Neutral Citation Number: [2022] EWHC 1027 (Admin)

Case No: CO/762/2021

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

Wednesday 4th May 2022

Before:
MR JUSTICE FORDHAM

- -

Between:

THE QUEEN (on the application of ZAMZAM ARAB TURE)	**Claimant**
- and -	
HER MAJESTY'S SENIOR CORONER FOR MANCHESTER NORTH	**Defendant**
-and-	
(1) CHILD 1	**Interested Parties**
(2) CHILD 2	
(3) CHILD 3	
(4) CHILD 4	
(5) BROADOAK SPORTS COLLEGE	

- -
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Stephen Simblet QC (instructed by Liberty Law Solicitors) for the **Claimant**
Sophie Cartwright QC (instructed by Rochdale MC Legal Services) for the **Defendant**
Alison Hewitt (instructed by Weightmans LLP) for Child 1
Joseph Hart (instructed by Clarion Solicitors Ltd) for Child 2-4
Andrew Cullen (instructed by Browne Jacobson LLP) for BSC

- -

Hearing date: 8.4.22

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Approved Judgment

I direct that no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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THE HON. MR JUSTICE FORDHAM

This judgment was handed down by the Judge remotely by circulation to the parties' representatives by email and release to The National Archives. The date and time for hand-down is deemed to be 10:00 on 4.5.22

MR JUSTICE FORDHAM:

Introduction

1. As the grounds of claim in this judicial review case explain, the Claimant ("Mrs Ture") is the mother of 12-year-old Shukri Yahye Abdi who died on 27 June 2019 by way of drowning in the River Irwell in Bury, Manchester. Shukri could not swim. She had accompanied two girls to the river, Child 1 and Child 2. At the river, she was taken by Child 1 into deep water, was left there while obviously in difficulties, and she drowned. A petition calling for "justice for Shukri" gained over one million signatories.

2. The Record of Inquest records that, following an investigation commenced on 2 July 2019 and an inquest ("the Inquest") opened on 9 July 2019, and at an inquest hearing ("the Inquest Hearing") at Rochdale Coroner's Court on 4 December 2020, heard by Ms J Kearsley Senior Coroner in the Coroner's Area for Greater Manchester (North) District ("the Coroner"), it was found and determined that the medical cause of Shukri's death was "drowning" and that the Coroner's conclusion as to the death was "Accidental Death". As to "how, when and where and in what circumstances" Shukri came by her death, the Record of Inquest records these facts:

> ***On the 27th June 2019, at a location on the River Irwell near to Dunster Road in Bury, [Shukri] entered the water with another 13 year old girl. She did so following some encouragement. The other child was aware that Shukri could not swim and was reliant on her to stay afloat. They swam out to an area where the water was deeper, at which point the other Child attempted to swim underwater. At this point a combination of the deeper water together with Shukri panicking and the other child struggling to swim meant that she probably pushed Shukri off. Shukri went under the water and drowned.***

Anonymity

3. The "other child" described in the Record of Inquest is "Child 1", as she has been described throughout the Coroner's proceedings. Other children were referred to as "Child 2, 3, 4 and 5". The Coroner made an order pursuant to section 39 of the Children and Young Persons Act 1933 to prohibit reporting of the names, addresses or schools or any particular calculated to lead to the identification of the child witnesses and in particular Children 1 to 4 until their 18th birthdays. I made an Order in the judicial review proceedings that: "(1) Nothing shall be published that would identify any child other than the deceased, including any person who was a child on 27 June 2019, until further Order of the Court. (2) Liberty to any person apply to vary or discharge this Order on notice to all parties. I agreed with all parties that this anonymity was and remains necessary to protect the legitimate interests of all children referred to and is necessary to secure the proper administration of justice. The parties collaborated in the production for the court file of: (a) a confidential list of those who were children at the relevant time, which can be consulted in any case of doubt; and (b) suitably redacted bundles of documents. I will use " Child 6-9" to refer to four further individuals who feature in this judgment and who are (or were at the relevant time) children.

Judicial review

4. This was an in-person hearing of a renewed application for permission for judicial review, following a refusal on the papers by Robin Knowles J on 20 May 2021. There have been some personnel changes in Mrs Ture's Counsel team. The original grounds

for judicial review (2 March 2021) and grounds of renewal (28 May 2021) were authored by Ashley Underwood QC and Judi Kemish, who had acted as Counsel for Mrs Ture and the rest of the family in the Inquest and at the Inquest Hearing. Amended grounds for judicial review (14 March 2022) together with submissions in support of an application to adduce further evidence (all of which evidence were materials which had been before the Coroner) were authored by Professor Leslie Thomas QC and Fatima Jichi. At the hearing before me Mrs Ture was represented by Stephen Simblet QC. There has been continuity throughout as to the solicitor acting for the family and Mrs Ture, who is Attiq Malik of Liberty Law Solicitors.

