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#GatehouseChambersBrew
Your Takeaway Cup

These notes follow the #GatehouseChambersBrew given by Emma Zeb Henry Slack and Helena Drage on 13th December 2021 which looked at Article 2 Inquests.

Is Article 2 Engaged In An Inquest?

The Starting Point

Article 2 of the European Convention of Human Rights (ECHR) states: "everyone's right to life shall be protected by law". This right places two distinct duties on member states:

1. A negative duty to refrain from taking life
2. A positive duty to take appropriate measures to safeguard life.

This positive duty has had a major impact on the inquest process. In general, in order to comply with Article 2, the state must set up a judicial system which, as a whole, enables any citizen to access an independent, practical, and effective investigation of the facts of any death. This is sometimes referred to as the 'general duty'.

The state must also put in place systems for the protection of life generally and, in certain circumstances, is under an 'operational duty' to take steps to protect someone from a known risk to life. These are referred to as Article 2 substantive duties.

It is out of these substantive duties that the Article 2 procedural duty arises. This is an enhanced duty to carry out a thorough, independent, and effective investigation into a death.

How is an Article 2 inquest different from other inquests?

Firstly, all inquests must comply with Section 5(1) of the Coroners and Justice Act 2009 which sets out that the purpose of a coroner's investigation into a person's death is to ascertain:

(a) who the deceased was;
(b) how, when and where the deceased came about his or her death; and
(c) certain formal particulars which need to be registered concerning the death.

Historically, the task of ascertaining 'how' the deceased came by his or her death had been understood narrowly as meaning "by what means".

Article 2 Inquests have greater scope and have developed into what are commonly known as Jamieson and Middleton inquests. What are the key concepts?

Jamieson Inquests

Inquests where the Coroner will consider whether a lack of care or common law neglect has led to the cause of death of the deceased are often termed as 'Jamieson inquests' and are based on the case of R v Coroner for North Humberside and Scunthorpe, Ex p Jamieson [1995] QB 1.

It is common for such inquests to be heard where the death occurred in a medical context, or where the deceased was in police or other custody immediately prior to his/her death (including where a suicide has taken place).

Prosecutors should note that in Jamieson, the Court of Appeal concluded that in cases where an individual has taken their own life, a conclusion of suicide will usually be recorded as opposed to lack of care or neglect that attributed to the individual committing suicide.

Coroners will not normally use neglect or self-neglect to form any part of their conclusion, unless a clear and direct causal link is established between the conduct described, and the cause of death.

Middleton Inquests

However, in the case of R (Middleton) v West Somerset Coroner in 2004 the House of Lords held that in order to comply with the state's obligation under Article 2, the purpose of the investigation extends to ascertaining "in what circumstances" the deceased came by his or her death. This is how Article 2 inquests came to be called Middleton Inquests.

Coroners may resume inquests where the State's agents have been involved following criminal proceedings, for example, such as in R (on the application of Middleton) v HM Coroner for Western Somerset [2001] EWHC Admin 1043. The involvement of the State was raised in this case when the inquest jury communicated to the coroner that an agent of the State (in this case, the Prison Service) had failed in its duty of care to the deceased. The deceased had hanged himself in prison, and whilst he had been identified as at risk the proper safeguards were never put in place.

Impact on State, State Agencies and the Inquest

An Article 2 Inquest means that the state has to carry out an 'enhanced investigation' into the death. Whereas a 'traditional', non-Article 2 inquest will look at when, where, and how a person died, an Article 2 Inquest also looks at the wider circumstances surrounding a person's death – "in what circumstances".

In short, this means that an Article 2 inquest is likely to be more detailed than a traditional inquest and may well consider issues which would otherwise be deemed to fall outside of the scope of a non-Article 2 inquest. Article 2 inquests can also qualify for additional funding which would otherwise not be available.

Other differences between an Article 2 inquest and an 'ordinary' inquest are that Article 2 inquest conclusions can, but don't have to, include reference to issues that may have made a difference but can't be said on the balance of probabilities to have done so, plus narrative conclusions in an 'ordinary inquest' must be brief, neutral and factual whereas Article 2 inquest conclusions may be judgmental (e.g. permitted judgmental words in Article 2 inquests include 'inadequate' and 'failure'). In practice, an Article 2 inquest is likely to mean more witnesses, more disclosure and more emphasis on policies/procedures/systems than an 'ordinary' inquest.

