 to 25 August 2016. In particular:
>
> a) Whether the police response to all allegations made by Shana Grice was appropriate and in line with local and national policies and procedures.
>
> b) Whether the action taken by police against Michael Lane in relation to the allegations made by Shana Grice was appropriate and in line with local and national policies and procedures.
>
> c) Whether police took necessary steps to safeguard and protect the welfare of Shana Grice.
>
> d) Whether police complied with local and national policies and procedures concerning; (i) Risk assessment (ii) Resolution of complains (iii) Recording of matters."

71. Although Shana's family was dissatisfied with the process of the IOPC investigation, some "meaningful updates" were provided to interested persons, including the family, during the course of the investigation.

72. 14 persons were made subject of investigation. Amongst them were PC Godfrey, the officer who received the report from Mr Cooke on 25 March 2015 and arrested and interviewed Mr Lane, and PC Mills, the investigating officer involved after the report on 8 July 2016. So were 12 others, including the supervising officers of those two constables, and the Resolution Centre investigator who had been contacted on 8 February 2016. Failings in the conduct of these officers were identified in the report. For example:

> "The evidence showed that at the time PC Godfrey was carrying out his investigation, he had information available to him on Sussex Police systems that showed history markers warning that Ms Grice was at risk of stalking by Mr Lane, a previous risk assessment that documented stalking, and a recent incident that had been resulted as first time harassment. However, the evidence showed PC Godfrey did not pursue an offence relating to harassment after it had been established that Ms Grice and Mr Lane had been in a relationship and arranged a meeting."

73. Similarly, finding were made in relation to PC Mills. For example:

> "The evidence showed PC Mills was notified that Ms Grice had been followed by Mr Lane for approximately five minutes. PC Mills had prior knowledge of the history between Mr Lane and Ms Grice, and the PIN that Mr Lane had recently been served. However, PC Mills did not consider the new allegation to be an incident relating to harassment."

74. Subjects for "organisational learning" for Sussex Police were identified, and recommendations were made, pursuant to Paragraph 28A of Schedule 34 to the Police Reform Act 2002, to which Sussex Police were required to respond. In respect of the constabulary generally, the report concluded that "police officers and staff reported to feel ill prepared to deal with allegations of stalking, and training was not provided by Sussex Police to deal specifically with this issue". The IOPC report, which was published online, prompted the disciplinary proceedings referred to below.

75. Between January and September 2017, a Domestic Homicide Review ("DHR") was conducted, in accordance with s.9 of the Domestic Violence, Crime and Victims Act 2004. That was overseen by the Brighton and Hove "Safe in the City Partnership". The purpose of a DHR is to:

(i) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

(ii) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

(iii) Apply these lessons to service responses including changes to policies and procedures as appropriate; and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims (including stalking victims) and their children through improved intra- and inter-agency working.

76. The Chair of the DHR, and author of the report, was independent of all agencies involved. She had had no prior contact with the family. No Panel member had had direct contact with the subjects of the review and were not the immediate line managers of anyone who had had direct contact.

77. The family of the victim were invited to participate. They did so, to a limited extent, partly directly and partly through a family friend. A copy of the draft report was sent to the family prior to submission of the report to the Home Office. The Chair of the DHR personally contacted the family who expressed their dissatisfaction with the report on the basis that it was unfair to their daughter. It is of note, however, that the family were critical of the outcome of the report rather than the extent of their involvement.

78. The report of the DHR was published in September 2017. It concluded, in the case of Sussex Police, that "there were shortcomings in respect of risk assessment and policy compliance." It made numerous recommendations including seven directed to Sussex Police. It was subsequently published online.

79. In 2016-2017, HM Inspector of Constabulary (HMIC) and Her Majesty's Crown Prosecution Service Inspectorate (HMCPSI) carried out a thematic inspection of the way that the police and the CPS dealt with stalking and harassment. They published a report, "Living in fear - the police and CPS response to harassment and stalking", which was published in July 2017. The report was critical of the police and made several recommendations for improvement. In April 2017, following the trial, the Police and Crime Commissioner for the Sussex Police area asked Her Majesty's Inspectorate of Constabulary Fire and Rescue Services ("HMICFRS") to carry out an inspection into Sussex Police's response to stalking and harassment. HMICFRS produced its report in April 2019. Ms Grice's family was not involved in the preparation of that report.

