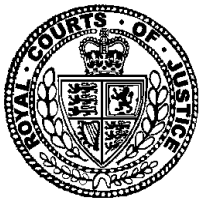

Neutral Citation Number: [2020] EWCA Civ 738

Case No: C1/2019/1301

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE QUEEN'S BENCH DIVISION, ADMINISTRATIVE COURT, DIVISIONAL COURT
THE RT HON LORD JUSTICE IRWIN, THE HON MRS JUSTICE FARBEY & HIS HONOUR JUDGE LUCRAFT QC (SITTING AS A JUDGE OF THE HIGH COURT)
[2019] EWHC 1232 (Admin)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 10 June 2020

Before:

THE RT HON THE LORD BURNETT OF MALDON
LORD CHIEF JUSTICE OF ENGLAND AND WALES
THE RT HON SIR ERNEST RYDER
SENIOR PRESIDENT OF TRIBUNALS
and
THE RT HON LADY JUSTICE NICOLA DAVIES DBE

- -

Between:

THE QUEEN on the application of MURIEL MAGUIRE	**Appellant**
- and -	
HER MAJESTY'S SENIOR CORONER FOR BLACKPOOL & FYLDE	**Respondent**
- and -	
(1) UNITED RESPONSE	
(2) NORTHWEST AMBULANCE SERVICE	
(3) BLACKPOOL VICTORIA TEACHING HOSPITAL	
(4) DR SAFARAZ ADAM	
(5) DR SUSAN FAIRHEAD	
(6) BLACKPOOL CITY COUNCIL	
(7) CARE QUALITY COMMISSION	
(8) KENNETH MAGUIRE	**Interested Parties**

- -
- -

Victoria Butler-Cole QC and Nicola Kohn (instructed by **Bindmans LLP**) for the **Appellant**
Jason Beer QC and Sophie Cartwright (instructed by **Corporate Legal Services, Blackpool Council**) for the **Respondent**
Claire Watson (instructed by **DAC Beachcroft LLP**) for the **First Interested Parties**
The **Eighth Interested Party** appeared in person
The **Second to Seventh Interested Parties** did not appear and were not represented

Hearing dates: 4 & 5 February 2020

- -

Approved Judgment

Covid-19 Protocol: This judgment was handed down remotely by circulation to the parties' representatives by email, release to BAILII and publication on the Courts and Tribunals Judiciary website. The date and time for hand-down is deemed to be at 10am on Wednesday 10 June 2020.

The Lord Burnett of Maldon:

Introduction

1. This is the judgment of the court to which all members have contributed.

2. The issue for determination in this appeal is whether the circumstances surrounding the death of Jacqueline Maguire (known as Jackie) required the coroner to allow the jury at her inquest to return an expanded conclusion in accordance with section 5(2) of the Coroners and Justice Act 2009 ("the 2009 Act"). Section 5 provides:

> "(1) The purpose of an investigation under this Part into a person's death is to ascertain -
>
> (a) who the deceased was;
>
> (b) how, when and where the deceased came by his or her death;
>
> (c) the particulars (if any) required by the 1953 Act to be registered concerning the death.
>
> (2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998 (c. 42), the purpose mentioned in subsection 1(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.
>
> (3) Neither the coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than -
>
> (a) the questions mentioned in subsections (1)(a) and (b) (read with subsection (2) where applicable);
>
> (b) the particulars mentioned in subsection (1)(c)."

Section 10(2) of the 2009 Act prohibits framing a determination under section 5 "in such a way as to appear to determine any question of (a) criminal liability on the part of a named person, or (b) civil liability."

3. Jackie was a woman born on 28 April 1964. She had Down's Syndrome, in addition to learning disabilities and behavioural difficulties, as well as some physical limitations. Since 1993 she had lived in a residential care home in Lytham St Anne's which was managed by United Response. Her placement was paid for and supervised by Blackpool Council. The home provided accommodation for adults with learning disabilities who required personal care. It was not a nursing home. Its staff had neither medical nor nursing training. At the time of these events there were five residents living at the home. Jackie was subject to a standard authorisation granted by Blackpool Council pursuant to the Deprivation of Liberty Safeguards ("DoLS") set out in Schedule A1 to the Mental Capacity Act 2005.

4. Jackie died in hospital on 22 February 2017. The cause of her death was: (i) perforated gastric ulcer and peritonitis; and (ii) pneumonia. Jackie became ill over the two days before her death. On 21 February a call to NHS 111 resulted in advice to consult a general practitioner. The consultation took place over the telephone but continuing concerns later in the evening led to an ambulance being called. The paramedics wished to transfer Jackie to hospital but she would not co-operate. They concluded that manhandling her might cause injury. An out of hours GP was telephoned who advised that attempts should be made to persuade Jackie to go to hospital but that if she refused, she should stay in the care home and be monitored overnight. That was what happened. The following morning Jackie's condition was worse. An ambulance attended and she was taken to hospital. She was found to be severely dehydrated with kidney failure and metabolic acidosis. She had severe infection. She died following a cardiac arrest later that day.

5. Before the coroner, Jackie's family argued that the circumstances of the death dictated that there should be an inquest which satisfied the procedural obligation under article 2 of the European Convention of Human Rights ("ECHR"). The coroner initially agreed. He called evidence at the inquest between 20 and 29 June 2018 which is accepted on all sides as satisfying the evidential obligations of the procedural duty. However, before the jury was asked to perform its function under section 5 of the 2009 Act at the conclusion of the inquest, the coroner revisited his earlier decision. In the light of recent authority, namely *R (Parkinson) v. HM Senior Coroner for Inner London South* [2018] 4 WLR 106, he decided that the evidence did not suggest that Jackie's death might have resulted from a violation of the positive obligation to protect life imposed by article 2 ECHR, also known as the operational duty. In consequence the procedural duty did not apply. The jury's conclusion was thus limited by section 5(1). It decided who the deceased was and how, when and where she came by her death. In answer to the question "how did Jackie come by her death?", the jury concluded that her death came about by natural causes. The jury also produced a short narrative description of the events of 21 and 22 February 2017.

6. Death by natural causes was the inevitable starting point for the jury's conclusion in this sad case. At the inquest Jackie's family sought to amplify that conclusion with "neglect" in the technical sense of coronial law: see *R v. HM Coroner for North Humberside ex parte Jamieson* [1995] QB 1 at 24G to 25F. They argued that the jury should be able to say that Jackie died of natural causes aggravated by neglect. The coroner refused to leave that to the jury. He was right to do so. The contrary argument, dismissed by the Divisional Court, is no longer advanced.

7. Had the coroner continued to consider that the inquest should satisfy the procedural obligation under article 2, the jury would have been asked to express a view on the "circumstances in which [Jackie] came by her death" in accordance with section 5(2) of the 2009 Act. Those circumstances might have included that Jackie's life-threatening condition was not appreciated by the several professionals who dealt with her on 21 February; that at various points there were failures in communication; and that no advance plan was in place to get her to a hospital in the event that she refused to co-operate and admission was urgent.

8. The Divisional Court (Irwin LJ, Farbey J and HHJ Lucraft QC) dismissed the claim for judicial review of the coroner's decision: [2019] EWHC 1232 (Admin). At para. 44 Irwin LJ, giving the judgment of the court, said:

> "We have reached the conclusion that the touchstone for state responsibility has remained constant: it is whether the circumstances of the case are such as to call a state to account: *Rabone,* para 19, citing *Powell.* In the absence of either systemic dysfunction arising from a regulatory failure or a relevant assumption of responsibility in a particular case, the state will not be held accountable under article 2."

9. The cases there referred to were *Rabone v. Pennine Care NHS Trust (Inquest and others intervening)* [2012] 2 AC 72 (to which we shall return) and *Powell v. UK* (2000) 30 EHRR CD362. The court concluded that the coroner was not wrong to decide that the procedural duty did not arise on the evidence deployed at the inquest.

Grounds of Appeal

10. The appellant advances three grounds of appeal:

    (i) Ground 1: The Divisional Court erred in concluding that the procedural obligation under article 2 ECHR did not apply. By parity of reasoning with *Rabone,* the circumstances of Jackie's care dictated that the procedural obligation applied. It was not a medical case of the sort considered in *Parkinson*.

    (ii) Ground 2: If *Parkinson* applied, the Divisional Court was wrong to conclude that the failure to have in place a system for admitting Jackie to hospital on the evening of 21 February 2017 – whether an advance plan drawn up by the care home and GP, or a plan on the part of the ambulance service faced with a patient without capacity in need of, but objecting to, hospital admission – did not amount to a systemic failure.