The "Findings and Conclusion" document

5. The Coroner's Findings and Conclusion document is important. It is 36 pages long and contains 200 paragraphs. The parties agree that its contents are in the public domain. I was told that they were read out, in their entirety, in the Coroner's court, in public. In order fully to understand this claim for judicial review, it would be a real and substantial advantage for anyone who wished to do so, to see the document to which the Court is referring in this judgment, in its entirety. Moreover, the document is one which was written so as to be – and would need to be – read and understood as a whole. I was surprised to learn that the Findings and Conclusion document is not publicly accessible as a document online. Nor indeed is the Record of Inquest, though I was told there is a mechanism by which a copy of that can be applied for. I have not enquired into this and will take it that there are considered to be good reasons why practices have been adopted and retained as they have, striking the balance that they do. Having said that, I am necessarily directly concerned with this Court's processes, which engage the legitimate interests of the parties, the public interest, and the open justice principle. Repeated reference to the Findings and Conclusion were made in open court. The Court needs to think about how the proceedings and the Court's response to them can be properly understood. If there were an application to the Court to obtain a copy of the document, I would consider it. Ms Hewitt submitted that the Court might choose to annex the entirety of the Coroner's Findings and Conclusion to this judgment. Nobody disagreed. With Ms Cartwright QC's assistance, I will instead set out in the next section of this judgment the Coroner's key "Findings". Later, I will also set out some other passages, including those to which Mr Simblet QC invited my attention. When I quote from and refer to the "Findings and Conclusion" document, I will retain the headings from that document and the original paragraph numbers (the underlining is in the original).

The Coroner's Key Findings

6. The Coroner's Findings and Conclusion document contains the following, as identifiable key "findings" (generally identifiable by the Coroner's use of italics), appearing under the following headings:

> ***27th June 2019 – At School***
> ***28. I find as a matter of fact that the suggestion to go to swimming was made by Child 1. That Child 2 extended the invitation to Shukri who at this stage seemed happy and willing to go with the children after school and that arrangements were made to meet at the school gates after school. As a matter of fact there was no discussion or indication given by Shukri at this stage that she could not swim. I also find that Child 1 who made the initial suggestion was not specific as to the location of where they would be going swimming and that at this stage Shukri would not have known this was to be a river.***
>
> ***27th June 2019 – From leaving School to being at the River***

Leaving School
39. I find as a matter of fact that Shukri had been in the changing rooms with the intention of attending her athletics class and then going home as she would normally have done so. Whether she had forgotten or had changed her mind in respect of meeting Child 1 and 2 cannot be determined but I am in doubt that had Child 1 and 2 not gone looking for Shukri then she would have remained at school and not left with them.

40. Having not met them at the school gates, Child 2 in particular wanted to locate Shukri and was unhappy she had not met up as arranged. Child 1 and 2 went looking for Shukri with the intention of finding her so that she would go with them as planned.

41. Having located Shukri in the changing rooms, I am satisfied that she was subject to peer-pressure in the manner in which she was spoken to, in particular by Child 1 and ultimately was persuaded to leave athletics and go with Child 1 and 2.

Primark
47. Having considered the evidence in relation to the time in Primark I am satisfied that Shukri was content to be with Child 1 and 2 at this time. I am satisfied all three children were involved in the attempt to take items of clothing from the store. I accept this behaviour was out of character for Shukri.

Bus Station
54. I find as a matter of fact that at the bus station Shukri would more than likely have returned home at this stage, if she had not again been persuaded, predominantly by Child 2 to stay. There is no evidence to suggest that this persuasion was in anyway threatening towards Shukri or that she did not willingly stay once persuaded to do so.

Mrs Cusack's Home
57. Whatever thoughts Shukri may have had previously, about returning home, I find on the balance of probabilities as a matter of fact that Shukri was entirely willing to be at Mrs Cusack's home and to leave with Child 1 & 2. Moreover she was happy and enjoying the company of Child 1 and 2 and she willingly left with them with a view to going swimming albeit, as I will come onto, it is unlikely she knew of the exact location.

Meeting Child 3 and 4
63. On the balance of probabilities having considered the evidence I find as a matter of fact that the meeting with Child 3 & 4 was unplanned and purely coincidental. It was only having met by chance, did the boys become aware that Child 1, 2 and Shukri were heading to the river, nothing more specific, and that they then all walked together down to the River Irwell following a route Child 4 knew, arriving at a part of the river not familiar to Child 1.

64. As a matter of fact I find whilst both Child 2 and Shukri were initially apprehensive about being in the company of boys they were happy to remain with the group and made no attempts to leave and go home.

Threat to Kill Shukri
71. On the balance of probabilities I am persuaded that the account given by Child 1 herself to Mrs Cusack some days after Shukri's death is, on balance an accurate account.

72. However and I must stress this, there is absolutely no evidence that there was any animosity between child 1 and Shukri on the walk to the river and that on the balance of probabilities, this is a phrase that Child 1 is likely to use frequently. For these reasons <u>I do not find that this was said with any malice or intent but very much in the context of a child who was keen to go swimming in the water and did not want to be the only one in the water.</u>

Location
81. On the balance of probabilities I am satisfied that none of the children present on that evening would have had knowledge and understanding of the dangers of swimming in this location.