80. The report noted a number of causes for concern in Sussex police, including failures to conduct risk assessments, to use the power of entry and search effectively, and to provide all officers with enhanced stalking training. They also noted as a subject for concern nationally that police forces were "dealing with breaches of orders in isolation and are not recognising or properly addressing the wider patterns of victimisation. As a result, forces might not be adequately assessing the risks to some victims and might not be appropriately investigating and prosecuting cases."

81. In July 2019, Police disciplinary proceedings were taken against PC Godfrey and PC Mills, two of the officers involved in dealing with Ms Grice's reports to the police. The Disciplinary panel found that PC Godfrey was guilty of misconduct (but not gross misconduct) by failing properly to investigate Ms Grice's complaints of harassment and issuing her with the fixed penalty notice. A separate panel found that PC Mills had committed gross misconduct by failing to contact Ms Grice or update her, and by failing to carry out proper investigations, following her calls in July 2016. The panel

indicated that PC Mills would have been dismissed had he not already resigned from the police force. He was placed on the College of Police's barred list.

82. In May 2019, at a disciplinary meeting, misconduct was proved in relation to a supervising officer, DS Arnold. This related to his supervision of PC Mills. A written warning was imposed. In July 2019 this decision and sanction were upheld on appeal.

83. The family attended the disciplinary hearings. They were informed at the start of proceedings, but not in advance, that they could pose questions of witnesses which the chairman would put to the witnesses. They expressed dissatisfaction with the conduct of the hearings and with the outcome.

Analysis: Art 2

84. I have set out at [64] above the positive requirements (the *Jordan* requirements) of an Article 2-complaint investigation. It is important also to record what is *not* required:

(i) It is not a requirement of the ECHR that any particular procedure be adopted to fulfil the *Jordan* requirements. The form of the investigation may vary according to the circumstances and those requirements can be satisfied by a set of separate investigations, rather than by a single, unified procedure (see *Jordan v UK* (2003) 37 EHRR 2; *Amin*, at [20]; and *R (Goodson) v HM Coroner for Bedfordshire* [2004] EWHC 2931 (Admin), at [59]).

(ii) The requirement for the family of the deceased to be involved in an investigation to the extent necessary to safeguard their interests does not mean that the investigating authorities must satisfy every request for a particular step to be taken in the investigation: see *Giuliani and Gaggio v Italy* (2012) 54 EHRR 10, [304].

(iii) The requirement of public scrutiny does not invariably require a public hearing: see *Ramsahai v Netherlands* (2008) 46 EHRR 43, [353]. And neither requirement means that the family of the deceased must be able directly to test evidence: see *R (D) v SSHD* [39]-[42].

85. Furthermore, in my view, there is no requirement that each element of the State's investigative procedure meets each one of those tests; the question is whether, viewed in its totality, the investigations meet the minimum requirements identified in *Jordan*. So, the fact that next of kin of the victim ordinarily play no active part in a criminal trial does not mean that the criminal trial falls out of account in assessing whether the totality meets the state's investigative obligation. Similarly, the fact that there is limited public scrutiny of one part of the process or limited involvement of the next of kin, will not necessarily invalidate the whole.

86. Here, there was a criminal trial before judge and jury at which the criminality of Mr Lane was identified, his guilt for this heinous crime established and a life sentence imposed. Family and friends of Ms Grice gave evidence and were able to, and did in

fact, attend throughout. The family were involved in that element of the process to the extent necessary to safeguard their interests. Green J's sentencing remarks made clear that the trial had considered in some detail the nature of the relationship between Mr Lane and Ms Grice in the lead up to the killing and the preparation made by Mr Lane for Ms Grice's murder.

87. Commonly, a murder trial alone will meet the state's article 2 obligations in respect of the death, and an inquest thereafter will not be necessary. An inquest following a criminal trial was described as "the exception" in *McMahon's Application* [2013] NIQB 22 at [22] because "in most cases a criminal trial will involve a sufficient exploration of the circumstances surrounding the death". It was not sufficient here because it became apparent that there were serious failings by the police which contributed to Shana's death. But, in my judgment, it is significant in Article 2 terms, that the criminal trial in this case did more than decide the criminal responsibility of Mr Lane. Green J's remarks at the end of the trial brought to public attention the evidence of the police's failings and prompted the IOPC investigation and doubtless encouraged that of the DHR.