    (iii) Ground 3: The Divisional Court erred in failing to take account of the wider context of premature deaths of people with learning disabilities (such information being known to the Senior Coroner at the time even if not in evidence before him) but in any event being relevant to the application of article 2 in these circumstances.

The Procedural Obligation under Article 2 ECHR

11. The procedural obligation to investigate deaths for which the state might bear responsibility was developed by the Strasbourg Court as an adjunct to the substantive positive obligations on the state not to take life without justification and, in limited circumstances, to protect life as well as to establish a framework of laws, procedures and means of enforcement that will protect life. The court set out its content in *Jordan v. United Kingdom* (2001) 37 EHRR 2 between paras 105 and 109. Critically, this procedural obligation requires the state to initiate an investigation into a death for which it may bear responsibility. The investigation must be independent of those responsible for the death and involve the family or representatives of the deceased. The *Jordan* formulation was reaffirmed in subsequent cases and received the approbation of the Grand Chamber in *Ramshahai v. The Netherlands* (2007) 46 EHRR 983 at paras 324 and 325.

12. The question arose in this jurisdiction whether the procedural obligation under article 2 required an adjustment to the product of an inquest, namely the way in which the coroner or jury expressed their conclusions. In 2004 the issue was decided by the House of Lords in *R v. HM Coroner for the Western District of Somerset ex parte Middleton* [2004] AC 182. In para. 3 of the considered opinion of the Committee, Lord Bingham of Cornhill explained that there was

> "a procedural obligation to initiate an effective public investigation by an independent official body into any death occurring in circumstances in which it appears that one or other of … the substantive obligations has been, or may have been, violated and it appears that agents of the state are, or may be, in some way implicated."

In para. 4 Lord Bingham identified three questions for consideration:

> "(1) What, if anything, does the Convention require (by way of verdict, judgment findings or recommendations) of a properly conducted official investigation into a death involving, or possibly involving, a violation of article 2?
>
> (2) Does the regime for holding inquests established by the Coroners Act 1988 and the Coroners Rules 1984, as hitherto understood and followed in England and Wales, meet those requirements of the Convention?
>
> (3) If not, can the current regime governing the conduct of inquests in England and Wales be revised so as to do so, and if so how?"

13. The *Middleton* case concerned a suicide in prison. At the heart of the factual issues was the question whether the risk of suicide was properly appreciated and guarded against by the prison authorities. There was no doubt that the circumstances gave rise to the possibility that the substantive duty to protect the prisoner's life had been violated.

14. The House of Lords decided that the procedural obligation under article 2 ECHR is ordinarily discharged by an inquest. Lord Bingham answered question 1 by holding that to meet the procedural obligation "an inquest ought ordinarily to culminate in an expression, however brief, of the jury's conclusion on the disputed factual issues at the heart of the case." See para. 20.

15. In answer to question 2, the House of Lords concluded that there were cases to which the procedural obligation applied where inquests as then conducted did not enable that to happen. The question now found in section 5(1) of the 2009 Act (how the deceased came by his death) reproduces the language of section 11(5)(b)(ii) of the Coroners Act 1988, with which *Middleton* was concerned. "How" had been interpreted in *Jamieson* at 24A as meaning "by what means" and not "in what broad circumstances". Lord Bingham explained that the procedural obligation might be discharged by criminal proceedings in some cases (para. 30), and in others by the traditional short form verdict,

but the strict *Jamieson* approach would not meet the requirements of article 2 in many cases (para. 31).

16. In answer to question 3, the House of Lords decided that only one change was needed to satisfy the procedural obligation under article 2 ECHR. "How" in section 11(5)(b)(ii) of the Coroners Act 1988 should mean "not simply 'by what means' but 'by what means and in what circumstances'" (para. 35). On the facts in the *Middleton* case a conclusion such as "the deceased took his own life, in part because the risk of his doing so was not recognised and appropriate precautions were not taken to prevent him doing so" would meet the article 2 procedural obligation as to outcome (paras 37 and 41). Lord Bingham emphasised (also at para. 37) the importance of the principle that the conclusion should not breach the statutory prohibition against appearing to determine criminal liability on the part of a named person or appearing to determine civil liability. His suggested wording,

> "embodies a judgmental conclusion of a factual nature, directly relating to the circumstances of the death. It does not identify any individual nor does it address any issue of criminal or civil liability. It does not therefore infringe [the statutory prohibition]."

17. Section 5(2) of the 2009 Act put the decision of the House of Lords in the *Middleton* case on a statutory footing. Section 10 preserved the prohibitions of the earlier statutory scheme against appearing to determine criminal liability of a named person and civil liability. It remains no part of the function of an inquest to determine civil liability, including whether there has been a breach of a substantive duty imposed by article 2, or to appear to do so.

Medical Cases

18. The Strasbourg Court considered the obligations under article 2 in cases of deaths which may have occurred as a result of medical mishap, both in the context of medical treatment following admission to hospital and also medical treatment of those more directly in the care of the state. Two recent decisions of the Grand Chamber have clarified the approach.

19. The first case, *Lopes de Sousa Fernandez v. Portugal* (2018) 66 EHRR 28, was concerned with the substantive positive obligations relevant to the denial of access to medical treatment. The second case, *Fernandez de Oliveira v. Portugal* (2019) 69 EHRR 8 concerned the suicide of a young man with mental illness and addiction to alcohol who had been voluntarily admitted to a psychiatric hospital. It concerned the obligations owed to a voluntary psychiatric patient at risk of suicide.

Lopes de Sousa

20. A 40 year old man died after routine surgery to remove nasal polyps. His widow argued that his death was the result of a hospital acquired infection and negligence in post-operative care. Disciplinary, civil and criminal proceedings in Portugal concluded that there was no negligence. The Chamber of the Strasbourg Court found a violation of both the substantive and procedural obligations under article 2. Whilst not speculating on the chances of survival, it concluded that the risk of infection warranted immediate

medical intervention, which had not occurred. It identified a lack of cooperation between departments in the hospital amounting to a failing of the hospital service which deprived the deceased of the opportunity to have access to appropriate emergency care. That was the foundation of the conclusion that the state had failed to protect the life of the applicant's husband.

21. Judges Sajó and Tsotsoria dissented. They considered that finding a violation of the positive obligation to protect life on the basis of a lack of coordination between the various departments in the hospital amounted to a radical departure from the case law of the Strasbourg Court and would lead to its becoming a court determining questions of medical malpractice.

22. The case was referred to the Grand Chamber. It confirmed that in cases involving alleged medical negligence the State's positive obligations were regulatory, "including necessary measures to ensure implementation, including supervision and enforcement" (para.189). It continued by noting that in "very exceptional circumstances" a state may be responsible under the substantive limb of article 2. It enumerated those circumstances between paras 191 and 196.

23. First, "a specific situation where an individual patient's life is knowingly put in danger by denial of access to life-saving emergency treatment. It does not extend to circumstances where a patient is considered to have received deficient, incorrect or delayed treatment" (para. 191).

24. Secondly "where a systemic or structural dysfunction in hospital services results in a patient being deprived of access to life-saving treatment and the authorities knew or ought to have known about the risk and failed to undertake the necessary measures to prevent the risk from materialising, thus putting the patients' lives, including the life of the particular patient concerned, in danger" (para. 192).

25. The Grand Chamber devised a strict test to determine whether the exceptional circumstances were satisfied in any given case. It identified four cumulative factors: (a) The acts or omissions of the health care providers "must go beyond mere error or medical negligence, in so far as the health care professionals, in breach of their professional obligations, deny a patient emergency medical treatment despite being fully aware that the person's life is at risk if that treatment is not given" (para. 194); (b) The dysfunction "must be objectively and genuinely identifiable as systemic or structural in order to be attributable to the state authorities, and must not merely comprise individual instances where something may have been dysfunctional in the sense of going wrong or functioning badly" (para. 195); (c) There must be "a link between the dysfunction complained of and the harm which the patient sustained (para. 196); (d) "The dysfunction in issue must have resulted from the failure of the state to meet its obligations to provide a regulatory framework …" (para. 196).

26. At paras 214 and 215 the Grand Chamber restated the Convention jurisprudence on the procedural obligation arising in medical cases. The state is required to set up an effective and independent judicial system to enable the cause of death of individuals in the care of the medical profession, whether private or public sector, to be determined and those responsible (in a culpable sense) to be held accountable. Between paras 222 and 228 the Grand Chamber explained that it considered that the disciplinary, criminal

and civil proceedings were ineffective. As a result there was a breach of the procedural obligation applicable in cases involving alleged medical negligence.