Events at the River
Knowledge as to whether Shukri could swim

> ***109. Having considered the evidence I am satisfied on the balance of probabilities: (a) That Child 1 was aware that Shukri could not swim. (b) That Shukri was sitting in the shallow area of the water before there was then a conversation with Child 1 which was held in the presence of Child 3. (c) That Child 1 encouraged Shukri to into the water telling her she would teach her to swim. (d) That it was during this conversation that Child 1 encouraged Shukri to move from the shallow water, further into the river with her and they did so initially holding hands.***
>
> ***Child 1 and Shukri in the water***
> ***112. I find on the balance of probabilities that having agreed to enter the water with Child 1 in order for her to teach her to swim, Shukri and Child 1 then moved further out into deeper water with Shukri holding onto Child 1 for support. I am equally satisfied that Shukri was a willing participant.***
>
> ***Crisis Point***
> ***136. On the balance of probabilities I find (a) that Child 1 guided both herself and Shukri into deeper water in an attempt to teach Shukri to swim both of them having agreed to this (b) Shukri was reliant on Child 1 to stay afloat once they were in the deeper water.***
>
> ***137. On the balance of probabilities I find the account given by Child 1 in her interview the next day and reiterated to her family support worker days later is probably the most reliable account and that there came a point whereupon Child 1 attempted to swim underwater.***
>
> ***138. On the balance of probabilities, it was at this stage, a crisis developed, either as a consequence of the following factors taken together or individually (a) the deep water and likely current, (b) Shukri panicking as described by Child 3, (c) Child 1 herself being pulled down and/or (d) Shukri trying to climb on top of her. (e) On the balance of probabilities Child 1 let go of Shukri in order to prevent herself from drowning and probably pushed Shukri away and swam back to the rocks.***
>
> ***Conclusion as to the Death***
> ***Gross Negligence Manslaughter***
> ***Duty of Care and Breach of Duty***
> ***177. On balance I am satisfied that a reasonable, ordinary and prudent 13 year old would foresee a risk of injury in the circumstances of this case ie in swimming out into deeper water with someone who you are aware cannot swim, is holding onto you and whereupon you then attempt to swim underwater. In all the circumstances of the case I am satisfied applying the three stage test that Child 1 by her actions assumed a duty of care towards Shukri.***
>
> ***Grossly Negligent so as to be criminal***
> ***195. Which leads me to consider whether the actions of Child 1 in this case were so atrocious, the breach so flagrant, that her actions could properly be characterised as amounting to the most serious of criminal offences namely gross negligence manslaughter.***
>
> ***196. I find they are not and in my judgment fall far from being so, even applying the balance of probabilities. Child 1 was naïve, she was foolish, she thought she could teach Shukri to swim and this ill-considered act went badly wrong. She did not force Shukri into the water, she did not undertake any actions with the explicit intention of causing her harm. She was in unfamiliar water the dangers of which I am satisfied were not fully appreciated. At its highest this was a serious error of judgment. I am sure the ramification of the 27th June 2019 will be felt by many for a long time.***
>
> ***197. I am not satisfied applying the facts I have found to the law that a conclusion of unlawful killing is made out, so cannot return such a conclusion.***

Some further key passages

7. To these key findings, I add the following further specific passages, also taken from the Findings and Conclusion document:

> ***Shukri – Background Facts***

> ***17. Mrs Ture told the court that as far as she was aware there had been no issues between Shukri and Child 1, her recent statement clarifies that, in fact, she (Mrs Ture) did not even know Child 1. However, Mrs Ture told the court that as far as she was aware Shukri did not want to be friends with Child 2.***
>
> ***18. Child 2 acknowledged in her evidence that there were occasions when herself and Shukri had disagreements but on several occasions during the Inquest the court heard how Child 2 found Shukri to be a "funny and entertaining" child who was fun to play with.***
>
> ***Events at the River***
> ***Knowledge as to whether Shukri could swim***
> ***108. There has been much speculation and rumour following Shukri's death suggesting she was pushed into the River. I will state now and make it as clear as I can, there is no evidence whatsoever that I have heard to suggest that Shukri was pushed into the River from the rocks. Such suggestions are simply rumours and unhelpful speculation. There is no place for speculation in court and in this case such rumours are totally incorrect.***
>
> ***Crisis Point***
> ***132. I have considered extremely carefully all of the evidence surrounding the events in the water. I acknowledge the care which must be taken when considering evidence from children taking into account their age, their levels of understanding, a child's perception of events, and their understanding of the actual significance of events as they unfolded.***
>
> ***133. Ms Hewitt made representations to the court that there was no evidence of Child 1 deliberately leading Shukri into the deeper water. I do not accept this. Both Child 3 and 4 described how Child 1 and Shukri moved into the deeper part of the water. Child 3 was clear in his evidence that he was of the view they did this in order to allow Child 1 to teach Shukri to swim.***
>
> ***134. I found the evidence of Child 3 and 4 in particular to be very honest, reliable and told in a very matter of fact way describing the events with what I considered to be a good recollection. I accept they had all witnessed an extremely distressing incident which without any doubt must have been very shocking for them.***
>
> ***135. What happened once Shukri and Child 1 were in or near to the deeper part of the water has required very careful deliberation by me and I have looked with care at all of the evidence available to me in making my findings.***
>
> ***Back at the Rocks***
> ***139. Having swam back to the rocks, there has been evidence heard by the court that Child 1 and 2 were laughing. Whilst I appreciate the distress caused to the family listening to such evidence about laughter between Child 1 and 2, I do not accept, nor is there any evidence to suggest that this was malicious. Child 2 was not in the water, in those initial moments I find she is not likely to have appreciated the true nature of the events which were unfolding. Likewise when Child 1 returns to the rocks I find any laughter was not malicious but rather inappropriate, and more likely to have been an unfortunate childish reaction to what was by now an extremely serious situation.***

Nature of the claim for judicial review

8. Mrs Ture's case is as follows: that, in a number of respects, the Coroner acted unreasonably or unfairly in her approach to key aspects regarding the nature and scope of her inquisitorial investigative enquiry into the relevant facts; that she gave legally inadequate reasons; and that she arrived at conclusions which were not reasonable or justified on the evidence. Mrs Ture submits that the public law errors to which she points, or any of them, should or at least could have led – and if a fresh inquest were

now held there should or at least could be – a different overall outcome from the "Accidental Death" conclusion at which the coroner arrived. One such outcome would be a conclusion of "Unlawful Killing". Another would be recording "Open Conclusion" or a "Narrative Conclusion". The central remedy sought by way of judicial review is the quashing of the Coroner's findings and conclusion, and an order requiring a new inquest.

