Neutral Citation Number: **[2025] EWHC 362 (Admin)**

Case No: AC-2023-MAN-000263

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

Manchester District Registry,
Civil Justice Centre, 1 Bridge Street West,
Manchester M60 9DJ

Date: 20/09/2024

Before:
HHJ Sephton KC, sitting as a Judge of the High Court

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Between:

Sharon O'Brien	**Claimant**
- and –	
HM Assistant Coroner for Sefton, Knowsley and St Helens	**Defendant**
(1) Chief Constable Merseyside Police **(2) Alan McMahon**	**Interested Parties**

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Kate Stone instructed by Irwin Mitchell LLP for the Claimants

Louis Browne KC and David Illingworth instructed by Sefton MBC Legal Services Department for the Defendant

Robert Cohen instructed by Legal Services Department, Merseyside Police for the First Interested Party

The Second Interested Party did not appear and was not represented.

Hearing date: 20 September 2024

JUDGMENT

1. Linda O'Brien ("Linda") died on 9 May 2020 after emerging from the fourth-floor window of her flat and falling, suffering fatal injuries. At the start of the hearing, I expressed my sympathy to Linda's family for their loss. I explained to them that my concern in this hearing must be exclusively with the legal principles in play, and I apologised if the language used by the lawyers might appear cold and analytical. I repeat those words now.

2. This is the claimant's application for judicial review of a decision taken on 15th March 2023 by Mr Graham Jackson, HM Assistant Coroner ("the Coroner"), that there was no coronial causation established linking previous conduct by officers of the Merseyside Police and the events resulting in Linda's death.

Legal Framework

3. Section 5 of the Coroners and Justice Act 2009 ("the 2009 Act") identifies what the Coroner is required to ascertain:

> "(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 (c. 42)), 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."

It will be seen from subsection (2) that in cases where Convention rights are engaged, the Coroner is required to undertake an enhanced investigation.

4. I was referred to a number of authorities which expound the investigation a coroner ought to undertake into "how… the deceased came by his or her death."

5. In *R v. North Humberside Coroner, Ex p. Jamieson* [1995] QB 1, Sir Thomas Bingham MR reviewed the then current legislation and the authorities. Sir Thomas extracted a number of propositions from his review. The 14th proposition (at p 26) was this:

> "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."

6. In *Dove v HM Assistant Coroner for Teesside and Hartlepool* [2023] EWCA Civ 289, Whipple LJ, having considered the authorities, said (at [72]):

> "The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires (*Sutovic*), it is to establish the 'substantial truth' (*Hillsborough*)."

7. In *R(Morahan) v HM Assistant Coroner for West London* [2022] EWCA Civ 1410 Lord Burnett of Maldon LCJ, giving the judgment of the court, explained at [7]:

> "An inquest remains an inquisitorial and relatively summary process. It is not a surrogate public inquiry. The range of coroners' cases that have come before the High Court and Court of Appeal in recent years indicate that those features are being lost in some instances and that the expectation of the House of Lords in *Middleton* of short conclusions in article 2 cases is sometimes overlooked. This has led to lengthy delays in the hearing of inquests, a substantial increase in their length with associated escalation in the cost of involvement in coronial proceedings. These features are undesirable unless necessary to comply with the statutory scheme."

8. A number of authorities establish that it is for the coroner to determine the scope and breadth of the inquiry.

9. I have already recorded that in *Jamieson,* Sir Thomas Bingham MR stated that it is for the coroner to set the bounds of the inquiry.

10. In *R v Inner West London Coroner ex parte Dallaglio* [1994] 4 All ER 139, the Court of Appeal considered the coroner's role in defining the scope of the enquiry. Sir Thomas Bingham MR explained at page 164 j:

> "It is for the coroner conducting an inquest to decide, on the facts of a given case, at what point the chain of causation becomes too remote to form a proper part of his investigation. That question, potentially a very difficult question, is for him."

Simon Browne LJ said this at page 155 b:

> "The inquiry is almost bound to stretch wider than strictly required for the purposes of a verdict. How much wider is pre-eminently a matter for the coroner whose rulings upon the question will only exceptionally be susceptible to judicial review."

