IN THE WEST SUSSEX CORONERS' COURT
IN THE MATTER OF THE INQUESTS TOUCHING THE DEATHS OF
THOSE WHO DIED AT THE SHOREHAM AIR SHOW ON 22ND AUGUST 2015

RULING ON RECUSAL APPLICATION

Background

1. On August 2015 an aircraft crashed at the Shoreham Airshow killing eleven men who were either travelling on the A27 or watching the air display from the vicinity of the road.

2. In 2019, following the acquittal of the pilot of charges of manslaughter at a criminal trial, I resumed the adjourned inquests into the eleven deaths. Those inquests are presently scheduled to be heard in September 2021.

3. In submissions dated 3 January 2021 Mr Andrew Hill, the pilot of the aircraft, has now submitted that I should consider standing down (recusing myself) from being the coroner investigating these men's deaths.

4. Mr Hill had earlier written to the Chief Coroner on 22 November 2020 stating "*it is arguable that 4 or 5 state bodies including the West Sussex coroners service may have contributed to the deaths – all of whom would ideally see only the pilot implicated, absolving themselves*." On being provided with a copy of that letter I invited Mr Hill to make a formal submission to me if he wished to maintain those allegations.

5. Mr Hill now submits that "*the West Sussex Coroners service may have contributed to the deaths of the eleven men at Shoreham, and therefore you should consider recusing not just yourself, but the entire West Sussex Coroners service*" from hearing these cases. He suggests that I should request that another Senior Coroner for another area conducts the investigation and inquests.

6. Mr Hill ends his seven page written submission by saying "*please note I am not suggesting you should recuse yourself...I do not have the experience and knowledge to make such suggestions*" (emphasis in the original). This is semantic hair-splitting. Given the manner in which Mr Hill has raised extremely serious allegations both in correspondence and now in a formal submission to the court I cannot accept that his submission is anything other than a formal recusal application. That application has been made by an interested person in these inquests and it is one that I should now address in full in a decision that I will make public.

The grounds

7. Mr Hill's submission that I should stand down is based on bias. Bias arises when a judicial decision maker (be it judge, coroner or juror) is unsuitable to hear a case because of a personal interest in the outcome of the case or because the decision maker is in some other way, or appears to be, unable to form an independent view of the case in issue.

8. Mr Hill cites the Chief Coroners Guidance No. 15 on apparent bias and he summarises his submission as follow: "*From Porter v Magill [2002] 2 AC 357 the West Sussex Coroner appears to have an apparent bias by preferring to avoid investigating state bodies such as the CAA, since this in turn may lead to investigation and potentially adverse findings of the West Sussex Coroners Service.*"

9. I take into account that Mr Hill's submissions are made without the benefit of any legal representation at these inquests. Therefore, whilst his position is articulated only on the basis of perceived or apparent bias what I have drawn from Mr Hill's application is that he is also asserting a form of actual bias ie that my bias can effectively be presumed because the outcome of this case can realistically affect my own interests (as head of the West Sussex Coroners service).

10. Mr Hill does not cite any occasion where he says that I have actually shown bias in my own conduct of the investigation and these inquests to date. Indeed, he specifically clarifies that he does not assert that I am *personally* biased (using his italics) but that my role might "*lead to a conflict of interest*". He also suggests that Ms Dolan QC should be stood down from her role as Counsel to the Inquest ('CTI') because she too sits as an Assistant Coroner in West Sussex.

Position of other interested persons

11. On receipt of Mr Hill's recusal submission I invited all other interested persons to respond if they so wished by 22 January 2021. I received a submission on behalf of a number of the bereaved[1] which stated: '*The families do not believe that there are any grounds to suggest any perceived or apparent bias by the Senior Coroner overseeing this inquest or indeed the West Sussex Coroner's Service.*'

12. A submission on behalf of the Chief Constable of Sussex Police, dated 20 January 2021, notes how it is '*rather late in the day to be raising these issues'* and that '*the function of a Coroner is a judicial one, i.e. to investigate a death and to answer the four statutory questions. The Coroner's role is not to "prevent future deaths".*' The Chief Constable states that she does not believe that myself or CTI has displayed actual or even apparent bias.

13. No other interested person has expressed a view.

The Law

14. In *Locabail v Bayfield Properties Ltd* [2000] QB 451 the Court of Appeal made clear that if the requisite facts did establish that a judge had an interest in the outcome of a case this would call for automatic disqualification. In effect the maxim that 'no man is to be a judge in his own cause' is not to be confined to a cause in which he or she is a party, but applies to a cause in which the judge has an interest.