9. Two grounds for judicial review were originally advanced in March 2021 when the judicial review proceedings were filed, and were maintained in May 2021 when the Notice of Renewal of the application for permission for judicial review was issued. One of those original grounds alleged a misdirection in law. That ground was abandoned when the March 2022 proposed amendments were put forward. The original ground which has survived is "misdirection in fact": that the Coroner "misdirected herself in failing to find the components of manslaughter made out". That ground for judicial review is sought to be expanded by the March 2022 proposed amendments. Two further grounds for judicial review are sought to be added by virtue of those amendments.

10. The essential public law errors of approach which the Coroner is said by Mrs Ture to have made are really of three types. (1) Enquiry. What is said is that there was a failure on the part of the Coroner as to the scope and nature of the enquiry, in not following up certain matters that required investigation and consideration, in not obtaining further evidence, and in not calling further witnesses to give evidence. This type of error is really all about material which the Coroner did not have but ought to have had. (2) Reasons. What is said here is that there was a failure on the part of the Coroner to deal in the Findings and Conclusion document – and so in the Record of Inquest – in a legally adequate, reasonable and fair way with certain matters. This type of error is really all about the way in which the Coroner's reasons dealt with the material which she did have. (3) Conclusions. What is said here is that there were conclusions arrived at by the Coroner which were unreasonable or unfair, unsupported by a sufficiency of evidence, and the Coroner failed to make findings which reasonableness and fairness required her to make, on the evidence. This type of error is really all about the ultimate conclusions at which the Coroner arrived, in light of the material which she had.

11. The three grounds, on which permission for judicial review is now sought, are in several respects interlinked. A good example of this was the submission made that the scope and nature of the enquiry served to 'shut down' certain aspects, with the consequence that the Coroner denied herself adequate evidence so as to be able to arrive at proper evidenced conclusions. One key theme concerned the implications of the fact that Child 1, in the event, did not give oral evidence as a witness at the Inquest Hearing. That was for reasons concerned with her health. It meant that evidence from Child 1 was restricted to an ABE (Achieving Best Evidence) recorded interview. Mr Simblet QC submitted that a materially different enquiry and materially different reasons and conclusions should have followed from that absence of direct witness evidence from Child 1. As Mr Simblet QC emphasised, Child 1 was the person in the water with Shukri in the moments before Shukri drowned.

12. With Mr Simblet QC's assistance, I was able to identify key areas of subject-matter for evidence, enquiry, reasoning and conclusions, which feature heavily in Mrs Ture's judicial review grounds as now constituted. Those key areas were these. (1) Background evidence of "bullying", relating to past bullying of Shukri and past bullying of Child 6, including information emanating from Child 6 and Child 7. (2)

Evidence of "planning", including information emanating from Child 8. (3) Evidence of Shukri having been "forced" or "pushed" into the water, including information emanating from Child 9.

13. One of the advantages of having an oral hearing was that I was able to ensure that Mr Simblet QC took me to specific documents and passages which best exemplified the points being made about the way in which the Coroner dealt with the enquiry and the information available to her. He was able to show me the most significant reference-points in the materials before this Court – all of which were also materials before the Coroner – which are relied on to support or best illustrate the arguments being made.

14. Just as certain points gained prominence and focus, there were points which subsided as a result of the oral argument. One example was a submission that there were material discrepancies in the accounts of Child 3 and Child 4, with which the Coroner failed to deal. Asked at the hearing, and given time for reflection and consultation with Mrs Ture's solicitor, to show me an example of such a discrepancy, Mr Simblet QC ultimately accepted that he was not able to point to one.

15. In relation to the topic of background "bullying" of Shukri, and of Child 6, Mr Simblet QC showed me four key reference points in the materials before the Court (and before the Coroner), which he submitted provided material and illustrative support in relation to the criticisms being made of the Coroner's enquiry, reasoning and conclusions:

    i) First, there was a witness statement which Mrs Ture had made. This statement said: "Shukri was subjected to a daily campaign of bullying by [Child 2] and her friends". It also said that Mrs Ture had reported Shukri missing prior to her learning of her death, and when speaking to the police officer about her worries had told the police that "the last two people [Shukri] was with were the same people" that Mrs Ture thought "had been causing harm to her" and that she was "concerned for [Shukri's] safety". Mrs Ture's statement says: "In my opinion, Shukri was being bullied by this group of students".

    ii) Secondly, there was a witness statement which had been made by Abdirahman Musa, Mrs Ture's fiancé. That statement referred to bullying in the context of Shukri and the school. It also referred to a man called Billy Keenan, a fisherman who had tried to save Shukri.

    iii) Thirdly, there was a witness statement which had been made by Child 6. That statement spoke of Child 6 having herself been bullied and having been threatened by Child 1. It also went on to say that if Child 1 had bullied Shukri, then that "would not surprise" Child 6.

    iv) Fourthly, there was a statement made by Child 7, which said that Child 7's cousin had told her that Shukri's friends used to bully Shukri and that people were mean to Shukri at school and at the mosque. Child 7 also spoke of seeing Child 1 bully others (not Shukri).

16. In relation to the topics of "planning" and "pushing", Mr Simblet QC showed me two further key reference points in the materials before the Court (and before the Coroner) which he submitted provided material and illustrative support in relation to the criticisms being made of the Coroner's enquiry, reasoning and conclusions:

i) First, as to "pushing", there was the same statement of Child 7, which described Child 7's cousin having told him that Child 3 had told Child 8 – a close friend of Child 3 – that Child 1 had "planned it all" and wanted to "push" Shukri into the river to "scare" her.

ii) Secondly, there was a witness statement by an officer which quoted from a conversation which had been captured on police body worn video. In it, a police officer had spoken to Child 9 who said he (Child 9) had heard that the friend of one of his (Child 9's) friends had told that friend that they had been at the river at the time and that "they were all forcing Shukri to jump into the pool", "and then one of them pushed her", and "they all started laughing thinking it was a joke that she could swim but was acting like she couldn't".

