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IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
DIVISIONAL COURT
[2024] EWHC 1085 (Admin)

No. AC-2023-LON-002561

Royal Courts of Justice

Tuesday, 23 April 2024

Before:

LORD JUSTICE SINGH
MRS JUSTICE COLLINS RICE DBE, CB

I N T H E M A T T E R O F :

HM ASSISTANT CORONER FOR INNER LONDON COURT

No attendance was required.

J U D G M E N T

LORD JUSTICE SINGH:

Introduction

1 This is an application made pursuant to s.13(1)(b), s.13(2)(a)(i) and s.13(2)(c) of the Coroners Act 1988 which, so far as material, provide as follows:

> "(1) This section applies where, on an application by or under the authority of the Attorney-General, the High Court is satisfied as respects a coroner ('the coroner concerned') either …
>
> (b) where an inquest or an investigation has been held by him, that (whether 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 by, another investigation) should be held.
>
> (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—
>
> (i) by the coroner concerned …
>
> (c) where an inquest has been held, quash any inquisition on, or determination or finding made at that inquest."

2 The factual background is as follows. Karina Jane Brandt ("Karina") was found dead at her home at 29A De Beauvoir Square, London on 24 July 2020. Karina's body was found by officers from the Metropolitan Police Service, or MPS, who had attended at the address because of concerns as to her safety. She was 43 years old at the date of her death.

3 Her death was referred by the police to His Majesty's Coroner for Inner North London as her death came within s.1(2) of the Coroners and Justice Act 2009. An inquest into her death was opened on 28 July 2020. A post-mortem examination was carried out on Karina's body on 28 July 2020 by Dr Laura Casey, a consultant pathologist. Subsequently, a toxicology report dated 2 September 2020 was produced by Dr Rebecca Andrews, Deputy Head of the Toxicology Unit at Imperial College London. That report recorded post-mortem levels of blood alcohol of 194 mg/100 ml and post-mortem levels of gamma-hydroxybutyrate (GHB) of 37 ug/ml. The report stated that in post-mortem blood endogenous – in other words, naturally occurring – GHB levels are usually "below 50 ug/ml". GHB is an anaesthetic and hypnotic drug which is abused as a drug for its euphoric effects.

4 Dr Casey produced a post-mortem report dated 28 October 2020 following her post-mortem examination of Karina's body and the toxicology report. Dr Casey noted the findings of the toxicology report of Dr Andrews in her post-mortem report, but incorrectly recorded that Dr

Andrews had stated that in post-mortem blood endogenous GHB levels are usually "below 30 ug/ml" and concluded that the death was "1(a) mixed alcohol and gamma-hydroxybutyrate toxicity".

5 The inquest into Karina's death was resumed on 9 November 2020 but was adjourned so that further evidence could be obtained by the police. The inquest resumed on 18 March 2021. At the end of the inquest, the claimant recorded a narrative conclusion that, "Death was as a result of alcohol and drug toxicity in circumstances which are unexplained."

6 At the hearing on 18 March 2021, the claimant expressed his concerns at the inadequacy of the MPS investigation of the scene where Karina's body had been discovered. Consequently, after the inquest, the MPS instigated a review by a senior police officer. As part of that review, the post-mortem and toxicology findings were reviewed by Stuart Curtis, an officer in the Metropolitan Police Forensic Services Unit. Mr Curtis noted that the level of alcohol found in the toxicology report were levels associated with drunkenness, but well below those associated with death. He noted the levels of GHB appeared to be within naturally occurring limits and raised the question as to whether the toxicology report had been misinterpreted by the pathologist or whether the presence of any GHB was an anomaly.

7 The claimant asked Dr Casey to comment on Mr Curtis' findings. On 3 October 2022, Dr Casey indicated to the claimant that there had been a transcription error in her original report, such that she had recorded that toxicologists have indicated that in post-mortem blood endogenous GHB levels are usually "below 30 ug/ml", when Dr Andrews had, in fact, stated in her report that such levels are usually "below 50 ug/ml".