> "The question is not whether the judge has some link with a party involved in a cause before the judge but whether the outcome of that cause could, realistically, affect the judge's interest."[2]

The interest Mr Hill raises is my position as the Senior Coroner in the service that he now claims is implicated in contributing to the eleven deaths.

---

[1] Members of the families of Mr Abrahams, Mr Archer, Mr Brightwell, Mr Jones, Mr Mallinson, Mr Polito, Mr Reeves, Mr Schilt and Mr Smith.

[2] *Locabail* para 8

15. A second type of bias arises if, on examination of all the relevant circumstances, the court concludes that there was a real danger (or possibility) of bias. The well-known test for this apparent bias was set out by Lord Hope in *Porter v Magill* [2002] 2 AC 357. The court will consider:

> 'whether the fair minded and informed observer, having considered the facts, would conclude that there was a real possibility that the judge was biased'.

16. In *R v Gough* [1993] AC 646 Lord Goff (giving the leading speech at p668) had earlier said that what was required was a real likelihood in the sense of a real possibility (not probability) of bias, but that a mere suspicion, or even a reasonable suspicion, would not suffice.

17. The test of apparent bias was further explained in the coronial context more recently by Burnett J (as he then was) in *R v. (Pounder) v HM Coroner for Durham and Darlington (No. 2)* [2010] ILR 38. The point is made that:

> "the fair-minded and informed observer is neither unduly sensitive nor suspicious yet he is not complacent. He is assumed to have taken the trouble to acquire knowledge of all relevant information before coming to a conclusion…The fair minded and informed observer is also expected to be aware of the law and the functions of those who play a part in its administration."

18. The onus of establishing apparent bias rests upon the applicant. The reasonableness of the apprehension must be assessed in the light of the oath of office taken by judges and coroners to administer justice without fear or favour. The judge or coroner must take into account the fact that they have a duty to sit in any case in which they are not obliged to recuse themselves and so should not accede to an unfounded disqualification application. However, a judicial officer should not hesitate to recuse herself or himself if there are reasonable grounds for apprehending the possibility that they may not be impartial.

<u>Delay</u>

19. The factual background relied upon by Mr Hill in support of his application that I should now stand down relates to the conduct of an earlier inquest held in West Sussex by a different coroner in November 2009.

20. In June 2019 Mr Hill requested that I provide to him the Record of Inquest and r.43 report from the inquest into the death of Mr Brian Brown who crashed his aircraft near Shoreham in September 2007. Those documents were provided to Mr Hill on 5 July 2019. I should make it clear I did not provide those documents because I had come to the view that they were relevant to this investigation and the forthcoming inquests. Rather they are public records from an inquest which members of the public, like Mr Hill, are entitled to see.

21. There is no reasonable explanation now offered for why it has taken Mr Hill 18 months from being provided with these documents to first raising his allegation of bias with me. The authorities are clear:

> 'If, appropriate disclosure having been made by the judge, a party raises no objection to the judge hearing or continuing to hear a case, that party cannot thereafter complain of the matter disclosed as giving rise to a real danger of bias. It would be unjust to the other party and undermine both the reality and the appearance of justice to allow him to do so.' (see *Locabail* at para 26)

22. This could be a complete and final answer to dismissing Mr Hill's application in so far as it is founded on apparent bias. However, in *Locabail* it is also suggested that if, before a hearing has

begun, the judge is alerted to some matter which might, depending on the full facts, throw doubt on his fitness to sit, the judge should inquire into the full facts, so far as they are ascertainable.

The basis for the allegation of bias

23. In September 2007, an ex-military aircraft crashed at the Shoreham Airshow in a field between the A27 and Lancing College. The pilot, Mr Brian Brown, was killed. An AAIB investigation concluded that, having explicitly stated he would not perform any rolling manoeuvres during the display, the pilot did attempt a rolling manoeuvre and lost control of the aircraft. No contributory defect in the aircraft was found. The AAIB issued a number of recommendations concerning airshow safety, pilot training and authorisation.