11. In *R(Hambleton) v Coroner for the Birmingham Inquests (1974)* [2018] EWCA Civ 2081 Lord Burnett LCJ said at [48]

> "A decision on scope represents a coroner's view about what is necessary, desirable and proportionate by way of investigation to enable the statutory functions to be discharged. These are not hard-edged questions. The decision on scope, just as a decision on which witnesses to call, and the breadth of evidence adduced, is for the coroner. A court exercising supervisory jurisdiction can interfere with such a decision only if it is infected with a public law failing. It has long been the case that a court exercising supervisory jurisdiction will be slow to disturb a decision of this sort… and will do so only on what is described in omnibus terms as *Wednesbury* grounds. That envisages the supervisory jurisdiction of the High Court being exercised when the decision of the coroner can be demonstrated to disable him from performing his statutory function, when the decision is one which no reasonable coroner could have come to on the basis of the information available, involves a material error of law or on a number of other well-established public law failings."

12. It is relevant to identify what is meant by "coronial causation". In *R (Tainton) v HM Coroner* [2016] EWHC 1396 (Admin) ("*Tainton"*) Sir Brian Leveson PQBD pointed out at [41] that there was a difference between the threshold for causation of death and the standard of proof required to prove causation of death. He concluded that for the coroner,

> "the question is whether, on the balance of probabilities, the conduct in question more than minimally, negligibly or trivially contributed to death."

At [62] he said:

> "The conduct or event must make an actual and material contribution to the death of the deceased. As Ms Dolan pointed out, it is not enough, in the present context, to show that a particular event, or particular conduct, deprived the deceased of an increased chance of life or, to put the point the other way round, made his death more probable than it would otherwise have been."

13. Section 7 of the 2009 Act deals with the circumstances in which a jury is required. By section 7(2), "An inquest into a death must be held with a jury if the senior coroner has reason to suspect … that the death resulted from an act or omission of… a police officer in the purported execution of the officer's… duty as such…"

14. The obligation in section 7(2) was considered by the Divisional Court in *R(Fullick) v HM Senior Coroner for Inner North London* [2015] EWHC 3522 (Admin) ("*Fullick")*. The court noted (at [36]) that 'reason to suspect' does not require positive proof or even formulated evidence; any information giving 'reason to suspect' will suffice: *R v Inner London Coroner, ex parte Linnane* [1989] 1 WLR 395, 398. The court endorsed the

words of Hickinbottom J in *R (Davey) v HM Coroner for Leicester City and South Leicestershire* [2014] EWHC 3982 (Admin) at [7]:

> "'Reason to suspect' is a low threshold for the triggering of the obligation to empanel a jury, 'suspicion' for these purposes being a state of conjecture or surmise arising at the start of an investigation in which obtaining a prima facie proof is the end… "

Background

15. Linda had been in a relationship with the Second Interested Party, Mr McMahon.

16. On 14th December 2017, a restraining order was made against Mr McMahon preventing him from contacting Linda for a period of 18 months.

17. On 25th August 2019, Mr McMahon was arrested on suspicion of assault and theft from Linda. PC Lee Wood was the officer tasked with the investigations into the allegations of theft and assault. On 26th August 2019, Mr McMahon was sentenced to 22 weeks' imprisonment for assault occasioning actual bodily harm. On 2nd September 2019, the Merseyside Magistrates' Court made a restraining order against Mr McMahon for 5 years. It read (so far as relevant):

> "This order is made to protect Linda O'Brien from further conduct which amounts to harassment or will cause fear of violence.
>
> Details of the Order: not to approach, contact or communicate with Linda O'Brien by any means whatsoever. not to enter Greenall Court, Prescot."

18. At 00:40 on 7th April 2020, Anthony Larkin made an anonymous 999 call to Merseyside Police to report an ongoing domestic incident at Linda's flat. Mr Larkin said that he could hear screaming. As a result of the call, four police officers attended at Linda's flat: PC Hilton, PC Edwards, PC Judge and PC Dowdall. They found Linda and Mr McMahon present. The officers said that Mr McMahon appeared to be intoxicated. Linda was calm, and according to PC Judge, she said that nothing had happened and she could not understand why the police had been called. None of the officers was aware that Mr McMahon was the subject of a restraining order when they attended on 7th April. PC Judge checked on the police national computer ("PNC") and on the STORM log; PC Hilton checked on NICHE and on the PNC; PC Dowdall checked on the STORM log. None of these checks contained any mention of Mr McMahon being subject to the restraining Order. The officers each said that had they

known that Mr McMahon was present at Ms O'Brien's flat in breach of a restraining order, they would have arrested him.