27. The approach of the Grand Chamber in *Lopes de Sousa* now governs cases of this sort. As the difference of view between the Chamber and the Grand Chamber demonstrates, identifying clearly how medical deaths fit into the positive obligations under article 2 has not been free from difficulty. A series of cases in this jurisdiction sought to extract clear principles from the Strasbourg jurisprudence (*R (Goodson) v. Bedfordshire and Luton Coroner* [2006] 1 WLR 432; *R (Takoushis v. Inner London Coroner* [2006] 1 WLR 461; *Savage v. South Essex Partnership NHS Foundation Trust* [2009] AC 681; *R (Humberstone) v. Legal Service Commission* [2011] 1 WLR 1460 being examples). As Singh LJ concluded in *Parkinson*, at para. 90, the principles set out in *Lopes de Sousa* are not inconsistent with what has been decided in this jurisdiction at every level:

> "Rather the distinction between systemic failure and ordinary negligence cases is one which is also to be found in the domestic cases law, for example in *Savage* and *Rabone*."

28. At para. 163 of its judgment, the Grand Chamber entered an important caveat about the application of the principles it set out in *Lopes de Sousa:*

> "The Court would emphasise at the outset that different considerations arise in certain other contexts, in particular with regard to medical treatment of persons deprived of their liberty or of particularly vulnerable persons under the care of the state, where the state has direct responsibility for the welfare of these individuals. Such circumstances are not in issue in the present case."

29. The next decision of the Strasbourg Court concerned a "particularly vulnerable person under the care of the state."

Fernandez de Oliveira

30. This case, decided by the Grand Chamber in January 2019, concerned the suicide of a man aged 36 who had been a voluntary inpatient in a psychiatric hospital on eight occasions. He was addicted to alcohol and prescription drugs and suffered from schizophrenia and depression. On 1 April 2000 he attempted to commit suicide and returned voluntarily to hospital under a restrictive regime. His condition improved sufficiently for him to be allowed to move within the grounds of the hospital. He spent Easter with his family but was taken by his mother on 25 April to the emergency department of the local hospital because he had consumed a very large amount of alcohol. He returned to the psychiatric hospital and to the same regime. He spent most of the day of 26 April in bed. There were no records of his condition or movements between 16.00 on 26 April and 08.00 on 27 April. At 16.00 on 26 April he was noted to be calm and strolling outside the pavilion where he resided. His mother was told that he was fine but he did not appear for dinner at 19.00. A search failed to find him by 20.00 when he was reported missing. It was not known when he left the hospital grounds, but he had in fact jumped in front of a train at a nearby station at 17.37.

31. A Chamber of the Strasbourg Court found a violation of both the substantive and procedural limbs of article 2. It concluded that the risk of suicide should have been clear to the hospital staff and that they should have foreseen an attempt to leave the hospital. The state should have protected the deceased from the risk he posed to himself. It considered that there was no difference between a voluntary patient and one detained under mental health laws. The procedures on checking his whereabouts were inadequate and there was too ready access to a railway platform near the hospital.

32. In its assessment, the Grand Chamber noted (para. 103) that the case concerned "an alleged act of medical negligence within the context of a suicide during a period of voluntary hospitalisation in a state psychiatric institution." It followed that two distinct positive obligations developed by the Court might be engaged. First, the positive obligation "on the state to put in place a regulatory framework compelling hospitals to adopt appropriate measures for the protection of patients' lives." Secondly, the positive obligation "to take preventive operational measures to protect an individual from another individual or … from himself." The Grand Chamber then summarised the regulatory framework obligation by reference to *Lopes de Sousa* and stated that "the mere fact that the regulatory framework may be deficient in some respects is not sufficient in itself to raise an issue under art.2 of the Convention. It must be shown to have operated to the patient's detriment." (paras. 105 to 107). So far as the second obligation was concerned, the court referred to the well-known test derived from *Osman v United Kingdom* (2000) 29 EHRR 245 at para. 115 relating to imminent threats of death from third party criminal action. It must be established that the authorities knew, or ought to have known, of the existence of a real and immediate risk to the life of an identified person from the criminal acts of another; and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk (para. 109). It continued at para. 110:

> "In a series of cases where the risk derived not from the criminal acts of a third party, but from self-harm by a detained person, the Court found that the positive obligation arose where the authorities knew or ought to have known that the person posed a real and immediate risk of suicide. Where the Court found that the authorities knew or ought to have known of the risk it proceeded to analyse whether the authorities did all that could reasonably have been expected of them to prevent that risk from materialising. Thus, the Court assesses whether, looking at all the circumstances of a given case, the risk in question had been both real and immediate."

33. The Grand Chamber referred to *Osman* at para. 116 in support of the proposition that this positive obligation should not be interpreted to impose a disproportionate burden on the authorities. Accordingly, "not every claimed risk to life can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising" (para. 112). The Grand Chamber continued by reiterating the need for the authorities to discharge their duties in a manner compatible with the rights and freedoms of the individual concerned which diminishes the risk of self-harm, without infringing personal autonomy. In this regard, it referred to articles 3, 5 and 8 of the ECHR (para. 112). The Strasbourg Court had always considered mentally ill persons to be particularly vulnerable:

> "Where the authorities decide to place and keep in detention a person suffering from a mental illness, they should demonstrate special care in guaranteeing such conditions as corresponds to the person's special needs resulting from his or her disability. The same applies to persons who are placed involuntarily in psychiatric institutions." (para. 113)

34. The Grand Chamber agreed with the Chamber that the positive obligation to take preventive operational measures to protect a psychiatric patient against suicide applied also to those who were voluntary patients. It identified a number of factors leading to that conclusion. In particular, the mental disorder was likely to impair the patient's ability to make rational judgement; hospitalisation involves a level of restraint resulting from treatment; and recourse to further kinds of restraint was always available. However,

> "the specific measures required will depend on the particular circumstances of the case, and those specific circumstances will often differ depending on whether the patient is voluntarily or involuntarily hospitalised. Therefore, this duty, namely to take reasonable measures to prevent a person from self-harm, exists with respect to both categories of patient. However, the Court considers that in the case of patients who are hospitalised following a judicial order, and therefore involuntarily, the Court, in its own assessment, may apply a stricter standard of scrutiny." (para. 24)

35. The Grand Chamber concluded that it had not been established that the authorities knew or ought to have known that there was an immediate risk to life in the days before the suicide. It also concluded that there was no deficiency in the regulatory framework which gave rise to a violation of article 2, in particular because the regime which allowed significant freedom to patients was in line with the way in which psychiatric patients were generally treated.

Dumpe v. Latvia (App. No. 71506/13)

36. Ms Watson for United Response drew our attention to another recent decision of the Strasbourg Court, with underlying facts closer to those with which we are concerned. *Dumpe* was a decision of the Fifth Section of the Strasbourg Court given on 16 October 2018 and thus after the decision of the Grand Chamber in *Lopes de Sousa*. The applicant's son, who suffered from Down's Syndrome and epilepsy had been in long term state care since he was 16 in 2007. Between 2009 and 2012 he was seen by a range of doctors for skin problems. When he was seen on 11 April 2012 he was noted to be undernourished and suffering from skin disorders. He was admitted to hospital but died on 17 April 2012. The direct cause of death was heart failure, but he also suffered from acute hepatitis B, organ dystrophy and extensive psoriasis. His mother's complaint was that her son's medical problems had been ignored by health professionals in the state social care home in which he had been resident since 2009. She said that she had been pressing the medical staff there for action for months. She was concerned that her son was being given drugs to control his behaviour and "made to walk barefoot so that he would not attempt to escape". There was a criminal investigation following the death which identified failings and shortcomings in the

medical care provided but concluded that they did not give rise to criminal liability. The Health Inspectorate conducted an investigation which was highly critical of the care provided to the deceased. Two members of staff were disciplined.

37. The applicant complained of a violation of article 2 ECHR because her son had not been provided with adequate medical assistance, in particular because the medical staff at the care home and the general practitioner who had last seen him before his death had not reacted to the deterioration in his condition. The state contended that the applicant had not exhausted her domestic remedies because civil proceedings were open to her. The court agreed. Yet its assessment casts some light on the question before us.

