Adam Farrer
Inquests, Public Inquiries and Coronial Law

Practice

Adam specialises in Inquest work, Health & Safety and Personal Injury work. Adam’s Inquest and Health and Safety work consists of serious and complex cases. The majority of Adam’s Inquests are Article 2 Inquests heard with Juries.

Adam is on the Attorney General’s Specialist HSE and Environmental Law Panel “A” List on the Attorney General’s Civil (Junior Counsel to the Crown) Panel. The Civil Panel encompasses Inquest and civil work on behalf of Government departments and includes personal injury work and judicial review work. Adam regularly appears for the Prison Service in death in custody Inquests.

Adam is listed in the Chambers UK Bar Directory as a “Leader in their field” for health and safety work.

Adam finds that the Inquest work, Health & Safety and Personal Injury work compliment each other, with Adam regularly appearing at an Inquest and then acting in a subsequent Health & Safety prosecution and then the Personal Injury claim. Adam regularly defends Article 8 ECHR claims arising from deaths in custody and claims brought by prisoners.

Adam’s recent Inquest work has primarily involved acting for companies and large organisations, such as the Prison Service and Ministry of Defence. However, Adam has considerable experience of acting for families in a range of cases, such as death’s at work, road traffic accidents and deaths in Hospitals.

A Selection of Recent Cases:

Oxford Coroner’s Court – February 2018 – 6 day Article 2 Inquest, into the death of Justin Skrebowski, who was unlawfully killed whilst shopping in Poundland in Oxford by Trevor Joyce, a paranoid schizophrenic (with multi substance abuse issues). The killing was a completely random, unprovoked act. Mr Joyce pleaded guilty to manslaughter. Acted for Oxford Health NHS Trust, who had provided recent in-patient care and on-going care in the community to Mr Joyce. The Inquest closely examined the recent in-patient admission, the decision to discharge Mr Joyce, his risk to the public and the care he was provided with in the community during the weeks up to the killing. Mr Joyce had made previous threats to harm strangers. The Inquest heard evidence that Mr Joyce’s mental health deteriorated in the two months prior to the killing due to drug abuse, during which time his involvement with the Police and criminal justice system increased. The Coroner returned a conclusion of unlawful killing, together with a non-causative narrative conclusion, which found a number of failings by the NHS Trust which could have possibly (but not probably) contributed to
Plymouth Coroner’s Court - October 2016 – 4 day Article 2 Jury
Inquest, acting for UK Border Force, in relation to the death of a Dutch
sailor. A Border Force Cutter Crew were tasked to search a lone
yachtsman’s yacht at the quayside in St Mary’s, Scilly Isles. The yacht
was had been towed into St Mary’s due to damage to its mast. The
yacht was of interest to the Dutch Authorities due to travelling to
Suriname. The sailor was co-operative with the Officers during their
search for about 2 hours, then without warning he climbed the mast and
jumped onto the quayside, dying almost instantly. Immediately prior to
the incident the Officers had started to open the water tank.
Subsequently Border Force Officers found 124 kilograms of cocaine
worth approximately £20 million. Jury/Article 2 Inquest due to the death
occurring in circumstances where the deceased was dealing with

Prison death Inquest – Ipswich Coroner’s Court – May 2016 (4 week
Article 2 Jury Inquest), acting for the Prison Service in relation to a
death by hanging of a 23 year old prisoner. The deceased was serving
an indeterminate sentence for public protection and was beyond his
minimum tariff. He suffered mental health problems. The Inquest
heard extensive evidence of his time in three different prisons over the
last year of his life, including his risk of self-harm and previous incidents
of self-harm. The Inquest also heard expert medical evidence in
relation to mental health issues. The Jury returned a conclusion of
suicide and did not find any relevant systemic failings.

Article 8(1) claim – Oxford County Court (sitting at HMP Woodhill)
before HHJ Harris QC - March 2015. Acted for the Ministry of Justice in
defence of a claim brought by Gary N, a category ‘A’ prisoner held in
the Close Supervision Centre, serving life for double murder. HHJ
Harris QC heard the case at HMP Woodhill in view of the claimant’s
high-risk status. The Defendant admitted liability for breach of Article
8(1) ECHR arising from two breaches. The first related to the Prison
wrongly opening and/or delaying in providing to the claimant (by 3 to 7
days) three items of legal mail (Prison Rule 39 mail). The claimant was
awarded damages of £1,500, on the basis of £500 per Rule 39 letter.

The second breach related to the failure to arrange an in-person visit
between the claimant and his younger brother over a 14-month period.
The claimant’s brother was also a long term serving prisoner. The
claimant had not seen his brother for over 9 years. The claimant was
awarded £2,000 for this breach. The claimant’s claims for aggravated
and exemplary damages were rejected.

Prison death Inquest – Stourport on Severn Coroner’s Court – January
2015 (7 day Article 2 Jury Inquest), acting for the Prison Service in
relation to a death by natural causes of a 43 year old prisoner, who died
from undiagnosed cancer. Healthcare staff believed the deceased had
mechanical back problems. The Inquest heard extensive evidence from
Healthcare staff (GP’s and nurses) in relation to the treatment given to
the deceased in the last month of his life up to 36 hours prior to his
death. The Inquest also heard expert evidence in relation to the
appropriate standard of care from doctors and nursing staff.

