IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT
[2023] EWHC 3476 (Admin)

No. CO/195/2023

Royal Courts of Justice

Thursday, 4 May 2023

Before:

LORD JUSTICE WILLIAM DAVIS
MRS JUSTICE HILL DBE

IN THE MATTER OF THE INQUEST INTO THE DEATH OF ROBERT LEECH:

HIS MAJESTY'S AREA CORONER FOR CUMBRIA — Applicant

MALCOLM LEECH — Interested Party

MR A MOSS (instructed by BDB Pitmans) appeared on behalf of the Applicant.

THE INTERESTED PARTY did not attend and was unrepresented.

J U D G M E N T

MRS JUSTICE HILL DBE:

1 This is the judgment of the court. By a Part 8 claim issued on 18 January 2023, Her Majesty's Area Coroner for Cumbria seeks an order under the Coroners Act 1988 s.13 to quash the determination and findings of the inquest into the death of Mr Robert Leech and to order that a fresh investigation into his death shall be held.

2 Under s.13(1):

> "If the High Court is satisfied as respects a coroner either that he refuses or neglects to hold an inquest or an investigation which ought to be held or where an inquest or an investigation has been held by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise it is necessary or desirable in the interests of justice that an investigation or, as the case may be, another investigation should be held."

3 Under s.13(2) the High Court may:

> "(a) order an investigation under Part 1 of the Coroners and Justice Act 2009 to be held into the death, either by (i) the coroner concerned or; (ii) by a senior coroner, area coroner or assistant coroner in the same coroner area;
>
> (b) order the coroner concerned to pay such costs of and incidental to the application as to the court may appear just; and
>
> (c) where an inquest has been held, quash any inquisition on or determination or finding made at that inquest."

4 As is required, the coroner brings this claim with the *fiat* or permission of the Attorney General, the same having been given on 13 December 2022. The claim is supported by a witness statement from the coroner dated 17 January 2023, together with 15 exhibits, which we have read.

5 We have been assisted at the hearing today by Mr Moss, counsel on behalf of the coroner. Mr Leech's son, Malcolm, who was an interested person in the inquest proceedings and who is therefore an interested party to this claim, has been made aware of the claim. He has previously signed a consent order indicating that he did not oppose the order sought. He is aware of today's hearing and we have seen email correspondence from him indicating that he does not propose to attend.

6 The background to the claim is as follows. Mr Leech died on 4 March 2019 at Workington Community Hospital, when he was 89 years old. He had an extensive history of respiratory illness. He had worked for British Rail from the age of 15 to when he retired at the age of 62, save for two years when he was required to do national service. He had a history of exposure to asbestos through his work as a cleaner and fireman on what he called the "locos" or "locomotive trains". Before he died, Dr Matthew Lane, a consultant respiratory physician at North Cumbria University Hospitals, indicated that CT scanning showed that he had asbestosis. We have seen a report dated 24 November 2016 to this effect.

7 Dr Joanne Leitch carried out a post-mortem examination in respect of Mr Leech. By her report dated 1 April 2019, she explained that plural plaques were present in both the plural cavities. She noted that his lungs showed fibrosis and superimposed infection, namely, bronchopneumonia. She examined samples of his lung tissue. She identified more than 20 asbestos bodies in a single 20-micron thick pearl-stained section, which was in keeping with asbestosis. In her conclusion, she gave the cause of Mr Leech's death as 1a) Bronchopneumonia due to 1b) Asbestosis.

8 On 7 August 2019, the inquest into the death of Mr Leech took place at Cockermouth Coroner's Court. Malcolm Leech attended. The coroner considered the post-mortem report; various documents Malcolm Leech had provided about his father; a statement Mr Leech Snr had written while he was alive, setting out his work history; Dr Lane's report and a report from Mr Leech's GP.

9 The Record of Inquest sets out the coroner's determinations and findings under the Coroners and Justice Act 2009, s.5(1). The coroner accepted Dr Leech's conclusion as to the medical cause of Mr Leech's death. As to how, when and where Mr Leech died, she found that he had died on 4 March 2019 at Workington Community Hospital in Workington "as a result of exposure to asbestos during the course of his employment". Her conclusion was that he had died due to industrial disease.

10 On 1 June 2020, Mr Leech informed the coroner that his solicitor had commissioned a report from Professor Michael Sheaff, a consultant histopathologist with a special interest in thoracic pathology. Professor Sheaff carried out a fresh examinations of Mr Leech Snr's lung tissue. He concluded that it did not meet the accepted criteria for a pathological diagnosis of asbestosis. These are set out in a joint publication by the Asbestos Committee of the College of American Pathologists and the Pulmonary Pathology Society. They state that there should be an appropriate pattern of pulmonary fibrosis, with a finding of alveolar septal fibrosis and an average rate of asbestos bodies of at least two per square centimetre of lung.

11 The coroner provided Professor Sheaff's report to Dr Leitch. On 25 June 2020, she provided a revised post-mortem report, amending the cause of death to 1a) Bronchopneumonia due to 1b) Idiopathic Pulmonary Fibrosis, adding that "the lung fibrosis cannot be directly attributed to asbestos exposure".

12 The coroner's witness statement is to the effect that if this had been the cause of death recorded by the pathologist at the outset she would have considered that Mr Leech's death was due to natural causes. On that basis, the investigation into his death would have been discontinued under the Coroners and Justice Act 2009 s.4(1), with no inquest.

13 It is therefore clear to us that fresh and cogent evidence now indicates a different medical cause of death to the one found at the original inquest. In particular, it suggests that there is insufficient evidence to conclude that Mr Leech died due to exposure to asbestos. It is highly likely that a different outcome would be reached if his case was reconsidered.

14 In those circumstances, we are satisfied that the criteria set out in s.13(1)(b) are met, because an inquest has been held but by reason of the discovery of "new facts or evidence" it is both necessary and desirable in the interests of justice that another investigation should be held.

15 We therefore quash the determinations and findings made at the inquest of 7 August 2019 under s.13(2)(c). We order that a fresh investigation is held by the same coroner under s.13(2)(a). We make no order for costs.

CERTIFICATE

Opus 2 International Limited hereby certifies that the above is an accurate and complete record of the Judgment or part thereof.

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This transcript has been approved by the Judge.