38. In para. 56, the court noted that there was no suggestion that the deceased had been intentionally killed. It then distinguished the facts from those "cases where the domestic authorities had been aware of appalling conditions that later led to the deaths of young people placed in social care homes or hospitals and had unreasonably put the lives of those people in danger." It cited *Nencheva v. Bulgaria* (App. No 48606/06) at paras 113 and 121-124; and *Câmpeanu v. Romania* [GC] (App. No. 47848/08) at paras 141-144. It continued at para. 57:

> "In contrast, here the applicant argued that her son, who suffered from several serious illnesses, died owing to the social care home's, in particular its medical staff's failure to provide him adequate medical care when his health condition deteriorated. Accordingly, the Court considers that the applicant's complaint pertains to medical negligence in the care provided to her son."

39. The applicant did not argue that the state had failed in its obligation to put in place an effective regulatory framework. Neither did the court consider that the complaint fell within the very exceptional circumstances in which state responsibility may be engaged as explained in *Lopes de Sousa* at paras 190- 192. It followed that the procedural obligation on the state was to establish an effective judicial system which affords a remedy in the civil courts, either alone or in conjunction with the criminal courts.

Rabone v. Pennine Health Care NHS Trust

40. The main issue for determination by the Supreme Court in *Rabone* was whether in principle the state was under a positive operational duty to take reasonable steps to protect the life of a voluntary patient in a psychiatric hospital. At the time, the Strasbourg Court had not decided the point. If so, the ancillary question was whether there was a real and immediate risk to the life of Melanie Rabone from suicide of which the NHS Trust knew or ought to have known and which they failed to take reasonable steps to avoid: in short whether the *Osman* duty applied and had been breached. There were additional subsidiary issues which are not material to this appeal.

41. The NHS Trust had admitted negligence causative of the suicide. The action brought by her parents included a discrete claim for damages for a violation of article 2 ECHR. The article 2 claim failed at first instance and in the Court of Appeal on the basis that no positive obligation was owed to voluntary psychiatric patients to protect them from suicide, by contrast with involuntary patients. It was a medical negligence case.

42. *Rabone,* decided in 2012, long pre-dated the decision of the Strasbourg Court in *Fernandez de Oliveira* which resolved the main issue and provided additional guidance on how to approach the ancillary question (the substantive duty was owed to voluntary psychiatric patients but in assessing whether there had been a breach (i.e. applying the *Osman* test) the standard applied would be less strict than for detained patients).

43. In *Savage v South Essex Partnership NHS Trust* [2009] AC 681 the House of Lords had earlier decided that the substantive duty applied to psychiatric patients detained under the Mental Health Act 1983. At the time the Strasbourg Court had developed its jurisprudence by reference to prisoners but had not yet considered detained psychiatric patients. The House of Lords concluded that there was no difference in principle. By reference to that decision and an analysis of extant Strasbourg jurisprudence, the Supreme Court in *Rabone* reasoned that there was no distinction in principle between voluntary and involuntary psychiatric patients: see Lord Dyson at para. 34; Baroness Hale of Richmond at para. 105; Lord Mance at para. 118. The operational duty applied to both detained and voluntary psychiatric patients. As Lord Brown of Eaton under Heywood put it, the conclusion flowed naturally from existing Strasbourg case law (para. 112).

44. One of the conundrums faced by the Supreme Court was to draw a distinction between the cases concerning deaths in the medical context, where no general operational duty arose, and cases of psychiatric treatment in a hospital which resulted from mental illness that gave rise to a risk of suicide see, for example, Lord Dyson at para. 119. Many of those in hospital, or using the emergency services, are at real and immediate risk of death, and rely upon paramedics, doctors and other medical professionals to take urgent action to preserve their lives; yet there is no operational duty under article 2. The existence of such a risk is not sufficient to trigger the operational duty. The court did not have the benefit of the decision of the Grand Chamber in *Lopes de Sousa* which also was long in the future. Nonetheless, Lady Hale encapsulated the reasons why the operational duty should apply to voluntary psychiatric patients in terms which foreshadowed the decision of the Grand Chamber in *Fernandez de Oliveira:*

> "[Miss Rabone] was admitted to hospital precisely because of the risk that she would take her own life. The purpose of the admission was both to prevent that happening and to bring about an improvement in her mental health such that she no longer posed a risk to herself. . .. Her mental disorder meant that she might well lack the capacity to make an autonomous decision to take her own life. Although she was an informal patient, the hospital could at any time have prevented her leaving. … The experts are agreed that it would have been appropriate to detain her under the 1983 Act if she had intended to leave the hospital without medical approval …
>
> The analogy with a patient detained under the Mental Health Act is much closer than the analogy with a patient admitted for treatment of a physical illness or injury." (paras 105 and 106)"

45. Lord Dyson (starting at para. 15) traced the development of the positive operational duty through protecting prisoners from other prisoners (*Edwards v. United Kingdom* (2002 35 EHRR 487), protecting prisoners from suicide (*Keenan v. United Kingdom*

(2001) 33 EHRR 913), protecting detained immigrants (*Slimani v. France* (2004) 43 EHRR 1068) and protecting military conscripts (*Kilinç v. Turkey* (App. No. 40145/98)). He noted *Savage* on detained psychiatric patients and *Oneryildiz v. Turkey* (2005) 41 EHRR 325 which applied the operational duty to a potential lethal hazard arising from a rubbish tip. At para. 18 he considered *Watts v. United Kingdom* (2010) 51 EHRR SE 66:

> "The applicant complained that her transfer from her existing care home to another care home would reduce her life expectancy. The court held, at para 88, that a badly managed transfer of elderly residents of a care home could well have a negative impact on their life expectancy as a result of the general frailty and resistance of change of older people. It followed that article 2 was "applicable". The operational duty was, therefore, capable of being owed in such circumstances, but for various reasons, the claim failed on the facts."

46. These cases contrasted with hospital deaths resulting from what Lord Rodger of Earlsferry had described in *Savage*, at para. 45, as "casual acts of negligence". Lord Dyson (para. 21 et seq) then sought to "discover the essential features" of the cases where the operational duty to protect life had been recognised by the Strasbourg Court. There were cases involving the assumption of responsibility, the paradigm of which was a person detained as a prisoner or a psychiatric patient. He also noted that in circumstances of "sufficient vulnerability" the Strasbourg Court had applied the duty, citing *Z v. United Kingdom* (2001) 34 EHRR 79 which concerned a known risk of neglect and abuse of children ignored by social services for four and a half years. The nature of the risk played a part in determining whether the operational duty was in play. If the risk was an ordinary risk there was no such duty, but an exceptional risk might support it. In the military context the Strasbourg Court (in *Stoyanovi v. Bulgaria* App. No. 42980/04) had considered a soldier's death arising from a parachute accident. It drew a distinction, at paras 59-61, between risks which were an ordinary incident of military life and "dangerous situations of specific threat to life which arise exceptionally from the risks posed by violent, unlawful acts of others or man-made or natural hazards" where the operational duty would arise.

47. Although these factors provide pointers, Lord Dyson acknowledged at para. 25 that they were not a sure guide to whether the Strasbourg Court would hold that the operational duty applies in any given circumstances which it had not considered before. The jurisprudence on the operational duty was young and the boundaries were being explored by the court as new circumstances arose. Nonetheless, for reasons in essence the same as those of Lady Hale he considered that the operational duty should apply to voluntary psychiatric patients. Melanie Rabone had been admitted to the psychiatric hospital because she was suffering from a psychiatric condition and had previously attempted to commit suicide. There was a marked contrast with patients in hospital for treatment or surgery and a psychiatric patient who presents a real and immediate risk of suicide. Lord Dyson concluded by observing that "the Strasbourg jurisprudence shows that there is such a duty to protect persons from a real and immediate risk of suicide at least where they are under the control of the state."

48. This last observation is important. The operational duty under article 2 rests on the state. One of the features of the medical cases is that the Strasbourg Court has taken

care to ensure that that any breach of this duty must be linked to state responsibility: see para. 24 above in our discussion of *Lopes de Sousa.*

Medical Deaths in Custody

49. The paradigm example of the application of the operational duty was said in *Rabone* to involve individuals detained by the state. In *R (Tyrell) v. HM Coroner for County Durham and Darlington* [2016] EWHC 1892 (admin) 153 BMLR 208 the Divisional Court considered the reach of the operational duty in the context of the death from cancer of a prisoner serving a long sentence. The coroner declined to conduct an article 2 inquest. The claimant argued that the fact that the death occurred in custody was sufficient to trigger the requirement of a *Middleton* compliant inquest. Having reviewed the Strasbourg jurisprudence, the Divisional Court, at para. 24, extracted two principles. First, that whenever someone dies in custody there is a positive obligation on the state to provide an explanation of the cause of death. Secondly, that a suspicious death in custody inevitably raises the question of a breach of the operational duty under article 2 ECHR to protect life which means that the procedural obligation also arises.

