A review on causation in the Coroner's Court

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At the recent inquest touching the death of Steve Dymond, HM Area Coroner Jason Pegg concluded there was no clear and reliable causal connection between Mr Dymond's unfortunate death and his recent appearance on the ITV Jeremy Kyle Show. It was concluded that whilst "*possible*" the experience added to his distress it was not "*probable*", reiterating the often-nuanced complexities of causation in the Coroner's court.

Mr Dymond's inquest

The widely publicised facts of Mr Dymond's inquest confirm that he attended the Jeremy Kyle Show on 2 May 2019 to undertake a lie detector test, hoping to prove that he had not cheated on his partner.[1] Failing the lie detector test, he was visibly upset and believed that his relationship had irretrievably broken down. Mr Dymond sadly died on 9 May 2019, and the Jeremy Kyle Show was permanently cancelled on 15 May 2019.[2]

The inquest was a *Jamieson* (non-Article 2) inquest with the findings handed down on 10 September 2024. The Coroner recorded a short-from conclusion of suicide. ITV report that the Coroner explained as follows: "*Having considered the evidence carefully there is an absence of reliable evidence that demonstrates that Steve Dymond's appearance on the Jeremy Kyle Show probably caused or contributed to his death to do so would be speculative... Steve Dymond had a history of a diagnosed personality disorder and mental illness which presented on a number of occasions before any appearance of the show and resulted in self-harming or displaying thoughts of suicide.*"[3]

Causation and findings at an Inquest

When considering the Coroner's determination and contents of the Record of Inquest, the starting point for many practitioners will often be the Chief Coroner's Guidance No.17, which re-iterates that "*the coroner (or the jury, if there is one) is required, having heard the evidence, and in addition to deciding the medical cause of death, to arrive at a conclusion by way of a three-stage process.*" The three-stage process can be summarised as follows:

(1) "*To make findings of fact based upon the evidence.*

(2) *To distil from the findings of fact* 'how' *the deceased came by his or her death and to record that briefly on the Record of Inquest in Box 3.*

(3) *To record the conclusion, which must flow from and be consistent with* (1) *and* (2) *above, on the Record of Inquest in Box 4.*"[4]

Any finding or conclusion, must pass the Galbraith Plus test, as per Haddon-Cave J in *R (Secretary of State for Justice) v HM Deputy Coroner for the Eastern District of West Yorkshire* [2012] EWHC 1634; [2012] A.C.D. 88: "*when coroners are deciding whether or not to leave a particular [verdict] to a jury, they should apply a dual test comprising both limbs or* "schools of thought" *[as discussed in* R v Galbraith *[1981] 1 WLR 1039], i.e. coroners should (a) ask the classic pure Galbraith question* "Is there evidence on which a jury properly directed could properly convict etc?"*... plus (b) also ask the question* "Would it be safe for the jury to convict on the evidence before it?".[5]

1 *BBC live reporting from the inquest:* **https://www.bbc.co.uk/news/live/cx293v0dy3kt**

2 *Press release, Bindmans LLP for the family :* **https://www.bindmans.com/knowledge-hub/news/hm-coroner-concludes-that-stephen-dymond-took-his-own-life-after-appearing-on-the-jeremy-kyle-show-on-2-may-2019/**

3 **https://www.itv.com/news/meridian/2024-09-10/no-causal-link-found-following-death-of-guest-on-the-jeremy-kyle-show**

4 *Paragraph 8, Chief Coroner's Guidance No.17*

5 R (Secretary of State for Justice) v HM Deputy Coroner for the Eastern District of West Yorkshire *[2012] EWHC 1634; [2012] A.C.D. 88, H8*

When applying the Galbraith Plus test to issues of causation, whether an event or conduct is causally connected to death may be safely concluded in the affirmative where there is evidence upon which the Coroner (or jury if applicable) could properly and safely find that on the balance of probabilities the acts or omissions in question more than minimally, negligibly or trivially contributed to death.[6]

Put simply, the enhanced investigative duty is engaged under Article 2 of the Human Rights Act in certain circumstances automatically and in other cases, where there is an arguable breach of Article 2 by a public authority. The engagement of Article 2 affects the findings at an inquest in three main ways. Firstly, section 5 of the Coroners and Justice Act 2009 provides that the purpose of an inquest is to ascertain: "*(a) who the deceased was; (b) how, when and where the deceased came by their death; and (c) the particulars (if any) required under other legislation to be registered concerning the death*".[7] In a non-Article 2 inquest '*how*' means "*by what means*", however, when Article 2 is engaged the '*how*' question addresses not only by what means, but also "*in what circumstances*" the deceased came by their death.[8]

Secondly, non-Article 2 narrative conclusions should be brief, neutral and factual, whereas Article 2 narrative conclusions may be judgemental conclusions of a factual nature, as long as no issue of criminal or civil liability is addressed.[9]

Finally, on the issue of causation, as explained within the Chief Coroner's Guidance No.17, "*the coroner has a power in an Article 2 inquest (but not a duty) to leave to the jury, for the purposes of a narrative conclusion, circumstances which are possible (i.e. more than speculative) but not probable causes of death. A narrative conclusion may also (but does not have to) include factual findings on matters which are possible but not probable causes of death where those findings will assist a coroner in a Report to Prevent Future Deaths*".[10]