24. An inquest into Mr Brown's death was held on 25 November 2009, by Mr Martin Milward, who was then the Deputy Coroner for West Sussex. At the time of that inquest I was the Coroner for West Sussex.[3]

25. Mr Hill has requested that I make the recording of the inquest into the death of Mr Brown available to him. I emphasise that in the light of my decision below I do not deem the recording to be in any way relevant to the current inquests, but I shall offer its disclosure to all interested persons in this inquest if they so wish because of its potential relevance to this recusal application.

26. Rule 43 Coroners Rules 1984, as amended by the Coroners (Amendment) Rules 2008,[4] was in force at the material time. That rule provided that where the evidence at inquest gives rise to concern on the part of a coroner that circumstances creating a risk of death will occur (or continue to exist) in the future and, in the coroner's opinion, action should be taken to prevent the continuation of those circumstances then the coroner may report the circumstances to a person who has power to take action.

27. Rule 43 did nothing more than permit a coroner to make a report about circumstances to someone who *may* be able take action to change them, it did not give the coroner any power to make recommendations about what should be done by those that were notified, nor did it give a coroner any power to require any action to be taken by those receiving the report.

28. Following Mr Brown's inquest on 3 December 2009 the Deputy Coroner issued a 'Rule 43 report' in which he notified the CAA of the fact of the crash and in which he stated that he "hoped that consideration could be given" to five recommendations contained the AAIB's report into the 2007 crash. In brief summary these recommendations related to: (1) the authorisation of aerobatic manoeuvres as a member of a tail chase; (2) introducing a recurrent programme of human factors training for display pilots; (3) requiring pilots to demonstrate competence in each aircraft category flown before display authorisation is given; (4) reminding aircraft operators of the need to identify the level of initial and recurrent training required; (5) periodically reviewing operating requirements to ensure they provided adequate safety for display flying.

29. Mr Hill now asserts that the majority of these recommendations were repeated in the AAIB report following the 2015 Shoreham crash and that "*had the 2007 crash safety recommendations been suitably implemented and enforced by the CAA, there would have been no need for the recommendations to be repeated after the 2015 crash*". Mr Hill alleges that "*the Rule 43 matters were not adequately followed up, in that a similar crash occurred 8 years later*". The causal connection that Mr Hill perceives is that "*had the 2007 accident*

[3] The term Senior Coroner not being introduced until 2013 with the coming into force of CJA 2009
[4] https://www.legislation.gov.uk/uksi/2008/1652/pdfs/uksi_20081652_en.pdf

been fully investigated in accordance with Art 2 procedural obligations then future Shoreham airshows would likely have been restricted."

30. Mr Hill's basis for implicating the West Sussex Coroners Service in this causative chain is his (incorrect) assertion that a coroner issuing a Rule 43 report "*has an ongoing obligation to ensure*" the matters reported upon are then followed up in practice. No such obligation exists. It appears that Mr Hill has misunderstood the legal duties and powers under r.43. He does not seem to appreciate that a coroner has no enforcement powers over those to whom he or she reports. The Deputy Coroner had no power to make any recommendations to the CAA himself in 2009. Further, the Deputy Coroner had no power to require any action be taken by the CAA (or anyone else) in response to his 2009 r.43 report. Nor did the Deputy Coroner have any power to follow up matters in any way if his report to the CAA was ignored.

31. Mr Hill's submission further claims that "*it appears arguable*" that the inquest held by the Deputy Coroner "*failed to consider*" the proximity of the A27 to the Shoreham Airshow site; the risks to secondary spectators and the show's organisation as a r.43 concern. It is this speculative assertion by Mr Hill that there were shortcomings in the 2007 inquest that he says makes it, "*arguable that the West Sussex Coroners service failed in the duty to prevent further deaths".*

32. However, it appears to me that these matters were not within the scope of the inquest into how Mr Brown came by his death. As the High Court made clear in *Speck v HM Coroner for York* [2016] EWHC 16, coroners' investigatory powers arise from their statutory duty under the Coroners and Justice Act 2009 s.5. Their discretion is limited to investigating only those factors that might arguably have contributed to a death. Even in an Art 2 inquest, where a factor could not even arguably be said to have made any real contribution to the death, then there is no discretion, or indeed power, to investigate that issue.

33. Nobody other than the pilot was killed in the 2007 crash. There was no obligation upon the Deputy Coroner in 2009 to investigate risks on the A27 or risks to secondary spectators. Mr Hill's premise is based upon a postulated duty that does not exist: there is no duty upon a coroner to prevent future deaths, nor is there any duty on a coroner to proactively seek out information that might give rise to a r.43 concern if that matter is outside the proper scope of an inquest. The effect of r.43 (as amended) was merely to give coroners a discretion to report to others any factual circumstances that emerged during an inquest.