HSE Inquest – Boston Coroner’s Court – October 2014 (4 day Article 2
Jury Inquest), arising from the death of a patient at Pilgrim Hospital
whilst using an Encore standing aid hoist. Physiotherapy staff had
removed a knee support from the device in an incorrect way, leaving a
vertical post exposed (whereas the complete mechanism should have
been removed). The patient collapsed and was impaled on the post by
the rectum, resulting in his death. The Jury found that the death was as
a result of a tragic accident that occurred as a result of the misuse of
the Encore hoist, through a lack of adequate formal training.
Prison death Inquest – Stourport on Severn Coroner’s Court – October 2014 (7 day Article 2 Jury Inquest), acting for the Prison Service in relation to a self inflicted death by a Polish prisoner in the segregation department in a high security prison. The Inquest heard expert medical/psychiatric evidence and concentrated on the assessment by Prison and Healthcare staff on deceased’s level of risk to himself and on the systems relating to detention in the segregation unit of the high security Prison.

Prison death Inquest – Leicester Coroner’s Court – September 2014 (4 day Article 2 Jury Inquest), acting for the Prison Service in relation to the self inflicted death of a 21-year-old prisoner, with mental health problems. The Inquest heard expert medical/psychiatric evidence and concentrated on the assessment by Prison and Healthcare staff on deceased’s level of risk to himself.

HSE Inquest – Lincoln Coroner’s Court – March 2014 (8 day Article 2 Jury Inquest), case of a restraint death of a patient in a secure residential unit following an act of aggression by the patient. The case involved a substantial amount of eyewitness factual evidence, complex expert evidence in relation to restraint, asphyxia and pathology. Sensitive case in view of a restraint death of a mentally ill patient.

HSE Inquest – Boston Coroner’s Court – August 2013, (5 day, Article 2 Inquest), death of a patient arising from a fall from a window at Pilgrim Hospital. Legal argument in relation to whether the Inquest should be adjourned until after the HSE prosecution of the NHS Trust, arising from the failure to maintain the window restrictors. HM Coroner rejected the NHS Trust’s argument that the Inquest should be adjourned until the conclusion of the criminal proceedings. Expert evidence in relation to lack of maintenance of the window restrictors.

Inquest – Gloucester Coroner’s Court – January 2013, 2 day Jury Inquest, acting for a site foreman (one of the interested parties) of a company that had resurfaced a road. The road surface mixture was defective resulting in the surface being extremely slippery when wet, which resulted in a fatal car crash. Expert evidence in relation to the motor car, the road surface/cause of the loss of grip and accident reconstruction evidence.

Inquest – East Sussex Coroner’s Court – May 2012, 7 day Jury Inquest, acted for the MoD in relation to a friendly fire death of a British soldier in Afghanistan, who was mistaken for an insurgent and shot by a British sniper at night. Technical evidence in relation to the capabilities of night vision glasses.

Inquest – HSE; Nottingham Coroner’s Court – June 2011, 8 day Inquest, acted for the HSE in relation to the death of a patient during an incident when he was restrained by Police Officers in Hospital. The patient became volatile and confused and locked himself in a shower room. Police Officers used force to extract him for the shower room, which ended in the patient’s death.

Inquest – Aberdare Coroner’s Court – January 2011, 5 day Inquest, acted for the MOD in relation to the death of two teenage air cadets and two RAF pilots. The air cadets were on air experience flights with the RAF in two Grob Tutor aircrafts. The aircrafts took off one after the other and sadly had a mid air collision, resulting in the four deaths. The Inquest heard technical evidence in relation to the causes of the collision and lessons learnt in order to avoid a similar incident. I also acted for the MoD in relation to the fatal accident claims by the families of the air cadets.

Inquest – Trowbridge Coroner’s Court – April 2010, 10 day Inquest, acted for the MOD in relation to the deaths of three soldiers arising from
a friendly fire incident in Afghanistan, when a British forward air controller and a US weapon systems operator from a US F15 Strike Eagle Fighter made errors in relation to the co-ordinates for a 500lbs bomb drop location. This case involved sensitive public interest immunity issues in relation to secret US documents.

Inquest – Sunderland Coroner’s Court – March 2009, 6 week Inquest, acting for the MOD in relation to the deaths of two submariners arising from an explosion of a self contained oxygen generator on HMS Tireless, whilst on an under ice operation near Alaska. The case had a substantial volume (over 10,000 pages) of technical and scientific evidence, including from NASA. The Coroner instructed Counsel to the Inquest. I also acted for the MoD in relation to a number of personal injury claims arising from the incident.

Inquest & Prosecution – Hull – January & September 2006, fatal forklift truck accident at the employer’s business. Acted for the company and its Managing Director who were also prosecuted for breach of sections 2 and 3 HSWA (plus specific breaches of regulations). Company fined £50,000 and the Managing Director was fined £10,000.

Inquest, Prosecution & Personal Injury claim– April 2006 to 2007. I acted for a galvanising company at the Inquest into the death of an employee who whilst attempting to move a 2 tonne steel beam, was crushed under the beam. I also acted for the Company in the HSE prosecution and the fatal accident claim.

**Experience before the Bar:** 1989–1992 Articles/Solicitor with Eversheds in Birmingham, concentrating on commercial law.

**QUALIFICATIONS**

LLB (Hons) (Nottingham)

**RECOMMENDATIONS**

‘An accomplished advocate.’

**Legal 500 2017**

**PERSONAL**

Year of Birth: 1967

Interests: golf, tennis & skiing.

**Clerks to Adam Farrer**

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