19. PC Judge completed a Vulnerable Person Referral Form ("VPRF") in relation to Linda's involvement in the incident. The form was not completed in Linda's presence and the form did not record (as it ought to have done, had it been completed accurately) that a restraining order had been made against Mr McMahon in order to protect Linda. The incident was not referred to the Multi-Agency Risk Assessment Conference; it ought to have been referred to the local Independent Domestic Violence Advocate, but was not.

20. On 15th April 2020, PC Lee Wood wished to notify Linda that police intended to take no further action in relation to the alleged theft in August 2019. In seeking contact details for Linda, PC Wood discovered that Mr McMahon had been seen at her house on 7th April 2020. He enquired whether Mr McMahon was being prosecuted for breach of the restraining order. By email dated 27 April 2020, PC Wood invited PC Dowdall to provide a witness statement for the purpose of prosecuting Mr McMahon for breach of the restraining order. He followed up his enquiry (this time copying in PC Judge) on 5th May 2020.

21. On 9th May 2020, Mr McMahon called the emergency services. He had been present when Linda exited a window in her flat and fell, sustaining injuries that proved to be fatal. The police attended and Mr McMahon was arrested on suspicion of her murder. Mr McMahon was remanded on bail following his arrest. He was later arrested for theft and multiple breaches of the restraining order.

22. Dr Rogers undertook a *post mortem* examination of Linda's body. He commented:

> "…the majority of the injuries to Linda O'Brien have been caused as a result of a fall from height but I am concerned by some of the injuries to the right side of the face which in my view would be consistent with assault injuries such as punches/slaps and there was evidence at post mortem that prior to her exiting the window she appears to have been struck with a weapon to the left shoulder/arm area and lower right shin/foot consistent with the broken mop at the scene."

Dr Rogers recorded that the level of alcohol in the blood was 193 mg / 100 ml. He commented that this was almost 2 ½ times the legal limit for driving and he would expect that there would be evidence of significant intoxication.

23. On 19th June 2020, Mr McMahon was sentenced to 20 months' imprisonment for breach of restraining order and theft. The accusation of murder was not proceeded with.

24. It is relevant to note that the Independent Office for Police Conduct ("IOPC") reviewed the actions of the police officers who attended on 7th April 2020. The IOPC investigator concluded that no officer had behaved in a way that justified disciplinary proceedings or committed a criminal offence. The IOPC reports that two officers who completed the VPRF were recommended for Practice Requiring Improvement. My attention was not drawn to any analysis of the fact that the officers who attended on 7th April 2020 say that the police databases contained no reference to the restraining order to which Mr McMahon was subject.

25. On 7th June 2022, HM Senior Coroner made a direction at a pre-inquest review hearing ("PIRH") as follows:

> "i. Jury & ii. Article 2 (i. Mandatory conditions for holding a jury inquest not met and discretion not exercised/ii. not arguably engaged but Article 2 will be kept under review)."

This direction was elaborated in a direction made on 8th June 2022 as follows:

> "HMSC confirmed the mandatory criteria for holding an inquest are not met. HMSC does not exercise her discretion to hold the inquest with a jury. Article 2 is not arguably engaged (on the evidence/information currently available) but this will be kept under review.
>
> The Scope of the Inquest is as stated on the agenda of the PIRH i.e. Events of 08 & 09/05/2020 and touching upon (for background information) the events of 07/04/2020."

On 16 December 2022, the Senior Coroner acceded to a request for a second PIRH which she said may result in changes to the decisions made at the PIRH as to scope (amongst other things) and in particular, "Relevant background information (including the restraining Order) the events of 07/04/2020."

26. On 15 March 2023, after considering submissions by the (now represented) claimant and from the Merseyside Police, the Coroner made the decision under review. He concluded that Article 2 was not engaged (which means that the enhanced investigation referred to in section 5(2) of the 2009 Act was not required). He continued:

> "5. Jury
>
>> By s7(2)(b) Coroner and Justice Act 2008, an Inquest must be held with a Jury if the Coroner has reason to suspect that the death resulted from an act or omission of a Police Officer in the purported execution of the Officer's duty.
>> The phrase: " act or omission" should be interpreted as there being a requirement for some form of inappropriate act.

