3PB
BARRISTERS

Ellena James

Year of Call: 2015
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Inquests

Ellena James is a member of 3PB's inquests team. She understands the importance of finding answers to the crucial questions which often remain following a death and she is happy to act for any interested person.

She has appeared on behalf of:

- His Majesty's Coastguard, at a pre-inquest review hearing, who had been involved in the rescue of a military personnel who later died in hospital
- A police force, at a pre-inquest review hearing, that had been involved in the search and investigation of the deceased
- A family, at a pre-inquest review hearing, where the deceased had died by suicide. Ellena understands the importance of ensuring that the Coroner has details of the relevant witnesses and documents ahead of the inquest
- A Local Authority in a 6-day Article 2, jury inquest into the drug overdose of a mental health patient who had been discharged into the community under section 17 leave
- The motor insurers following a fatal road traffic collision, where the court concluded that the deceased had pulled out of the junction and the insured, driving on the main road, was unable to avoid the collision
- Various care home providers, where the resident died at or was taken ill at the home. One particular inquest concerned a resident who died soon after removing their tracheostomy tube which the pathologist considered caused their death. Following further questioning and reviewing video footage the pathologist conceded that the removal of the tube was not causative.
- A mother whose premature baby had been discovered unresponsive by paramedics. The Coroner had to treat the evidence of the family's co-sleeping habits cautiously given the other risk factors involved
- A family, where the deceased had died by suicide following a declined referral to the Community Mental Health Team. Changes were subsequently made to the referral process helping the family in their bereavement
- A family in a 2-week jury inquest where the deceased had drowned when coasteering with an outdoor adventure company. The jury concluded that the deceased had died as a consequence of misadventure. A Prevention of Future Deaths Report was subsequently made
- A family where the deceased died from sepsis following a surgical procedure. The Coroner had to carry out a very difficult balancing act in ascertaining whether there were any missed opportunities by the hospital trust.

Academic qualifications

- BPTC – Very Competent, BPP University London
- LLB (Hons) Law – 2:1, University of Surrey

Professional bodies

- Member of the Western Circuit
- Dorset, Hampshire and Wiltshire representative, Western Circuit
- The Honourable Society of the Inner Temple