50. There was never any doubt in *Tyrell* that the death was from natural causes with no suggestion of a breach of the operational duty to protect life. The coroner was correct to rule that the procedural obligation did not arise on the facts of the case:

> "It would not arise in any case where it is established that the death arose from natural causes and there is no reason to suppose that the state failed to protect the life of the prisoner in question. The Strasbourg authorities … suggest that in the context of a natural death in custody the responsibility of the state for the purposes of the duty to protect life will arise only if there has been a failure to provide timely and appropriate medical care to a detainee obviously in need of it. The *Osman* test is applied in the context of the provision of medical care to those dependent upon the detaining authority to provide it." (para. 33).

51. That approach is consistent with *Fernandez de Oliveira.* The *Osman* operational duty on prison authorities extends to medical care provided within custodial institutions in the way discussed in *Tyrell* and in securing outside medical treatment in a timely way when it is needed. The approach to alleged medical negligence or mishap by outside medical professionals, to which a prisoner had been appropriately referred, would be no different from the ordinary approach in such cases. If the facts in *Tyrell* had included a suggestion that the NHS hospital had treated the cancer negligently, the operational duty would not have arisen save to the extent that the cumulative tests now found in *Lopes de Sousa* were satisfied.

Deprivation of Liberty under the Mental Capacity Act 2005

52. Jackie was placed by Blackpool Council in the small private residential home run by United Response in 1993. In doing so they were discharging their statutory functions of support for an adult with Jackie's combination of difficulties. She had lived at home between 1982 and 1991 but then exhibited bouts of extreme behaviour, diagnosed as a cyclothymic personality disorder. She first moved to an assessment centre before going to the United Response home. She could communicate – indeed her mother described

her as a chatterbox. In recent years spinal problems had restricted her mobility to the extent she used a wheelchair for trips outside the home.

53. Jackie was unable to care for herself and her circumstances made it unrealistic to suppose that she could continue to live with her family. The home provided a safe and caring environment in which Jackie could live. She was neither physically capable nor sufficiently aware to be able to leave the home on her own. It would have been dangerous for her to do so. As is universally the case in such homes, and in residential and nursing homes looking after the elderly who might harm themselves if they leave unsupervised, entrance and exit was strictly controlled. That ensured that residents could not leave unnoticed and thereby expose themselves (and others) to danger.

54. That state of affairs had been the reality on the ground for many decades. Nonetheless, the question whether such individuals were deprived of their liberty for the purposes of article 5 ECHR arose for consideration only relatively recently. The significance of the question, for the purposes of article 5 ECHR, was that deprivation of liberty is permitted in limited circumstances and then only supported by clear legal mechanisms.

55. In *HL v. United Kingdom* (2004) 40 EHRR 761 the Strasbourg Court was concerned with the question whether a mentally disabled and autistic man informally admitted to hospital for a protracted period, where he was sedated, keep under close supervision and would have been physically prevented from leaving had he tried to do so, was detained for the purposes of article 5. He was later detained under the Mental Health Act 1983. The court concluded that the care professionals exercised complete control over him and he was not free to leave. He was therefore deprived of his liberty. As Lady Hale later put it in *P v. Cheshire West and Chester Council* [2014] 1AC 896, at para. 8:

> "It therefore became necessary for this country to introduce some ... machinery for the many thousands of mentally incapacitated people who are regularly deprived of their liberty in hospitals, care homes and elsewhere."

56. The legislative solution was to amend the Mental Capacity Act 2005 by the Mental Health Act 2007. Deprivation of liberty was permitted: (a) if authorised by the Court of Protection; (b) if authorised under the procedures provided for in Schedule A1 which deals with hospitals and care homes within the meaning of the Care Standards Act 2000; and (c) in order to give life sustaining treatment or to prevent a serious deterioration in a person's condition whilst court proceedings are pending. The safeguards in the second category were designed to secure a professional assessment independent of the hospital or care home in which the person concerned was resident, directed at two questions. First whether the person lacks capacity to make the decision whether to be in the hospital or care home for care or treatment. Secondly, whether it is in his or her best interests to be detained. If the answer to both questions is yes, then a standard authorisation may be granted administratively, subject to challenge in the Court of Protection.

57. The degree to which an individual's living circumstances could be construed as constituting a deprivation of liberty within the meaning of Article 5 ECHR so as to require authorisation of the Court or some other form of administrative authorisation was considered in *Cheshire West*. Two of the appellants before the Supreme Court

were young adults. One lived in foster care, the other in an NHS facility. Both had complex needs including learning disabilities. The third was a man in his 30s with Down's Syndrome and cerebral palsy who had lived with his mother until her health deteriorated. The local authority obtained orders from the Court of Protection that it was in his best interests to live in accommodation arranged by them. There was no dispute that all the placements were suitable for all three with "positive features". Nonetheless, the question was whether they were deprived of their liberty. The Court of Appeal had concluded that they were not, but the Supreme Court, by a majority of four to three, came to the opposite conclusion.

58. The result was that across the country steps were taken in a substantial number of instances to seek authority to deprive people of their liberty in circumstances which had been thought unnecessary until then. Nothing changed in the practical arrangements in place for many in hospitals and care homes, but the appropriate authority was sought.

59. The five residents in Jackie's home were unable to leave the property. The doors were kept locked. It was apparent after the decision of the Supreme Court in *Cheshire West* that she was deprived of her liberty. The managers of the home made a request to Blackpool Council (the relevant local authority for the care home) for a standard authorisation. There was no dispute that Jackie's circumstances fell within the qualifying requirements. The authorisation was granted on 7 April 2016.

60. The qualifying requirements are described in part 3 of Schedule A1 of the Mental Capacity Act 2005. A person must have reached the age of 18, be suffering from a mental health disorder within the meaning of the Mental Health Act 1983, lack capacity in relation to the question whether or not he or she should be accommodated in the relevant care home for the purpose of being given the relevant care or treatment, meet the best interests requirements, not otherwise be ineligible to be deprived of his or her liberty by the Act and not have made a valid advance decision that is applicable to some or all of the relevant treatment (the 'no refusals requirement').

61. Dr Ali, a consultant psychiatrist, certified that Jackie had a mental health disorder and that she did not have capacity to make decisions about her care and treatment. Mr Davies Fryer, an appropriately qualified social worker, certified that it was in Jackie's best interests for an authorisation to be made.

62. At paras. 12 to 14 of its judgment, the Divisional Court referred to their assessment:

> "12. Dr Ali concluded that, as a consequence of her learning disabilities, Jackie lacked capacity to make her own decisions about whether she should be accommodated in the care home for the purpose of receiving care and treatment. He noted that Jackie was 'totally dependent' on staff for her day-to-day care. He described her as 'a vulnerable adult with no insight'. In his opinion, Jackie fell to be considered for deprivation of liberty safeguards in her best interests.
>
> 13. Mr Davies Fryar also concluded that it was in Jackie's best interests to be deprived of her liberty for the purpose of being given care and treatment. His report noted that staff in the care home made sure that she had appropriate and timely access to

> her GP and other NHS services. The home was said to maintain Jackie's safety and welfare which she would not otherwise be able to maintain for herself.
>
> 14. On the basis of these two reports, Blackpool City Council had on 7 April 2016 renewed its decision to deprive Jackie of her liberty, imposing deprivation of liberty safeguards (DOLS) on a one-year standard authorisation under section 4 and Schedule A1 of the 2005 Act. It appears that United Response had put in place a care plan (dated April 2016). Like the Coroner, we were supplied only with an incomplete copy."

Submissions in Outline

63. Ms Butler-Cole QC for the appellant submits that the DoLS authorisation is not decisive of the question whether the operational duty was owed to Jackie, recognising that it is of a different character from custody, detention in a psychiatric hospital or admission to a psychiatric hospital as an involuntary patient. She submits that it is relevant to an assessment whether Jackie's overall circumstances, in particular her vulnerability, triggered the duty. Although the Strasbourg Court has not considered the circumstances of adults, including the elderly, in care homes in the context of deaths following the suggestion of inadequate medical intervention, parity of reasoning with *Rabone* suggests that the operational duty is owed to those in care who lack capacity. She submits that there was a systemic or structural failure by the care home to have an advance plan to make sure that Jackie could be transferred to a hospital if she resisted, there being an intermittent history of reluctance to cooperate with doctors. There was a failure by the paramedics (or the ambulance service) in not having a plan for transferring to hospital a reluctant patient in Jackie's position. She submits that there was a real and immediate risk of death for the purposes of article 2 by the evening of 21 February of which the paramedics and GP should have been aware. There was reason to suppose that the state failed in its operational duty to protect Jackie's life. Therefore, the procedural obligation arose and the coroner should have allowed the jury to return an expanded conclusion in accordance with section 5(2) of the 2009 Act.