On the evidence before the Court, it is my opinion that the death did not result from an act or omission of a Police Officer.

In relation to my determining Coronial Causation between the events occurring on 7th April 2020 and 9th May 2020:
• The Standard of Proof is on The Balance of Probabilities;
• The Threshold of Proof is that the events and Police involvement on 7th April 2022 *(sic)* must have contributed more than "Minimally" to the death on 9th May 2022 *(sic)*;
• The Causation question is whether, on the Balance of Probabilities, the Event or Conduct in question more than Minimally, Negligibly or Trivially contributed to the death; and
• The event or conduct (on 7th April 2022 *(sic)*) must make an actual and material contribution to the death of the deceased.

In my opinion, on the evidence before the Court, there is no Coronial Causation established linking events involving Police Officers on 7th April 2022 *(sic)* to those events on 9th May 2020 resulting in the death.
For these reasons, the Inquest will be heard by The Coroner sitting alone.

6. Scope

As Counsel have correctly stated, it is for the Coroner to "set the bounds of the Inquiry". The Coroner must act reasonably and fairly both in deciding what matters will be investigated and which witnesses are to be called. Fairness will mean that the persons whose acts or omission may have caused or contributed to the death are advised of the situation and the Coroner must exercise discretion reasonably and fairly.
For the above reasons I directed, at the PIRH held on 19th January 2023, that Mr McMahon will be an IP and be called to the Inquest to give oral evidence .

The events of 7th April 2020 and the restraining order made against Mr McMahon will not require extensive investigation at the Inquest and mention of such will be for background purposes and information..

The Scope of the Inquest will focus upon events of 8th and 9th May 2020 in particular."

27. The claimant's solicitors served a pre-action letter which suggested that the Coroner had erred in a variety of ways. A letter in reply dated 21 April 2023 was sent on the Coroner's behalf in which it was stated that on the issue of causation, the Coroner had accepted the following submissions:

"(a) None of the individual errors/issues can arguably be said to have been causative of Linda's death more than a month later.

(b) A "best case" scenario would have resulted in officers arresting Mr McMahon for breach of the restraining order on 7/4/20.

> (c) However, it is pure speculation that his arrest would have meant Mr McMahon would not have been with Linda on the morning of 9 May 2020.
>
> (d) It simply cannot be known that such an arrest would have resulted in Mr McMahon's incarceration before or on the date of death or that it would have deterred or prevented his reattendance at the address on the date of death (in particular where his disobedience to previous orders is so clear); or in fact that his presence at the address on 9/5/20 was the cause of death.
>
> …
>
> (h) In any event, it is pure speculation that the arrest of Mr McMahon on 7/4/20 would have prevented his presence at the address on 9/5/20, or that his presence was in fact causative of death."

28. The claimant commenced these proceedings. She challenged the decision on three grounds. HHJ Davies, sitting as a judge of the High Court, gave permission for judicial review on the first ground, that it was arguable that the Coroner had erred in

> "Prematurely and irrationally deciding that there is no causative connection between the acts and omissions of Merseyside Police and the death of Linda O'Brien and thereby unlawfully limiting the scope of the investigation."

Submissions

29. For the claimant, Ms Stone submitted that there had been a failure to enforce a clear breach of an extant restraining order; it was possible that if the officers had been aware of the Order and acted upon it, Mr McMahon would have been prosecuted for the breach; he would not have been present at Linda's flat on 9th May.

30. Ms Stone submitted if it were found that Mr McMahon's acts or omissions contributed to Linda's death and that if he had been arrested on 7 April 2020 he would not have been with Linda on 9 May 2020, then the failure to arrest him had made a contribution to her death sufficient to meet the causation test in *Tainton*. In her oral submissions, she supported the factual assertion that Mr McMahon may not have been at liberty on 9th May, had he been arrested on 7th April, by referring to the Sentencing Guidelines and to the sentence Mr McMahon eventually received (though she conceded that the post-incident sentence was not directly applicable, since sentence was passed after the incident on 9th May when a further breach of the restraining order had been committed). She submitted that the Coroner should receive expert evidence about what the likely progress and outcome of any prosecution would have been; such evidence, she submitted, would enable a jury to reach a conclusion whether the acts and omissions of police officers contributed to Linda's death.