88. The IOPC, an independent and expert body, then investigated the circumstances surrounding all police contact with Ms Grice and Mr Lane from 8 February 2016 to 25 August 2016 and produced a detailed and comprehensive report, identifying failings by the police, both individually and corporately.

89. Very properly, there is no challenge to the independence of the IOPC. The publication of its report ensured there was a sufficient element of public scrutiny of its results to secure accountability in practice. In the light of the way the IOPC went about its investigation and the breadth and thoroughness of its report, it cannot be doubted, in my judgment, that its investigation was effective in the article 2 sense; in other words that it was conducted in a manner consistent with an ability to establish the relevant facts. And, although the family were unhappy about the process, there was, in my view, a degree of involvement of the family which was enough to safeguard their proper interests in that process. The family's unhappiness with the result does not make the process any less effective.

90. The DHR carried out an independent inspection of Sussex Police's response to stalking and harassment. It published a report in April 2019 which noted a number of causes for concern in Sussex police. The HMICFRS report provided further oversight of Sussex police's methods and identified further and persisting areas of concern. These were effective and prompt investigations with a proper element of public scrutiny in their results. The fact that the Claimant could not be present whilst the reviews were ongoing does not undermine their value (see [80 (iii)] above). The fact that the HMICFRS report found that Sussex police had made some improvements in its practice but still had more work to do cannot undermine the value of the reports in the present context.

91. The disciplinary proceedings, attended by the family, ensured that the officers directly concerned in the case were held to account for their actions. The family were involved in those disciplinary proceedings to the extent necessary to safeguard their legitimate interests in those proceedings. The fact that the family were unhappy with the result is immaterial; the obligation to ensure an effective investigation is "one of means rather than results". Contrary to the Claimant's contentions, the fact that the rules of evidence in such proceedings are different from those in Crown Courts does not get close to

establishing either bias or an appearance of bias against Ms. Grice. The panels' function was to determine whether the disciplinary offences were made out, not to resolve a dispute between the officers and Ms Grice's family.

92. In my judgment, there were here prompt, independent enquiries initiated by the state of its own motion, which were effective, both in the manner in which they established the relevant facts and in the results they achieved, which provided a sufficient element of public scrutiny of the investigation or its results to secure proper accountability and which involved the family to the extent necessary to safeguard their legitimate interests. In my judgment the Coroner was not only entitled to find that these enquiries satisfied article 2; she was right to do so.

93. It is apparent that what the Claimant seeks is a much more detailed enquiry than any of those that have taken place hitherto with a much fuller analysis being produced in consequence. In my judgment, as Mr Hough submits, a fully Article 2-compliant inquest would not produce such an outcome. The Courts have repeatedly made clear that in Article 2 inquests determinations should be relatively succinct. The sample conclusion suggested at [38] in *Middleton* read as follows*:* "*The deceased took his own life, in part because the risk of his doing so was not recognised and appropriate precautions were not taken to prevent him doing so*". (See also the observations of the Court of Appeal in *Clayton v South Yorkshire Coroner* [2005] EWHC 1196 (Admin), [31]). While it may be appropriate for conclusions to address underlying causes of death, they should not usually address matters of policy and resourcing: see *Scholes v SSHD* [2006] HRLR 44, [69]; *R (Smith) v Oxfordshire Asst. Deputy Coroner* [2011] 1 AC 1, [81].

94. It follows, in my judgment, that the Coroner's decision did not involve any breach of Article 2. So far as the same arguments are said to support a conclusion that the decision was irrational, they are hopeless. Ms Brimelow was wise not to pursue that point.

Irrationality

95. The one potential point on which there was room for a separate irrationality argument concerned the possibility of a PFD report.

96. As noted above, a coroner will issue a prevention of future deaths (PFD) report if the investigation gives rise to a concern about the risk of future deaths and "in the coroner's opinion", action should be taken in response. But in addressing that issue she is bound to have regard to the enquiries that have already taken place and the reports that have already been published. Certainly, it cannot be said to be irrational for her to do so. In my judgment, given the nature and extent of those other enquiries, it cannot possibly be said to be wrong or irrational of the Coroner here to conclude that any PFD report would not, and could not, provide any more information regarding Ms Grice's death than has already been provided.

Conclusion

97. For those reasons, this application must be dismissed.