17. As I have already indicated, central aspects of the claim for judicial review are the contentions that these key reference points illustrate matters that should have been followed up; that further information should have been obtained; that there were witnesses (including Child 6, 7 and 8) who should each have been called as witnesses to give evidence at the Inquiry Hearing; that the Coroner could not in the absence of a full enquiry of that kind arrive at appropriate and evidenced findings; that the Coroner failed to deal with the evidence that was available to her; and that the Coroner made findings and reached conclusions that were not justifiable on the evidence in light of these problems and all the circumstances, including that Child 1 did not in the event give live evidence as a witness and answer questions at the Inquiry Hearing.

The law

18. The authorities to which Mr Simblet QC referred me included, of particular relevance to the arguments which he advances, the following four cases:

i) R (S) v Inner West London Coroner [2001] EWHC 105 (Admin) (2001) 61 BMLR 222, which reiterates that coroner's proceedings are by nature "inquisitorial" (see §§13 and 22).

ii) R (Mack) v HM Coroner for Birmingham and Solihull [2011] EWCA Civ 712, which is an illustration of the fact that public law grounds for granting judicial review claim can arise notwithstanding that the coroner's conduct of the inquest was "conscientious" (see §§13 and 22).

iii) R (Le Page) v HM Assistant Deputy Coroner for Inner South London [2012] EWHC 1485 (Admin), which is authority for these points. A coroner must "investigate fully, fairly and fearlessly" but "must also be allowed to set the bounds of the inquiry" (see §49). The question, when a judicial review claim impugns decisions such as whether to call an individual to give evidence as a witness at the inquest hearing, is to ask whether the coroner's discretion and power have been exercised "reasonably and fairly" (see §57).

iv) Frost v HM Coroner for West Yorkshire (Eastern District) [2019] EWHC 1100 (Admin), which explains that it is the function of an inquest to "seek out as many of the facts concerning the death as the public interest requires" (see §29) and that one of the key functions of an inquest is to "allay rumour or suspicion" (see §§35 and 41).

Viability of the claim for judicial review

19. In this part of the judgment I am going to address whether the grounds for judicial review which are now put forward in the amended grounds for judicial review – the original and amplified first ground and the two new grounds – are viable in public law terms. At this permission stage in a judicial review claim, the viability question is whether the grounds (or any of them) are arguable with a realistic prospect of success.

20. Judicial review is a supervisory jurisdiction. The judicial review court does not step into the shoes of a coroner, substituting the judgment of the judicial review court for the ways in which a coroner has exercised their judgment. Whether the intervention by the judicial review court is warranted, in the exercise of the supervisory jurisdiction, depends on the application of well-established public law principles – in broad terms – of 'lawfulness, reasonableness and fairness'. They include the standards of 'reasonableness and fairness' to which reference was made in Le Page.

21. In considering whether there are, in this most anxious case, viable grounds for intervention in the exercise of the judicial review court's supervisory jurisdiction, it is helpful to keep in mind the procedural time-line of the Inquest, within which the Coroner was discharging her functions and exercising judgment. The Coroner's investigation opened on 2 July 2019 in the Inquest itself opened on 9 July 2019. The Coroner gave a reasoned ruling on the scope of the inquest on 9 December 2019. After that, a witness list for the Inquest Hearing was drawn up. Further rulings were made by the Coroner. These included a reasoned ruling by the Coroner on 21 January 2020, deciding that it was appropriate for her to see Child 1's social services records. There were pre-inquest review hearings on 11 and 14 February 2020. The Inquest Hearing, at which evidence was received, took place over 5 days between 24 February 2020 and 28 February 2020. By that stage Child 2, Child 3 and Child 4 had all given their oral evidence, but Child 1 was assessed as medically unfit to appear at the Inquest Hearing as a witness. Several months passed and the Inquest Hearing resumed for two days of hearings on 25 November 2020 and 26 November 2020. Further evidence was heard on 25 November 2020. The circumstances were that Child 1 remained medically unfit to appear as a witness, and so Child 1's ABE interview was the evidence received from her. There was a day of oral submissions on 26 November 2020.

22. It is also relevant to have in mind the following. A number of interested parties were legally represented, with the following advocates appearing at the Inquest Hearing: Mrs Ture and the family (Ashley Underwood QC, Judi Kemish, Mr Malik), Child 1 (Alison Hewitt, Anna Naylor), Children 2-4 (Joseph Hart), Broad Oak School (Andrew Cullen) and the Greater Manchester Police (Mark Monaghan). Materials had been disclosed on an ongoing basis to the interested parties and their legal representatives. The interested parties were able to, and did, make representations to assist the Coroner as to the approach to the Inquest, the Inquest Hearing, the law and the evidence.

23. A key time-line so far as the judicial review claim is concerned is that Mrs Ture's judicial review letter before claim was written on 11 February 2021, her original grounds for judicial review followed in March 2021, her grounds of renewal were dated 28 May 2021 and the amended judicial review grounds were filed in March 2022.