31. Ms Stone submitted that in the absence of investigation into the likely course of events if the restraining order had been enforced on 7 April 2020 or thereafter, it was irrational and unlawful to conclude that there was no causal link between Linda's death and the events of 7 April 2020 and afterwards. She submitted that the decision on scope was fatally flawed by the decision on the causative effect of the acts or omissions of the police. She made the point that the Coroner had not decided that the events of 7 April were too remote to be considered; instead, he had decided that there was no causal link.

32. Ms Stone reminded me that the Coroner has a duty under paragraph 7 of Schedule 3 to the Act of 2009 to report any concern about circumstances creating a risk of death to others. She submitted that the Coroner ought to investigate the fact that Mr McMahon was not arrested on 7 April or subsequently with a view, potentially, to making a report under paragraph 7.

33. Mr Browne KC for the defendant emphasised that the authorities show that the coroner has a wide discretion about the scope of the inquiry with the exercise of which the courts are slow to interfere. He submitted that the decision should be read as a whole; paragraph 5 of the decision reflected a conclusion on the scope of the inquiry which the Coroner was entitled to make. He submitted that it was pure speculation to suppose that if Mr McMahon had been arrested on 7 April, he would not have been present at Linda's flat on 9 May: he invited me to reflect on the many possibilities that might have arisen and what evidence would be called at an inquest in which the possibilities were explored.

34. Mr Browne submitted that the coroner was bound to reach a decision on the scope of the inquest at some stage prior to the actual hearing; the Coroner's decision on scope could not be said to be premature. He invited me to conclude that I should be very slow to find the Coroner's decision was *Wednesbury* unreasonable, given that the Senior Coroner had previously made a similar decision about the scope of the inquest.

35. Mr Browne submitted that the Coroner had no free-standing duty to investigate future potential causes of death. The duty to report under paragraph 7 of Schedule 5 to the 2009 Act arises only if, in the course of the Coroner's investigation, anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur or continue to exist.

36. Mr Cohen for the First Interested Party relied upon and supported the submissions of Mr Browne. He submitted that in this *Jamieson* inquest, the question "how [Linda] came by her death" falls within a narrow compass. He reminded me that section 10(2) of the Act of 2009 provides that the determination of the Inquest may not be framed in such a way as to appear to determine any question of criminal liability on the part of a named person, or civil liability.

Discussion

37. I find it helpful to make some observations about the submission that Linda's death might have been avoided if Mr McMahon had been arrested on 7 April or subsequently.

38. The officers who attended Linda's flat on 7 April did not know that Mr McMahon was subject to a restraining order. They say that, between them, they interrogated the relevant police databases and found no indication that Mr McMahon was subject to a restraining order. If this is true (and there is no evidence that it is not) it is difficult to see how they could be criticised for not arresting Mr McMahon on the spot. Plainly, something went wrong on 7 April in that interrogating the relevant databases apparently did not reveal the fact that Mr McMahon was subject to the restraining order. This could have been due to a technical fault, to some data processing error by civilian staff or to some other reason which may have included an error by a police officer. I simply make the point that the failure to arrest Mr McMahon on 7 April does not necessarily mean that a police officer made a mistake.

39. It is possible that if PC Judge had completed the VPRF in Linda's presence, the fact that Mr McMahon was the subject of a restraining order would have been brought to the officer's attention shortly after the incident on 7 April. If this had happened, it is possible that PC Judge would have taken steps to arrest Mr McMahon for breach of the restraining order. Mr McMahon had left Linda's flat by the time consideration was given to completing the VPRF, so that he would have had to be tracked down before being arrested.

40. PC Wood identified that Mr McMahon was in breach of the restraining order on 15th April. It is possible that the enquiries he made of PC Dowdall and (later) PC Judge could have been expedited. It is possible that, had they been expedited, Mr McMahon might have been arrested before 9 May. I would add that presently, I see no basis upon which to criticise PC Wood; on the contrary, it seems to me that he should be

commended for realising that Mr McMahon had been in breach of the restraining order and seeking to do something about it.