Dove v Assistant Coroner for Teesside [2023] EWCA Civ 289 re-affirms the appropriate causation test specifically in a case of suicide. This case considered the unfortunate death of Ms Whiting. By way of background, Ms Whiting had been in receipt of welfare benefits from the Department for Work and Pensions (DWP) which were withdrawn in the weeks prior to her death. At the initial inquest, the Coroner stated it was not her role to question decisions made by DWP and that this was outside the remit of the Coroner's Court. However, the Court of Appeal confirmed the importance of considering Ms Whiting's state of mind in the lead up to her unfortunate death stating: "*causation… encompasses acts or omissions which contribute (more than trivially) to death and that it is open to a coroner in a suicide case to consider the extent to which acts or omissions contributed to the deceased's mental health deterioration, which in turn led them to take their own life.*"[11]

Comment

Against the above background, the relevant case law and the Chief Coroner's Guidance, a number of interesting observations on causation may be made about the inquest into the death of Mr Dymond.

Considering Mr Dymond's appearance on the Jeremy Kyle Show during the course of the inquest itself is an example of an application of the principles consolidated by the Court of Appeal in *Dove*, specifically that when considering a death by suspected suicide events in the lead up to the death may be relevant to the question of scope, as the Coroner considers a deterioration in mental health.

Furthermore, given the Chief Coroner's Guidance stipulates that in Article 2 inquests narrative conclusions may include factual findings on matters which are "*possible*", had Article 2 been engaged in Mr Dymond's inquest, it would have been at the discretion of the Coroner to record possibly causative factors, specifically the view that it was "*possible*" the experience on the Jeremy Kyle show added to his distress.

Following the inquest Jeremy Kyle's spokesperson issued the following statement:

"*Jeremy Kyle is pleased that His Majesty's Coroner has found clearly and unequivocally that he did not in any way cause or contribute to the tragic suicide of Steve Dymond*".[12] Had this been an Article 2 inquest, the position could have been far less clearcut.

6 R (Childlow) v HM Senior Coroner for Blackpool and Fylde *[2019] EWHC 581, 36,52, citing* R (Tainton) v HM Senior Coroner for Preston and West Lancashire *[2016] 4 WLR 157.*

7 *Section 5, Coroners and Justice Act 2009*

8 *Paragraph 8, Chief Coroner's Guidance No.17;* R v HM Coroner for North Humberside and Scunthorpe, ex parte Jamieson *[1994] 3 W.L.R. 82*

9 R (Middleton) v HM Coroner for West Somerset *[2004] 2 AC 182, 37.*

10 *Paragraph 33, Chief Coroner's Guidance No.17*

11 Dove v Assistant Coroner for Teesside *[2023] EWCA Civ 289; 69.*

12 **https://www.phb.co.uk/article/decision-of-his-majestys-coroner-in-the-inquest-of-steve-dymond/#:~:text=%E2%80%9CJeremy%20Kyle%20is%20pleased%20that,name%20has%20finally%20been%20cleared**

The scope, findings and purpose of an inquest differ greatly to the approach taken in an inquiry, with the distinction between the two not always being immediately clear to the public. The Digital, Culture, Media and Sport Committee launched the Reality TV inquiry following Mr Dymond's death, specifying: *"The inquiry will consider production companies' duty of care to participants, and ask whether enough support is offered both during and after filming, and whether there is a need for further regulatory oversight in this area. The DCMS Committee's decision to launch the inquiry into reality TV comes after the death of a guest following filming for The Jeremy Kyle Show and the deaths of two former contestants in the reality dating show Love Island."*[13]

Chair Damian Collins reiterated throughout the inquiry the different jurisdictions, for example stating prior to the questions relating to the Jeremy Kyle Show: *"I welcome the witnesses for this evidence session of the Digital, Culture, Media and Sport Select Committee as part of our inquiry into reality television. Before we start the questions and the evidence session, I remind Members that in accordance with the House's sub judice resolution, reference should not be made to matters before the coroner's court and, therefore, the inquest into the death of Steven Dymond should not be referred to. However, discussion of the wider issues relating to "*The Jeremy Kyle Show*" and other shows is permissible. I state that for the record."*[14]

The inquiry considered in detail the reliability of lie detector tests. Lie detector tests are not admissible as evidence in criminal proceedings in the UK.

Following the evidence, the Chair to the inquiry comments: "*We've shown this recording to expert advisers who are deeply concerned at ITV's apparent failure to prioritise the welfare of participants over the demands of the show, exploiting their vulnerability for the purpose of entertainment... What we've seen demonstrates a failure on the part of ITV studios in its responsibility towards contributors and makes a mockery of the 'aftercare' it has claimed to provide."*[15]

The findings in both the inquest and the inquiry need to be considered in the correct context. An inquest must remain focused on the death of the deceased and is limited to answering the four statutory questions. An inquiry is far broader in its purpose.

However, the Coroner does have a regulation 28 duty to make a report to prevent future deaths if anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future.[16] This extends the role beyond the immediate remit of the inquest and provides an important safeguard for the public.

13 https://committees.parliament.uk/work/6345/reality-tv-inquiry/publications/

14 https://committees.parliament.uk/oralevidence/9470/pdf/

15 https://committees.parliament.uk/work/6345/reality-tv-inquiry/news/103545/committee-publishes-written-submission-regarding-the-jeremy-kyle-show/

16 *Regulation 28 of The Coroners (Investigations) Rules 2013; Schedule 5 paragraph 7(1) Coroners and Justice Act 2009*