64. In support of the alternative ground 2 (if this is properly treated as a medical case that the *Lopes de Sousa* tests are satisfied) Ms Butler-Cole draws attention to what she suggests were cumulative failures by the medical professionals concerned, which she characterises as "egregious failure to provide timely medical assistance" in the context of the systemic failure she identifies. Ground 3 (relying on evidence that those with learning disability have shorter life expectancy than those without such disability) provides, she submits, additional support for the proposition that individuals in Jackie's position are owed the operational duty under article 2 ECHR.

65. Mr Beer QC, for the coroner, submits that although Jackie's liberty was restricted, it was not relevantly restricted. It is different from the psychiatric and prison cases where the detention may give rise to the risk of suicide or is necessary to protect against it. The coroner was right to conclude that the sad circumstances surrounding Jackie's death gave rise, at most, to concerns about the medical interventions leading up to it, with no question of state responsibility. This was a "medical negligence" case. The cumulative exceptional circumstances tests in *Lopes de Sousa* are not made out.

66. Ms Watson, for United Response, adopts Mr Beer's submissions. She took us in detail to the evidence to support the proposition that this was a "medical" case without the features that engaged the operational duty in the exceptional circumstances described in *Lopes de Souza*. She submits that *Dumpe* provides the closest factual guide from the Strasbourg Court of the correct approach.

67. Jackie's brother, Kenneth Maguire, made written submissions in support of the grounds of appeal.

Discussion

68. Jackie was a vulnerable adult who was unable to care for herself. She had learning disabilities which affected her ability to make choices for herself. She lacked capacity to make decisions affecting her living arrangements, healthcare and welfare. She shared those characteristics with a large number of young adults who, for a wide variety of reasons, are in a similar position. An increasing number of elderly adults are in a parallel situation as a result of the infirmities of old age, especially diminished mental faculties or dementia. Individuals who share these characteristics may be accommodated in a range of different circumstances. Many live at home cared for by family members. Large numbers live in care or nursing homes, some paying for the care themselves, others with public funding. Others are under the more direct care of a local authority or the NHS. Since the amendment to the Mental Capacity Act 2005 made in 2007, and more particularly since the decision of the Supreme Court in *Cheshire West*, a substantial number of them will be subject to DoLS with the consequence that were they to seek to leave the home or hospital in which they reside their carers would have lawful authority to stop them.

69. The number of applications for DoLS has grown substantially each year since the decision in *Cheshire West*. For example, figures published by the NHS (Mental Capacity Act 2005, Deprivation of Liberty Safeguards, England 2018-2019) suggest that there has been a 15% annual growth since 2014 with applications made in 2018 to 2019 in respect of about 200,000 individuals, something over half of which were granted.

70. The underlying argument of the appellant is that the undeniable vulnerability of an individual in Jackie's position, coupled with the fact of a DoLS authorisation dictates that she was owed the operational duty under of article 2 ECHR with the result that the procedural obligation explained in *Middleton* applied and the jury should have been able to comment on the quality of medical care provided to Jackie and the absence of any plan for emergency admission.

71. It is important, however, to focus on the scope of any such duty and why it might be owed.

72. The Divisional Court was right to identify the unifying feature of the application of the operational obligation or duty to protect life as one of state responsibility. That, for example, is the theme which emerges from the Strasbourg authorities discussed in *Tyrell* and supports the conclusion that the article 2 procedural obligation does not apply to cases of deaths in custody arising from natural causes. In both *Nencheva* and *Câmpeanu* (noted in para. 38 above) the substantive article 2 duty owed to the people concerned was to protect from a type of harm entirely within the control of those who

cared for them. They were in the institutions to be cared for. In *Nencheva* the Bulgarian state was in breach of its positive obligation for failing to take prompt action to protect the lives of young people in a residential care home where 15 disabled children died. The authorities were aware of the appalling conditions in the care home and of an increased mortality rate (paras 121-123). In *Câmpeanu*, the Grand Chamber concluded that the domestic authorities knew that the facility in which the deceased was kept lacked proper heating and food, had a shortage of medical staff and resources and inadequate supplies of medication. That led to an increased mortality rate. It found:

> "...in these circumstances, it is all the more evident that by deciding to place Mr Câmpeanu in the PMH, notwithstanding his already heightened state of vulnerability, the domestic authorities unreasonably put his life in danger. The continuous failure of the medical staff to provide Mr Câmpeanu with appropriate care and treatment was yet another factor leading to his untimely death.
>
> The foregoing considerations are sufficient to enable the court to conclude that the domestic authorities have failed to comply with the substantive requirements of Article 2 of the Convention, by not providing the requisite standard of protection for Mr Câmpeanu's life." (paras 143 and 144)

73. Both the prison cases and those concerning conditions within an institution where vulnerable people are cared for demonstrate that the article 2 substantive obligation is tailored to harms from which the authorities have a responsibility to protect those under its care. It cannot be supposed that if a child in a care home or an adult in a position such as Mr Câmpeanu had suffered an isolated medical emergency that the substantive obligation would have applied to the manner in which that was dealt with. The reasoning of the Strasbourg Court which supported the imposition of the operational duty would not apply.

74. The argument advanced before the coroner, the Divisional Court and us was largely structured around a binary question: is this a *Rabone* case or a *Parkinson* case? That, however, is not the approach of the Strasbourg Court. The fact that an operational duty to protect life exists does not lead to the conclusion that for all purposes the death of a person owed that duty is to be judged by article 2 standards.

75. The need to determine the nature or scope of any operational duty owed under article 2 becomes clear in the reasoning of the Strasbourg Court in *Dumpe*. The applicant's contention was that her son had been the subject of protracted sub-standard medical attention for some time both in the home in which he resided and also at the hands of a general practitioner. He was, of course, vulnerable as a result of his impaired intellectual functioning and his mental illness. Indeed, his circumstances are not dissimilar from those of Jackie. He was also restricted in his liberty, as is clear from the use of the language of "escape", although there is no discussion in the judgment of whether Latvia has an equivalent of DoLS as part of its legal system. The court decided that the facts in *Dumpe* supported the conclusion that it was a medical case in the sense discussed in *Lopes de Sousa*. That was despite the underlying suggestion that the failures in treatment and care were not isolated. There was no breach of the operational duty owed under article 2. The operational duty did not apply to the provision of

medical treatment to someone in a care home. Had the death resulted from neglect or abuse of the sort in play in *Nencheva* and *Câmpeanu* the position would have been different. It followed that the procedural obligation imposed by article 2 was not of the sort discussed in *Middleton* and with which we are concerned, namely the parasitic procedural obligation to investigate when a credible suggestion is made that the state has breached its substantive article 2 obligations. The procedural obligation in a medical case is to set up an effective judicial system to determine liability.

76. A similar approach is apparent in the military cases discussed by Lord Dyson in *Rabone* and from the discussion in the Supreme Court in *R (Smith) v. Oxfordshire Assistant Deputy Coroner (Equality and Human Rights Commission intervening* [2011] 1 AC 1. That concerned the death from hyperthermia of a soldier on active service in Iraq. The substantive obligation is owed to protect soldiers from some hazards but not all: see, for example, Lord Rodger of Earlsferry at paras. 126 and 127.

77. The intense, indeed hard-fought, debate preceding many inquests about whether the coroner's investigation is one governed by article 2 centres on whether the coroner, or jury if there is one, is liberated from the strictures of section 5(1) of the 2009 Act (determining how the deceased came by his or her death) and enabled by section 5(2) to say how and in what circumstances the deceased came by his or her death. The scope of the investigation and thus evidence called at the inquest is unlikely to be affected by the question whether the article 2 procedural obligation applies. An analysis of the speeches in the House of Lords in *R (Hurst) v. London North District Coroner* [2007] 2 AC 189 and the judgments in *Smith* does not deliver a clear answer to the question whether as a matter of law there is any difference in scope between article 2 and traditional inquests (see for example Lord Mance at para. 207 and 208 in *Smith).* In any event, it was not an issue in this appeal. But the peculiarity of the article 2 question for inquests is that in statutory terms it concerns the product and not the content of the investigation. It is a peculiarity which arises in this jurisdiction because the inquest is ordinarily the mechanism by which the article 2 procedural duty is satisfied. There is no issue that the other indicia of an article 2 compliant investigation identified by the Strasbourg Court in *Jordan* will be satisfied by a properly conducted inquest.