34. A further misconception underlying Mr Hill's application is that I had "*some oversight and supervisory role*" over the Deputy Coroner and the inquest. Mr Hill is again mistaken in his belief about the position and responsibilities of a Senior Coroner. The Deputy Coroner was an independent judicial officer exercising his own judicial discretion and coming to his own independent judicial findings for the purposes of Mr Brown's inquest. Beyond allocating cases to be heard by my fellow coroners in West Sussex, as the Senior Coroner I have no role or right whatsoever to supervise or influence judicial decision making by any of my fellow coroners.

35. It is against this background that Mr Hill now suggests that the present inquests "*may have to investigate the role of West Sussex Coroners service, and may have to have to record criticism or shortcomings [in respect of the Deputy Coroner's actions] in a narrative finding*". Mr Hill suggests that "*Mr Milward may be called as a witness, or interested party, and as such be questioned*" by myself.

36. This proposition is simply fanciful. An investigation into the inquest conducted by the Deputy Coroner in 2009 clearly does not and cannot fall within the scope of these present inquests. There is no sensible basis upon which it can be suggested that a coroner who sat on

a separate inquest six years before the 2015 crash can give any relevant evidence or opinion that would require him to be called as a witness in the present inquests.

Subsequent allegation of impropriety

37. Subsequent to his initial recusal application Mr Hill has raised a further allegation of impropriety against me personally. In a letter dated 13 January 202 Mr Hill alleges that two letters to him from me were not authored by me.

38. Those letters dated 12 January 2021, were each sent to Mr Hill by Ms Stanton in my office on 13 January 2021 in the covering email Ms Stanton stated: *Please find attached two letters from HM Senior Coroner, Ms Penelope Schofield*. The letters were in a pdf format, each was set on coronial headed notepaper and each bore my signature. These letters were my responses to two other formal complaints that had been made by Mr Hill on 7th January 2021 against my personal conduct and the actions of the West Sussex Coroner's service.[5]

39. Mr Hill now asserts that both letters "*purporting to be from you as Senior Coroner were written by Ms Dolan. There are frequent references in the letters to you in the first person making judicial decisions. It seems inappropriate…that the letters were actually written by CTI… particularly letters dealing with judicial decisions.*"

40. I am solely responsible for the content of all letters which are signed by me. It is an irrelevance that, as the electronic information in the documents' properties shows, the pdf files were created by Ms Dolan when she assisted me by converting my approved text into a letterheaded pdf. Mr Hill's allegations of impropriety are unfounded.

Decision

41. In conclusion, the fundamental point Mr Hill puts forward is that it would be wrong for me to continue to conduct this investigation and these inquests because there would be actual bias or an appearance of bias on my part because the West Sussex Coroners service may have contributed to the deaths of the eleven men.

42. As set out above, the scenario upon which Mr Hill relies is a combination of speculation on his part combined with spurious arguments regarding the extent of coronial powers and duties that have no basis in law.

43. I am not persuaded that a fair minded observer who: knew and understood the relevant background facts; correctly understood the extent and the limits of the statutory obligation upon a coroner to investigate a death; correctly understood the scope of the inquest into Mr Brown's death; correctly understood the extent of coronial powers and duties under r.43; and appreciated that a coroner acts as an independent judicial officer and that a Deputy Coroner is not supervised by a more Senior Coroner when making their judicial decisions, would perceive the bias that Mr Hill suggests exists.

44. I remind myself that when addressing an application of perceived bias I must consider the position of a fair-minded person. A fair-minded and informed observer would be neither unduly sensitive nor suspicious. He would have taken the trouble to acquire knowledge of all relevant information before coming to a conclusion. He would also be expected to be aware of the law and the functions of those who play a part in its administration.

[5] The complaints related to my having directed that an earlier email from Mr Hill to me should be shared with all interested persons and in doing so having inadvertently revealed his email address.

45. I am left in no doubt that (i) the facts do not establish that I have an automatically disqualifying interest in the outcome of these inquests and further that (ii) the fair minded and informed observer would not perceive any possibility of bias in the circumstances that have been relied upon by Mr Hill.

46. I therefore decline to stand down from hearing these inquests for the reasons I have given above.

Penelope Schofield
Senior Coroner

26 February 2021