When should consideration be given to whether an Article 2 inquest is required?

As soon as you have a case you should be thinking about whether there may be an arguable breach of Article 2 sufficient to engage Article 2. The issue should be canvassed at the Pre-Inquest Review hearing and submissions prepared. Bear in mind that Article 2 may be engaged and disengaged at any time and the issue as to whether Article 2 is engaged may change contingent on the evidence as it is disclosed/heard. Consider also whether an inquest is required to satisfy Article 2. The enhanced duty to carry out a thorough, independent and effective investigation into a death does not have to be done through an inquest. A death can be investigated in other ways as long as it satisfies some minimum requirements such as that that it is independent, effective, prompt and involves the family of the deceased. Consider whether the facts have been established through an HSE investigation or criminal trial.

The positive operational duty

Those cases that vex the court and lawyers most tend to fall within the category of the positive systemic/operational duties and particularly the latter 'positive operational duty'.

The real issue is this: is the proposed breach an arguable breach of systemic duty (easier to get Article 2 applied) or an arguable breach of operational duty (which is harder)?

<u>Basic concepts relevant to the operational duty</u>

The positive operational duty arises where the state agency knows or ought reasonably to know of a real and immediate risk to an individual's life and requires it to take such measures as could reasonably be expected of it to avoid such risk.

In this context:

a. Risk means a significant or substantial risk, rather than a remote or fanciful one. In Rabone the risk in question was one of suicide and was quantified as being 5%, 10% and 20% on successive days, which was held to be sufficient.
b. An immediate risk to life means one that is "present and continuing" as opposed to "imminent".
c. The relevant risk must be to life rather than of harm, even serious harm.
d. Real focuses on what was known or ought to have been known at the time, because of the dangers of hindsight.
e. Overall, viewed cumulatively, the test is a stringent one.

In Rabone, Lord Dyson identified four essential features of the cases which had recognised the existence of the duty. He concluded that all might be relevant in determining the existence of a duty in any given circumstances but recognised that they did not necessarily provide a sure guide in what was a developing jurisprudence. The four identified factors were:

a. The existence of a real and immediate risk to life as a necessary but not sufficient condition for the existence of the duty.
b. An assumption of responsibility by the state for the individual's welfare and safety, including by the exercise of control.
c. The special vulnerability of the individual.
d. The nature of the risk being an exceptional risk, beyond an "ordinary" risk of the kind that individuals in the relevant category should reasonably be expected to take.

It is also clear that the existence and scope of the duty must not impose an impossible or disproportionate burden on state agencies in carrying out their necessary state functions and must take into account the individual's rights to liberty (article 5) and private life (article 8).

In Osman it was said that the positive operational duty exists in "certain well-defined circumstances". However, its boundaries have been the subject of developing jurisprudence both in the European Court of Human Rights ("ECtHR" or "Strasbourg") and domestically.

However, in Rabone, Lord Dyson stated that the Strasbourg jurisprudence was young, and the boundaries were still being explored. He observed they might expand to include new categories of circumstances as giving rise to the operational duty as new factual circumstances were considered.

Examples of cases where the Courts have held the positive operational duty to exist include (but are certainly not limited to):

a. Detention cases - A duty to protect those detained by the state from harm inflicted by other detainees and from suicide, which applied to those in prison, immigrants in administrative detention and involuntary psychiatric patients detained in public hospitals.

b. Emerging dangers - The category had been expanded to include what might generally be described as dangers for which the state was in some way responsible. For example:
   i. Oneryildiz v Turkey 41 EHRR 325: A case in which deaths occurred in a house bordering on a household refuse tip where a methane explosion caused a landslide engulfing the house.
   ii. Mammadov v Azerbaijan (17.12.09 unreported): A case where the applicant's wife set fire to herself when police officers were attempting to evict them from residential accommodation.