78. That contrasts with what must happen in a medical case. Beyond an obligation to provide a cause of death, no further investigation is required of the state's own motion by article 2. The various mechanisms provided by law (civil and disciplinary and if appropriate criminal) may take their course.

The Facts in More Detail

79. Before turning to our conclusions, we set out the facts in a little more detail.

80. The inquest heard evidence from the staff at the care home, from Jackie's mother and from the general practitioners and paramedics who had dealings with her in the period before her admission to hospital on the morning of 22 February, as well as from experts.

81. In 2013 Jackie had refused a blood test at her GP's surgery. The notes record that "they will provide diazepam to relax her and come out to the house" if an injection was needed. In 2015 a GP home visit for Jackie was requested to enable a "well woman check" to be carried out. In November 2016 the GP notes record a four-day history of crying and agitation. Blood could not be taken from Jackie because of her refusal.

82. In a witness statement prepared for the inquest, Jackie's mother recalled three occasions when Jackie was required to go to hospital for a blood test. Jackie was unwilling to do so and was administered a sedative before going to the hospital in anticipation of her refusal of the blood test. She said, as a result, she suggested to the manager of the care home on the telephone on the evening of 21 February 2017 that Jackie could be administered a sedative in order to get her to hospital.

83. From 16 February 2017 Jackie was noted as not eating well and complaining of a sore throat. She was given paracetamol. On 20 February she vomited and was noted to have a raised temperature. Jackie asked to see a doctor but on that occasion staff at the home did not act on the request.

84. On the morning of 21 February 2017 there is some evidence that Jackie stated that she did not feel well and wanted to see a doctor. The member of staff who spoke with Jackie did not believe a doctor was required at that time. Later, at around 14.00, Jackie was seen to be having what was described as "some sort of fit". Her head went back, she made a rasping noise and her eyes started rolling. It lasted less than a minute. As a result, a member of staff telephoned the GP's surgery. She is noted as having told the receptionist that Jackie had suffered from "a possible collapsing episode" and had refused food and drink that day. The receptionist told the staff member that the request for a visit would be passed to a GP for his attention later that afternoon. The staff member said that the advice from the surgery was that she might be better telephoning NHS 111.

85. NHS 111 for the Northwest of England and NHS Out of Hours Medical Advice Service is run by the Northwest Ambulance Service. The advice given when the call was made was to telephone the GP surgery again and to say that Jackie needed to be seen within two hours. The call to the surgery was made at around 15.36. It was reported that the staff had noted blood in Jackie's urine and there had been an episode of vomiting. The receptionist at the surgery asked if Jackie could be brought to the surgery, but she was told that was not possible. The receptionist said that a GP would attend at approximately 18.00.

86. At 16.59 a GP at the practice telephoned the care home. The history he obtained was that Jackie had had diarrhoea for the past week. That morning she had started to vomit. She had blood spotting for the past week, particularly in the morning. Jackie's behaviour had not changed apart from reduced fluid intake. A fit-like episode between 08.00 to 09.00 was mentioned but the carer had not witnessed the event. Having reviewed the medical records, the GP concluded that Jackie was suffering from viral gastroenteritis and a urinary tract infection. He issued a prescription for anti-sickness tablets and an antibiotic suitable for a urinary tract infection.

87. At around 19.00 Jackie asked to go to bed which was unusual. She walked to the bottom of the stairs and collapsed. A member of staff with her was unable to say whether it was a faint or a fit. Two members of staff helped Jackie to the bathroom where she again collapsed. Jackie was taken to bed and a call was made to NHS 111 at 19.10. The history taken was that the patient was warm to touch and had had a "crushing pain in her chest/upper abdomen in the last 24 hours. Pain within the last 12 hours, vomiting coffee grounds." An emergency ambulance was sent but owing to administrative error, the ambulance crew were not informed that Jackie had Down's Syndrome and learning disabilities.

88. The paramedics arrived at 20.04. The lead paramedic stated that they were told by the staff that Jackie had had a "vacant seizure" at the bottom of the stairs at 15.00 that day and was staring blankly for about two minutes. She had had loose bowels for one and a half weeks and vomiting for two days. The paramedics were not informed by NHS 111 or by the staff at the home of Jackie's seizures at around 19.00. The Ambulance Service record notes that Jackie had not had any further vacant episodes since 15.00.

89. The paramedics carried out observations. Jackie's heart rate was 100 (raised), her blood pressure 93/58 (low) and oxygen saturation 92 per cent (low). Her temperature was normal. Her chest rattled. The paramedics wanted to take Jackie to hospital for assessment due to the unusual vacant seizure. The care home staff agreed, as did Jackie's mother, but Jackie repeatedly refused to go to hospital. The paramedics' concern was that Jackie did not have capacity to weigh up the consequences of not attending hospital. In order to take Jackie to hospital she would have to be manhandled. The paramedics thought the likelihood of causing injury or harm was very high and was disproportionate to the state in which Jackie was at the time.

90. At the inquest there was an evidential dispute between the paramedics and the staff about whether the paramedics had been told that Jackie's mother had suggested that if she could not be persuaded to go to hospital she should be sedated. In any event, the paramedics were not trained to give sedation.

91. The lead paramedic stated that despite the blood pressure and oxygen saturation readings, Jackie appeared fine in herself. She was not displaying any "red flag signs" which would have indicated that her life was at immediate risk. Jackie was alert, not complaining of any pain, showing no signs of discomfort. She was not cyanosed and was speaking.

92. The out of hours GP was consulted by the lead paramedic at around 20.30. The GP's evidence was that she was told that Jackie had had diarrhoea for a week and had started vomiting a couple of days ago. A small seizure was said to have occurred at about 14.15 when Jackie's eyes had rolled back in her head. The paramedic told the doctor that Jackie was refusing to leave her bedroom despite being advised that it was better for her to go to hospital. She was told that Jackie had had no further episodes of vomiting or further faints and that following the original episode she recovered quickly. The GP advised that as Jackie was stable, they should continue to try to convince her to go to hospital, but it would be inappropriate to manhandle her. She advised that Jackie should be monitored during the night and her GP called in the morning.

93. The paramedic agreed with the advice given by the doctor. A member of staff monitored Jackie at hourly intervals until 05.00 and then at 06.30 on 22 February when she was found in bed covered in faeces. Two members of staff were able to move Jackie to the lavatory where she had a further seizure just before 08.00. An emergency call resulted in an ambulance arriving 20 minutes later. The history was recounted. Observations by the paramedics confirmed that Jackie was in shock. She was transferred to Blackpool Victoria Teaching Hospital where she died that evening.

94. Dr Peter Goode, Consultant in Emergency Medicine, instructed on behalf of the coroner, concluded that the collapse during the afternoon of 21 February coupled with the observations of the paramedics indicated likely infection with a moderate to high risk of sepsis. The paramedics were correct to conclude that Jackie should go to

hospital. Jackie was demonstrating a systemic inflammatory response which untreated would lead to septic shock. On arrival at hospital the following morning sceptic shock had developed. The risk of mortality the evening before was around 40% but had grown to 70% by the time she arrived at hospital.

95. Ms Butler-Cole submits that there was "a structural or systemic dysfunction which prevented life-saving treatment" being given to Jackie. There should have been an advance plan in place, given Jackie's history of needing sedation in connection with blood tests, to get her to hospital in the face of opposition. The paramedics "could and should" have got the out of hours GP to attend to administer a sedative. The out of hours GP should not have given the advice she did. In summary she submits that the GP's failure:

> "was part of series of interlinked failures arising out of the absence of any clear structure in which information and case management regarding an incapacitous, vulnerable and desperately ill woman could be shared, and appropriate decisions made on her behalf and in her best interests."

Ms Butler-Cole submits that even if this is a medical case *(Lopes de Sousa*), it fell within the exceptions identified by the Strasbourg Court (see para. 25 above).