24. In considering the application of the supervisory jurisdiction of the judicial review court in relation to the Inquest, I need to keep in mind two key things. The first is that the

Coroner's Findings and Conclusion is a document which, as I have explained, needs to be read as a whole. The second concerns the material which has been placed before this Court, seen in the context of the Inquest. The Court has been given a large volume of material. All of it was material which the Coroner saw and considered, and all of it was available to all interested parties and their legal representatives. But it is very far from being the whole body of material obtained by the Coroner and disclosed to the parties. It is far from being the entirety of the evidence received by the Coroner, the points which were made about that evidence, and everything that was said and heard at the seven day Inquest Hearing. The reference points which Mr Simblet QC has helpfully shown me for the purposes of this claim for judicial review has involved picking up individual items of the materials, in order to illustrate points made about the Coroner's enquiry, reasoning and conclusions. That is no criticism. Indeed, it is inevitable in a judicial review claim, and the more so at the permission-stage, that the Court is not being placed in the same position as was the Coroner. It is important to be able to consider the viability of judicial review grounds by examining aspects of the materials which exemplify and illustrate the key points that are being made. But in considering those points – in picking up and examining pieces of the jigsaw – it is important to retain an appreciation that they form part of a multi-piece, overall and emerging, picture.

25. Having made those contextual points, I must turn to my discussion of the viability of the judicial review grounds which have been put forward in this case. My assessment of viability is this: I have been unable to find in this case any arguable ground for judicial review having a realistic prospect of success. I have been shown no aspect of the process, reasoning or conclusions which, in my judgment – whether individually or cumulatively with other features of the case – entails any arguable vitiating flaw in public law terms.

26. The important starting point is that the Coroner considered all of the materials that have been put before the Court to seek to demonstrate that there are grounds for intervention. For example, that there are aspects of the Inquest which involved an unreasonable or unfair failure to 'follow up' on evidence; or which involved a legally inadequate failure to deal with material features of the case in the Coroner's reasons; or which mean that evidence-based conclusions could not reasonably and fairly be arrived at on the materials before the Coroner. All of the materials were disclosed to the relevant interested parties. They were all available to be the subject of representations by the parties so that the Coroner could make appropriate, informed decisions in the exercise of her full and fearless, inquisitorial function of seeking out facts in the public interest. Those informed decisions included the appropriate 'case-management' of the Inquiry, including setting appropriate bounds and deciding who should be called as witnesses, and keeping those matters under review.

27. When I take the topic concerning evidence of a "background" of "bullying", with reference to Shukri and with reference to Child 6, key points which I find are these:

    i) Mrs Ture's witness statement – to which I was referred by Mr Simblet QC – was material which was considered by the Coroner and was available to all parties and their representatives. Mrs Ture was a witness who gave oral evidence at the Inquiry. In giving that evidence, she was specifically asked about her own prior knowledge of Child 1 and Child 2. Those questions were asked in the context of what she had said about previous bullying of Shukri, and about what

she had told the police about the people Shukri had been with. The questions included whether Mrs Ture had any prior knowledge of any problem between Shukri and Child 1. Given some issues with interpretation, Mrs Ture had given a clarificatory statement which addressed and corrected the transcript. The Coroner dealt with this at §17, which I will set out again here:

> ***Mrs Ture told the court that as far as she was aware there had been no issues between Shukri and Child 1, her recent statement clarifies that, in fact, she (Mrs Ture) did not even know Child 1. However, Mrs Ture told the court that as far as she was aware Shukri did not want to be friends with Child 2.***

ii) The statements of Abdirahman Musa, of Child 6 and of Child 7 – to all of which I was referred by Mr Simblet QC – were all considered by the Coroner, and available to the parties. The Coroner addressed them, the question of background "bullying" evidence, and the proper "scope" for the evidence at the Inquest. She did so with the benefit of submissions from interested parties. This was in a case-management decision: the Coroner's reasoned ruling on the scope of the Inquest (9 December 2019). These three statements were all expressly identified by the Coroner in that ruling, in the context of deciding scope in relation to background bullying evidence. The Coroner made clear in that ruling that she had considered the contents of those statements carefully.

iii) The Coroner's 9 December 2019 ruling on scope was a nuanced one. It involved a general exclusion but a specific inclusion. The Coroner ruled that: (i) "alleged incidents of bullying or violence prior to the day in question would not be included within the scope of the Inquest" (ii) "except in very limited circumstances" namely that the Coroner "would consider questions being put to the children along the lines of how long they had known Shukri, how well they knew her, their relationship with her, and whether they ever had any disagreements with her including on the day in question". An example of (ii) (the inclusion) is reflected in §18 of the Coroner's Findings and Determination (set out earlier), which arose out of questions, asked to Child 2 at the Inquest Hearing, about the relationship between Shukri and Child 1.

iv) In the ruling on scope, The Coroner reasoned that the statements of Abdirahman Musa, Child 6 and Child 7:

> ***… do not assist the court with the matters which have to be determined. None of the witnesses have witnessed any evidence of coercion or bullying directly. It is accepted that the question of whether the school knew of any bullying is not within the scope of the inquest. The court is going to hear direct and best evidence from some of the people referred to ie. Child 3 and Mr Keenan …***

The reference here to Child 3 is another illustration of feature (ii) (the inclusion) of the Coroner's nuanced ruling on scope. Mr Keenan, who gave evidence at the Inquest Hearing, was the person referred to in the statement of Abdirahman Musa. It was correct – as the Coroner reasoned in the ruling – that none of Abdirahman Musa, Child 6 or Child 7 were saying in their witness statements that they had directly witnessed coercion of Shukri or bullying of Shukri (including by Child 1-4 who were at the River with Shukri on 27 June 2019).