41. We do not know what would have happened if Mr McMahon had been arrested. It is not known whether the breach of the restraining order would have been prosecuted, and if so, when or what Mr McMahon's plea would have been. I consider it likely that he would have been released on bail following his arrest because the Bail Act 1976 applies a presumption in favour of bail and because, later on, Mr McMahon was released on bail after he had been arrested for the rather more serious charge of murder. We do not know the effect that conditions of bail might have had – a relevant consideration, given that Mr McMahon appears to have paid scant regard to the restraining order which forbade him from going to Linda's flat. If Mr McMahon had been sentenced before 9 May, it is not known what sentence would have been passed. Although I agree with the remarks that HHJ Davies made when granting permission that, having regard to the Sentencing Guidelines, a custodial sentence would have been a real possibility, it is in my judgment no more than a possibility.

42. I accept that it is *possible* that if Mr McMahon had been arrested before 9 May, he might have been imprisoned either on remand or serving a sentence on 9 May and it is possible that Linda's death would not have occurred. However, I accept the submission that whether he *would* have been in custody on 9 May is entirely speculative. I do not believe that it is possible to obtain reliable evidence that would enable the coroner or the jury to be satisfied on the balance of probabilities that Mr McMahon *would* have been in custody on 9 May, had he been arrested earlier. I reject the suggestion that the Coroner ought to receive opinion evidence about the likely progress of any prosecution following arrest; such evidence would, in my judgment, be purely speculative and of no probative value.

43. In my judgment, it could not be said that, on the balance of probabilities, Mr McMahon *would* have been in custody on 9 May, had he been arrested on or after 7 April. It follows that any failure to arrest Mr McMahon prior to 9 May cannot be proved to have contributed more than minimally, negligibly or trivially to Linda's death because the causative link between arrest and incarceration on the relevant date cannot be established on the balance of probabilities.

44. I accept that if Mr McMahon had been arrested before 9 May, it is more likely that he would have been on remand or serving a sentence on 9 May than if he had not been arrested at all. However, as *Tainton* explains, "it is not enough… to show that a particular event, or particular conduct, deprived the deceased of an increased chance of life."

45. I turn to consider paragraph 5 of the Coroner's order. The paragraph is headed "Jury." The Coroner was addressing the question whether he had reason to suspect that Linda's death resulted from an act or omission of a Police Officer in the purported execution of the Officer's duty, where "reason to suspect" has the meaning referred to in *Fullick.* I accept the submission that the Coroner was bound to reach a decision whether a jury should be sworn before the inquest took place. It was appropriate that the Coroner address the issue whether there should be a jury at this stage because he had received submissions and heard argument on the point.

46. The Coroner rejected the suggestion that there was reason to suspect that Linda's death resulted from the act or omission of a Police Officer. In my view, it is clear that he did so, not because there was no reason to suspect that an Officer's acts or omissions might be criticised, but because the causative link between any alleged act or omission and Linda's death was not (and could not be) established: that is what he said ("it is my opinion that the death *did not result from* an act or omission of a Police Officer" – my emphasis) and that is why he dealt with coronial causation in his directions. Since I do not believe that it is possible to obtain reliable evidence that would enable the coroner or the jury to be satisfied on the balance of probabilities that Mr McMahon would have been in custody on 9 May, had he been arrested earlier, I think that the Coroner was entitled to reach the conclusion that he did. I do not consider his decision to be premature or irrational.

47. In the light of my conclusion, I have not been assisted by the submission that the scope of the inquest ought to be expanded in order to investigate the actions of the police prior to 9 May. I have accepted that something plainly went wrong on 7 April because it appears that the officers' interrogation of the relevant databases did not disclose the fact that Mr McMahon was the subject of a restraining order. But in answer to the submission that what went wrong ought to be "fully, fairly and fearlessly investigated" there are several responses:

(a) The Coroner has decided the scope of the inquiry; he has decided that the inquest will focus upon events of 8th and 9th May 2020 in particular. In my judgment, the Coroner's decision about the scope of the inquiry is rational.

(b) The investigation proposed by the claimant would be extremely wide ranging and complex. Since the inquest is an "inquisitorial and relatively summary process" and "not a surrogate public inquiry," a decision to limit the scope of the enquiry to avoid this expensive and time-consuming investigation is consistent with the purpose of an inquest and could not be said to be irrational.

(c) The fundamental point is that the investigation proposed by the claimant is irrelevant, since it could not be proved on the balance of probabilities that anything done or not done by police officers on 7 April or subsequently more than minimally, negligibly or trivially contributed to Linda's death.

48. I conclude that the application for judicial review must be dismissed.