c. Care homes - A duty had also been held to be capable of existing in relation to transfer of elderly patients between care homes in a way which gave rise to a risk of reduced life expectancy in Watts v United Kingdom (2010) 51 EHRR SE 66.

d. The military - A duty has been held to be owed by military authorities to put systems in place to provide appropriate equipment to protect soldiers from the risk posed by extreme temperatures in which they had to serve. Further, inadequate equipment, planning and training for military operations abroad may breach Article 2 subject to the context.

e. Ambulances - The Ambulance Service has been held to owe a duty to put in place resources and operational systems to ensure ambulances are dispatched to home emergencies without delay.

f. Clinical negligence. For example:
   i. Lopes de Sousa Fernandes v Portugal (2018) 66 EHRR 28.
   ii. R (Parkinson) v. Kent Senior Coroner [2018] EWHC 1501 (Admin).

(See below for further detail on these cases)

The distinction between negligence and a systems issue

It has long been the position that where adequate general provision has been made for protecting patients' lives (e.g., via appropriate systems of working) mistakes/delays/errors of judgment by health professionals or negligent coordination among health professionals will not be sufficient of themselves to breach Article 2 (and therefore do not trigger the need for an Article 2 inquest).

However, where to draw the line between what is 'just' negligence and what is a systems issue which potentially breaches Article 2 is not always easy.

There have been two important cases recently which shed more light on this.

In Fernandes v Portugal (see also above) the European Court of Human Rights (Grand Chamber) found that - in relation to acts and omissions of healthcare professionals - Article 2 will only be breached in 'very exceptional circumstances' where the following 4 components are all present:

a. Acts or omissions by healthcare professionals must go beyond mere error or medical negligence and would need to involve denying a patient emergency treatment despite knowing that the patient's life is at risk if treatment is not given;
b. The dysfunction in question must be objectively/genuinely identifiable as systemic/structural in order to be attributable to the state - e.g. not just individual instances of something 'going wrong' or 'functioning badly';
c. There must be a link between the dysfunction and the harm;
d. The dysfunction must have resulted from a failure of the state to meet its obligation to provide an effectively functioning regulatory framework.

This sets a high hurdle for those trying to argue for an Article 2 inquest.

Until now, however, the application of these Fernandes principles had not been tested in our UK courts. That changed with the recent case of R (Parkinson) v HM Senior Coroner for Kent and others (see also above) which involved a judicial review challenge to the coroner's decision not to hold an Article 2 inquest into the death of a 91 year old lady who was brought to A&E in what the attending doctor felt was an already dying state with agonal breathing, but the son believing that more should have been done to try and save her.

Recognising the high hurdle set by Fernandes in cases involving the acts or omissions of healthcare professionals, the legal team for the family tried to argue that the Fernandes principles did not have to be applied. However, the High Court rejected that approach and embraced Fernandes as being 'the latest, very recent and authoritative summary of the applicable principles...'

The High Court also rejected the family's argument that, because the patient lacked mental capacity due to her dementia, the case should be regarded as analogous to the 'de facto' mental health detention cases which would trigger Article 2 obligations. The Court said this was nothing like the mental health suicide cases on the facts and that patients coming into A&E will often have mental capacity issues but the normal principles for medical cases will apply.

This leaves us with the position that an Article 2 inquest will only be indicated in medical cases in 'limited circumstances', where the Fernandes criteria set out above are satisfied.

As the High Court said in Parkinson: 'At the risk of over-simplification, the crucial distinction is between a case where there is reason to believe that there may have been a breach which is a "systemic failure", in contrast to an "ordinary" case of medical negligence'.

Importantly, though, '...care should be taken to ensure that allegations of what are in truth allegations of "individual negligence" are not "dressed up as systemic failures"'.

Summary of Approach When Considering Article 2

1. If arguing for / against an Article 2 inquest first identify the potential breaches by reference to their operational or systemic nature.
2. Will those potential breaches reach the causative threshold in respect of the death?
3. Why is it 'arguable' (or not) that those breaches could be after full evidence a breach of the Article 2 duty.
4. Invite court to impose 'anxious scrutiny' of those issues.
5. Consider whether the matters been properly investigated before i.e., through HSE investigation and/or criminal proceedings.

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