v) The Coroner maintained a nuanced approach to evidence of background bullying, and kept the issue of scope under review. These points are illustrated as features of the reasoning in the subsequent ruling (21 January 2020), in which the Coroner decided that it was appropriate that she should see Child 1's social services records. In that ruling, the Coroner disagreed with the representations made on behalf of Child 1, to the effect that viewing Child 1's social services records was outside the scope of the Inquest (on which the Coroner had ruled), was irrelevant to the statutory questions the Coroner had to determine, and could have no relevance to the Inquiry. The Coroner preferred the representations made on behalf of Mrs Ture and Shukri's family. The specific concern was as to whether Shukri was being bullied or coerced by Child 1. The Coroner ruled that access to Child 1's social services records was appropriate, so that she could consider them, alongside the other evidence. It was in that context, and in this ruling, that the Coroner explained that it was proper to keep the question of scope under review and that it was right for the coroner to have sight of the material and then consider the question of relevance of the contents.

vi) Mr Simblet QC, rightly, accepts that the Coroner's approach was a "conscientious" one. But, in my judgment, it was plainly a lawful, reasonable and fair approach. It is not, in my judgment, arguable with any realistic prospect of success that public law standards of lawfulness, reasonableness and fairness required the Coroner to require further investigation of Abdirahman Musa, Child 6 or Child 7 to elicit evidence from them as to background bullying; nor to call them as witnesses to give oral evidence at the Inquiry Hearing. No subsequent feature of the Inquiry – including the unavailability of Child 1 to give evidence at the Inquiry Hearing – arguably gave rise to a public law duty to take such steps. Nor do the points made about the background bullying evidence that was, and was not, heard at the Inquest support any arguable challenge to the Coroner's ultimate reasons or conclusions.

28. When I take the topics concerning evidence of "pushing" and "planning", and the statements of Child 7 and Child 9, key points which I find are these:

i) The Coroner had and considered the statements of Child 7, including its reference to Child 8, and relating to the body worn video recording of the conversation with Child 9. The Coroner referred to the statement of Child 7 in her ruling on scope, because of the references to bullying in that statement, saying (correctly) that Child 7 had not witnessed any "coercion" directly.

ii) The statements of Child 7 and Child 9 were the subject of decision-making by the Coroner in case-management of the Inquest. They were addressed by the Coroner in the context of drawing up an appropriate list of appropriate witnesses to give oral evidence at the Inquiry Hearing. On that subject, the Coroner circulated a draft List of Witnesses which she reviewed and revised having elicited representations from interested parties, including the family. The interested parties made those representations having had ongoing disclosure of the materials, including the police statements. The representations on behalf of the family specifically included, for example, the topic of "planning".

iii) In particular, representations were made on 15 December 2019 on behalf of the Chief Constable of GMP who addressed the question of relevant witnesses.

Those submissions were crisp: 9 paragraphs long. GMP's submissions specifically addressed the evidence of the police officer who had conversations with both Child 8 (the child referred to by Child 7) and Child 9, which officer had recorded those conversations on body worn video. Having received those GMP representations the family was able to put forward its representations, as it did four days later (19 December 2019) as to the witnesses who should be called. The Coroner then took a view (on 20 December 2019) in which she expanded the List of Witnesses for the Inquest Hearing, beyond that identified by the family.

iv) That was the case-management decision-making context, in which Child 7, Child 8 and Child 9 were not included in the list drawn up of witnesses who would be giving oral evidence to the Inquiry Hearing.

v) Again, this was – beyond argument – a lawful, reasonable and fair approach. Again, it is not arguable with any realistic prospect of success that public law standards of lawfulness, reasonableness and fairness required the Coroner to require further investigation of Child 7, Child 8 or Child 9 to elicit evidence from them as to "planning" or "pushing"; nor to call them as witnesses to give oral evidence at the Inquiry Hearing; nor to revise that position in subsequent circumstances including the unavailability of Child 1 as a witness at the Inquiry Hearing. Nor, again, do the points made about these topics and about the evidence that was, and was not, heard at the Inquest support any arguable challenge to the Coroner's ultimate reasons or conclusions.

29. I have been able to find no aspect of the Coroner's Findings and Conclusion which arguably fail to give legally adequate reasons; or fail to deal with relevant matters; or arrive at unsustainable, unsupported or unreasonable conclusions. The Coroner's reasoned Findings and Conclusion involved looking – in a manner which beyond argument was lawful, reasonably and fair – at the facts, circumstances and evidence, including as to how Shukri came to be at the River with the other children, how Shukri and Child 1 came to be in the water, what happened in the water, and what happened afterwards.

30. The absence of Child 1 as a witness at the Inquiry Hearing was, understandably, strongly emphasised by Mr Simblet QC. But it is rightly not said in these judicial review proceedings that there was any unlawfulness, unreasonableness or unfairness in the Coroner accepting that Child 1 was (in February 2020) and remained (in November 2020) medically unfit to be a witness at the Inquest Hearing; nor any unlawfulness, unreasonableness or unfairness as to the arrangements for receiving Child 1's ABE evidence. The Coroner was acutely aware of the situation regarding Child 1 and its implications. The Coroner dealt with the evidence, fully and fairly. She specifically addressed the number of "differing" and "unreliable" accounts which Child 1 had provided, to a number of people. She addressed the differing accounts which had been given by Child 1 in an interview with GMP on 28 June 2019, which material was before the Coroner and from which she quoted. She then went through the evidence which was available from others to whom Child 1 had provided information of the events, quoting from 11 different sources of that evidence. These parts of the reasons occupy nearly 5 pages of the Findings and Conclusion document. It was in this context that the Coroner arrived at the key passages at §§133-135 and 136-139, all of which has been set out in full above. In my judgment, it is not arguable with any realistic prospect of success that

the situation in relation to Child 1's unavailability as a witness at the Inquest Hearing robbed the Coroner's findings and conclusions of a proper evidential basis, nor rendered it unlawful unreasonable or unfair for the Coroner not to expand the nature or scope of the investigation or the calling of other witnesses.