8 On 28 October 2022, Dr Casey issued a supplementary post-mortem report in which she stated that, post-issuance of the below post-mortem report, it was noted that a transcription error had occurred in the portion of the quoted toxicology report that relates to GHB. On the basis of the corrected quotation from the toxicology report, Dr Casey concluded that there is no evidence to suggest that Karina had ingested GHB prior to her death. The cause of death formulated in the original post-mortem report relied on the additive/combined effects of GHB and alcohol, as the blood alcohol concentration alone does not fall within the range typically associated with fatality. For this reason, cause of death is revised to "unascertained".

9 Karina's parents, Mr and Mrs Brandt, were informed of the new evidence as to Karina's death. In the light of the revelation that Dr Casey had misinterpreted the toxicology report and that the new evidence indicated a different cause of death, the claimant sought authority from the Attorney General to apply to this court for an order quashing the inquest and ordering a fresh inquest pursuant to s.13 of the Coroners Act 1988. The application to the Attorney General was made on 28 April 2023. The Attorney General's office sought the views of Mr and Mrs Brandt as part of their consideration of the application. Mr and Mrs Brandt were supportive of the application for a new inquest.

10 The Solicitor General granted his authority or fiat for this application to be made on 24 July 2023. The claimant issued a claim form pursuant to CPR Part 8 on 28 August 2023. This was subsequently served on Mr and Mrs Brandt as interested parties.

11 The parties are agreed that, applying well-established principles in this area of law, it is necessary or desirable in the interests of justice for the determination and findings made at

the original inquest to be quashed and for a further investigation under Part 1 of the Coroners and Justice Act 2009 to be held into Karina's death to be ordered for the following reasons:

(a) Fresh evidence has emerged in the form of the supplementary report of Dr Casey which may reasonably lead to the conclusion that the substantial truth about how Karina met her death was not revealed at the first inquest;

(b) Dr Casey's supplementary report constitutes new evidence falling within the scope of s.13(1)(b) of the Coroners Act 1988;

(c) It is likely that the fresh inquest will result in a different conclusion, given the new evidence that GHB played no role in Karina's death;

(d) It is in the interests of justice that the record of the inquest accurately reflect the medical evidence as to Karina's cause of death;

(e) The recorded conclusion has had a negative impact on Karina's family. The interested parties consider that the good name and reputation of their daughter were besmirched by the conclusion of the inquest. An unnecessary stigma to the memory of Karina is to be avoided, consistent with the application in the coroner's jurisdiction of a clearly established policy of avoiding, so far as possible, any unnecessary stigma to the memory of the deceased. See *R v Inner South London Coroner, ex parte Kendall* [1988] 1 WLR 1186 at 1191-1192, per Simon Brown J;

(f) The Divisional Court has no power to amend the findings recorded in the record of inquest. See *HM Senior Coroner for South London v HM Assistant Coroner for South London* [2022] EWHC 1388 at para.20;

(g) It is not in the interests of justice for the court only to quash the record of inquest and order the claimant to amend the record of inquest simply to state that the cause of death was unascertained. The claimant and the interested parties consider that there should be a full investigation now that it has been established that GHB played no role in Karina's death;

(h) Accordingly, the claimant and the interested parties ask the court to quash the record of inquest and order that there should be a further investigation and inquest under the Coroners and Justice Act 2009.

12 We have considered the papers carefully. We are entirely satisfied that the reasons which have been put forward by the parties do make out the case for acting as requested. For those reasons, we make an order in the terms which have been drafted by consent in the following terms:

(1) The determination and findings made at the inquest into the death of Ms Karina Jane Brandt on 18 March 2021 are quashed;

(2) A further investigation and inquest under Part 1 of the Coroners and Justice Act 2009 shall be held into the death of Ms Karina Jane Brandt by the claimant;

(3) There is no order as to 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