Conclusions on Grounds 1 and 3

96. The question whether an operational duty under article 2 was owed to Jackie is not an abstract one which delivers a "yes" or "no" answer in all circumstances. She was a vulnerable adult incapable of looking after herself and lacking capacity to make decisions about her care. As the decisions of the Strasbourg Court in *Nencheva* and *Câmpeanu* show, the article 2 operational duty is owed to vulnerable people under the care of the state for some purposes. If a death in this jurisdiction in a hospital or care home for which the state was responsible resulted from conditions described in either of those cases, the substantive or operational duty under article 2 ECHR would be engaged. So too if the state was aware of the shortcomings, through regulatory inspections, and did not act on them. There would be a direct analogy in the latter situation with the failure of social services to protect children over a prolonged period when they knew of serious abuse (*Z v. United Kingdom* discussed in para. 46 above). The potential application of the operational duty discussed in *Watts v. United Kingdom* (see para. 45 above) when moving vulnerable elderly people from one home to another on account of the exceptional risk involved is another example of the operational duty arising within a defined area of activity.

97. The approach illuminated by those cases (and the prison cases) does not support a conclusion that for all purposes an operational duty is owed to those in a vulnerable position in care homes, which then spawns the distinct procedural obligation (with all its components) in the event of a death which follows either alleged failures or inadequate interventions by medical professionals. On the contrary, as *Dumpe* most clearly demonstrates, it is necessary to consider the scope of any operational duty. Had Mr Dumpe's death followed ill-treatment or neglect of the sort considered by the Strasbourg Court in *Nencheva* and *Câmpeanu* the position would have been different. The circumstances of the death would be judged by reference to the operational duty.

98. In our view, there is a close analogy between the circumstances of Jackie's death and that of Mr Dumpe. The criticisms of medical care in *Dumpe* were in fact more wide-ranging. *Dumpe* was a decision of a Chamber of the Strasbourg Court and so lacks the authority of a Grand Chamber judgment. Section 2 of the Human Rights Act 1998 requires us "to take into account" judgments of the Strasbourg Court. As was explained by Lord Bingham of Cornhill in *R (Ullah) v. Special Adjudicator* [2004] 1 AC 323 at para.20:

> "In determining the present question, the House is required by section 2(1) of the Human Rights Act 1998 to take into account any relevant Strasbourg case law. While such case law is not strictly binding, it has been held that courts should, in the absence of some special circumstances, follow any clear and constant jurisprudence of the Strasbourg court: *R (Alconbury Developments Ltd) v Secretary of State for the Environment, Transport and the Regions* [2003] 2 AC 295, paragraph 26. This reflects the fact that the Convention is an international instrument, the correct interpretation of which can be authoritatively expounded only by the Strasbourg court. From this it follows that a national court subject to a duty such as that imposed by section 2 should not without strong reason dilute or weaken the effect of the Strasbourg case law. … It is of course open to member states to provide for rights more generous than those guaranteed by the Convention, but such provision should not be the product of interpretation of the Convention by national courts, since the meaning of the Convention should be uniform throughout the states party to it. The duty of national courts is to keep pace with the Strasbourg jurisprudence as it evolves over time: no more, but certainly no less."

99. The decision in *Dumpe* may not represent "clear and constant jurisprudence of the Strasbourg Court" but there is no decision of that court to which our attention has been drawn which suggests that the operational duty is owed to those in an analogous position to Jackie in connection with seeking ordinary medical treatment. To hold that the operational duty was engaged in this case would certainly be to move beyond any jurisprudence of the Strasbourg Court. The conclusion would not flow naturally from existing Strasbourg jurisprudence, as the conclusion in *Rabone* did in respect of involuntary psychiatric patients at risk of suicide (see Lord Brown's observation quoted in para. 43 above). In any event, we respectfully agree with the reasoning in *Dumpe* which in our view flows from the decisions to which the court referred, is consistent with the approach to deaths from natural causes of prisoners, and applied the decision of the Grand Chamber in *Lopes de Sousa.* The caveat in para. 163 of *Lopes de Sousa* does not affect the outcome in a case of this sort.

100. In our judgment, the coroner was right to conclude that, on the evidence adduced at the inquest, there was no basis for believing that Jackie's death was the result of a breach of the operational duty of the state to protect life. It followed that the procedural obligations on the state identified in *Jordan* did not arise. For the purposes of the inquest the conclusions were governed by section 5(1) of the 2009 Act and in particular "how Jackie came by her death" rather than "how and in what circumstances".

101. Jackie's circumstances were not analogous with a psychiatric patient who is in hospital to guard against the risk of suicide. She was accommodated by United Response to provide a home in which she could be looked after by carers, because she was unable to look after herself and it was not possible for her to live with her family. She was not there for medical treatment. If she needed medical treatment it was sought, in the usual way, from the NHS. Her position would not have been different had she been able to continue to live with her family with social services input and been subject to an authorisation from the Court of Protection in respect of her deprivation of liberty whilst in their care.

102. It is strictly unnecessary to decide whether on the evening of 21 February the evidence suggested that the medical professionals knew or ought to have known that Jackie faced a real and immediate risk of death and did all that they reasonably should have done to prevent the risk from materialising (the *Osman* test). In determining that question the relatively light touch approach (compared with those detained by the state in prison or involuntary psychiatric patients) articulated by the Strasbourg Court in *Fernandez de Oliveira* would apply. Whilst the retrospective investigation of Dr Goode suggested that by the evening of 21 February 2017 Jackie was already subject to a high risk of mortality, we entertain doubt whether that is something that the two GPs and paramedics who had dealings with Jackie on 21 February ought to have been aware of. Collectively they did not think that the situation was dangerous. That was the positive finding of the paramedics supported by the out of hours GP and it underpinned the decision to let Jackie remain in the home under observation overnight.

103. In support of ground 3, the appellant placed before us the annual report, published in December 2017, of the University of Bristol Norah Fry Centre for Disability Studies entitled "The Learning Disabilities Mortality Review"; and a "Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD)" by Pauline Heslop et al dated March 2013. They are said to support the contention that the operational duty was owed to Jackie in connection with the medical attention she received leading up to her death. The first of these reports reviewed a total of 1,311 deaths from 1 July 2016 to 30 November 2017; the second 247 deaths between 2012 and 2014. They were concerned to examine the circumstances of deaths in the context that those with learning disabilities generally have a lower life expectancy than those without. They covered deaths of those living in any environment, the majority living in the community and many living on their own, and not only those who were accommodated in care homes.

104. Unsurprisingly, these reports were not in evidence because they do not illuminate how, when or where Jackie came by her death nor even in what circumstances she came by her death. The coroner was aware of them. The Learning Disabilities Review relies upon case details being referred via local authorities. Coroners assist in providing information. The coroner referred the details of Jackie's case to the local area contact for the Review. These reports, and in particular the continuing work of Bristol University, have made a valuable contribution to an understanding of the complex issues underlying why those with learning disabilities have reduced life expectancy. In our view, they do not provide additional weight to the argument that a relevant operational duty was owed to Jackie.

Conclusion on Ground 2

105. Was there reason to believe that the "very exceptional circumstances" which can give rise to a breach of the operational duty under article 2 in a medical case defined in *Lopes de Sousa* might be in play? We are unable to accept that the criticisms of the paramedics or out of hours GP come close to satisfying the first exception identified by the Strasbourg Court, namely that the patient's life was knowingly put in danger by a denial of access to life-saving emergency treatment. On the contrary, as we have noted, the collective judgement of the professionals was that Jackie was not in danger on the evening of 21 February 2017 and could be kept under observation at the home, even though it was preferable that she went to hospital. Moreover, we do not accept that this is a case which raises "systemic or structural dysfunction in [medical] services" which resulted in Jackie being denied life-saving treatment. As the Grand Chamber observed at paras 195 to 197

> "... the dysfunction at issue must be objectively and genuinely identifiable as systemic or structural in order to be attributable to the state authorities, and must not merely comprise individual instances where something may have been dysfunctional in the sense of going wrong or functioning badly.... The dysfunction at issue must have resulted from the failure of the state to meet its obligations to provide a regulatory framework in the broader sense indicated above."

106. There is nothing in the materials before us which suggests that there is a widespread difficulty in taking individuals with learning disabilities (or elderly dementia patients) to hospital when it is in their interests to do so. The criticism of the care home, the paramedics and the out of hours GP is that between them they failed to get Jackie to hospital on the evening of 21 February; and that a plan, protocol or guidance should have been in place that would have achieved that end. That is remote from the sort of systemic regulatory failing which the Strasbourg Court has in mind as underpinning the very exceptional circumstances in which a breach of the operational duty to protect life might be found in a medical case. The making of plans in individual cases and the detail of guidance given to paramedics is far removed from what the court describes in the passage we have set out.

Disposal

107. In the result, none of the grounds of appeal having succeeded, we dismiss the appeal.