31. In these circumstances and for these reasons, this claim for judicial review does not have the viability which is required in order for the Court to grant permission for judicial review. Since the new amended grounds lack viability, I will formally also refuse permission to amend. Having arrived at that conclusion, there are a few further topics which it is appropriate that I mention.

The family's representatives, at and after the Inquest

32. It is appropriate to reflect on some features of this case relating to the position adopted at and after the Inquest by the family's legal representatives. Those representatives were fully alive to topics such as bullying, planning and pushing. They had read and considered the materials which had been disclosed, and the representations made by the other parties. They had considered GMP's submissions and the list of witnesses. They were aware of the ongoing position regarding topics such as Child 1's inability to be called as a witness at the Inquest Hearing. The Coroner had ruled against their representations, as to the scope of the Inquest not extending to the entirety of the background regarding the topic of bullying. The Coroner had ruled in favour of their representations, and against those made on behalf of Child 1, in the context of keeping scope under review and having access to Child 1's social services record. They made submissions in relation to the case-management decisions, and they made submissions in writing and orally at the Inquest Hearing. They made submissions, including several sets of written submissions, to assist the Coroner as to appropriate findings and conclusions. So far as the scope of the Inquest not including background of bullying, which was an issue on which the Coroner had specifically ruled against the representations made by the family's legal representatives, Counsel who had acted at the Inquest, for their part, did not identify this as giving rise to a judicial review ground of challenge. Other than the representations which were made prior to the ruling on scope, in which the family failed to persuade the Coroner that the background bullying topic should in its entirety be within the scope of the Inquest, I was shown and referred to no representation made by them during the course of the Inquest which raised with the Coroner the points which were subsequently made within the amended grounds for judicial review. For example, I was shown no representation made on behalf of the family that the topics of "planning" and "pushing" required Child 7, Child 8 or Child 9 to be included in the list of witnesses. On the contrary, when representations for the family identified those who should be included in the list of witnesses, those three individuals were not named. I would accept that it is possible, in principle, for a coroner to act unlawfully, unreasonably or unfairly in their approach to an inquest, in a way which even Leading and Junior Counsel and their Instructing Solicitor acting for the judicial review claimant at the inquest did not spot at the time of the inquest. I would accept that it is possible, in principle, for a coroner to act unlawfully, unreasonably or unfairly in a reasoned ruling or in reasoned findings and conclusions in ways which Leading and Junior Counsel and their Instructing Solicitor acting for the judicial review claimant, having acted for the claimant in the Inquest itself, did not think gave rise to a ground for judicial review. But having said that, when the judicial review Court is asked to accept that there have been basic public law errors warranting the supervisory

jurisdiction of judicial review, it must stand at least as a potentially illuminating cross-check to see what Leading and Junior Counsel and their Instructing Solicitor were (and were not) putting forward in the Inquest itself, given their own knowledge and appreciation of the way in which the Inquest process was unfolding and had unfolded and the entirety of the factual and evidential picture, and were (and were not) putting forward when they came to evaluate and frame grounds for judicial review (and grounds of renewal) to impugn the Coroner's decision-making, reasoning and conclusions.

'No difference'

33. It is appropriate that I record that one of the submissions made on behalf of Child 1 and Child 2-4 was that, even on the premise that there were some public law error by the Coroner, that error would or could not have made any difference to the ultimate outcome (the conclusion), and so permission for judicial review should in any event be refused on that basis. The premise for that argument does not arise. To address this point would involve embarking on an artificial, hypothetical path of reasoning. What I will say is that I think it most unlikely, had I thought there was some arguable public law error by the Coroner, that I would have acceded to this 'no difference' submission as 'knock-out' permission-stage point.

Permission to amend: lateness

34. It is appropriate also to record that one aspect of the submissions made on behalf of Child 1 and Child 2-4 was that, leaving aside any question of viability, permission to amend should be refused on grounds of delay and prejudice. Again, the premise does not arise. Had I thought that there were some viable ground for judicial review with a realistic prospect of success, I would have been extremely reluctant to shut it out by reference to the timing of its adoption. It is right, of course, that there are questions of good administration and legitimate interests of others including the other children who feature in this case. Strong emphasis was placed on the prejudice for Children 1 and 2-4 which would arise from the prospect of the Inquest being reopened. But, in my judgment, the strong starting point – in a judicial review claim which was commenced with sufficient promptness – is the primacy of the interests of justice for the family of Shukri including Mrs Ture, in what I recognise – for them – has been an ongoing quest for truth and for justice, and which itself engages a strong public interest.

'Too late' to challenge 'scope'

35. Finally, it is appropriate to record that an oral submission was made by Ms Hewitt for Child 1, which she was able to link to a point made in correspondence by her instructing solicitors, that any challenge to the Coroner's action in not inquiring as to broader issues of background bullying ought to have been by way of a prompt judicial review challenge to the Coroner's reasoned ruling on scope. All Counsel told me that there are authorities 'going both ways' on whether judicial review challenges to coroners' case-management decisions are appropriate (in the interests of early clarity) or inappropriate (as constituting premature interference). In the circumstances, nothing turns on this point. But I would not have accepted Ms Hewitt's oral delay argument, on the background bullying part of the case, without being shown any of this authority. It might have been appropriate to allow her to preserve this delay point by reserving it to the substantive hearing or directing a rolled-up hearing.

Conclusion

36. Since – for the reasons I have given – I have been unable to find any arguable ground for judicial review having any realistic prospect of success, I refuse the renewed application for permission for judicial review, including on the proposed amended grounds and by reference to the proposed further materials, and I formally refuse permission to amend the grounds.