Neutral Citation Number: [2022] EWHC 107 (Admin)

Case No: CO/4780/2020

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Date: 21/01/2022

Before :

HER HONOUR JUDGE BELCHER

- -

Between :

The Queen on the application of **Kelly Anne Boyce**	**Claimant**
- and –	
HM Senior Coroner for Teesside and Hartlepool	**Defendant**
-and-	
Middlesbrough Borough Council (1) **Tees Valley Care Ltd (2)**	**Interested Parties**

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Dr Anton Van Dellen (instructed by **Watson Woodhouse Limited**) for the **Claimant**
Mr Jonathan Hough QC (instructed by **Middlesbrough Council, Legal and Governance Services**) for the **Defendant**
Mr Jonathan Walker (instructed by **Middlesbrough Council, Legal and Democratic Department**) for the **First Interested Party**
Mr Sam Faulks (instructed by **Taylor Law**) for the **Second Interested Party**

Hearing date: 14 December 2021

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Approved Judgment

Her Honour Judge Belcher :

1. The Claimant, Kelly Anne Boyce, is the mother of Grace Ann Peers ("Grace") who died on 10 September 2018, when she was 15 years old. At the time of her death, Grace was in the care of Middlesbrough Borough Council ("MBC") (the First Interested Party) which had placed her at Farm House, a private care home operated by Tees Valley Care Ltd ("TVC") (the Second Interested Party). On 28 September 2020, the Defendant Senior Coroner ("the Coroner") decided that the inquest touching upon Grace's death shall not be a full Article 2 European Convention on Human Rights ("the Convention") inquest. The Claimant challenges that decision in these proceedings.

2. The Defendant is a judicial officer. She has participated in these proceedings in a non-adversarial role both by filing submissions in response to the Claimant's Grounds, and by instructing counsel to appear before me in order to explain the factual background and her decisions, as well as to assist the Court on matters of coronial law and practice. I am grateful for that assistance. References to the trial bundle in this judgment will be by reference to the relevant page or page numbers contained in square brackets.

3. Grace was born on 25 June 2003. In February 2017 a care order was made placing Grace in the care of MBC. Grace was initially placed in the care of her maternal grandmother, but that placement broke down and in May 2018, Grace was moved to a children's home in Darlington. On 26 June 2018 Grace was placed at Farm House, initially for a six week placement pending the arrangement of a longer term placement elsewhere.

4. On 5 September 2018 Grace started her new school year. She had dyed her hair purple and following a confrontation with staff at the school, Grace was excluded from school. On 7 September 2018, at a reintegration meeting at the school, Grace was abusive and was excluded for two further days. On 10 September 2018, Grace was tragically found hanging from a scarf in the shower cubicle of her room at Farm House. A post-mortem examination gave the cause of death as cerebral anoxia due to hanging.

5. The Coroner opened an inquest into Grace's death. On 3 June 2019 the Coroner made directions that interested persons were to file written submissions as to Article 2 engagement. In a written ruling dated 1 July 2019 the Coroner determined that there was insufficient evidence that there had been a real and immediate risk to Grace's life and accordingly that there had been no breach of the operational duty under Article 2. Ground Four of the Claimant's grounds challenged this decision, notwithstanding that the claim in this matter was not filed until December 2020. However, at the commencement of the hearing in front of me, Dr Van Dellen advised me that Ground Four was no longer pursued, and I shall make no further reference to that Ground in this judgment.

6. Notwithstanding her conclusion that there was no breach of the operational duty under Article 2, the Coroner indicated that she remained open to considering whether there were flaws in higher level systems which gave rise to an arguable breach of the Article 2 general duty of the state. She directed that independent expert evidence be obtained into a number of specific matters [400 - 401] all of which are directed to the question of whether Farm House had been an appropriate venue for Grace given her needs and requirements.

7. Dr Charles Stanley, a Consultant in Child and Adolescent Psychiatry, provided a report to the Coroner dated 6 December 2019 [399 – 456], and an addendum report dated 9 December 2019 [483-484] produced following the receipt by Dr Stanley of additional documents.

8. In a written ruling dated 28 September 2020 [66-69], the Coroner accepted that there were clearly issues with the systems and procedures operated by MBC social services department and by Farm House. However, she concluded that it was not arguable that there was a real and substantial chance that improved systems and procedures would have saved Grace's life, given the level of care she in fact received at Farm House. She continued:

> "On the documentary evidence that I have considered I am of the opinion that this inquest shall proceed as a Jamieson, and not as a Middleton inquest; the four questions that will be answered at the end of the inquest shall not be extended to include "how and in what circumstances". I shall keep an open mind and if it becomes appropriate, the matter of engagement of Article 2 can be reconsidered at the conclusion of the inquest.
>
> I remind myself that a determination as to the applicability of Article 2 will not affect the scope of the inquest, just the conclusion. I am still likely to need to consider issues regarding procedures and systems when considering my duty under PFD" [69]

9. The four questions referred to by the Coroner are the four questions referred to in Section 5(1) Coroners and Justice Act 2009 ("CJA 2009") which provides that an inquest has the purpose of ascertaining the answers to four principal factual questions: who the deceased was; and how, when and where he/she came by his/her death. Section 10 CJA 2009 provides that the determinations at the end of an inquest must answer these questions.

10. The Coroner's references to Jamieson and Middleton inquests are shorthand references readily recognised by those practising in coronial law, and the names derive from case law involving parties with those names. There is no dispute that a Jamieson inquest is limited to an enquiry as to how in the sense of by what means the deceased came by her death. A Middleton inquest applies to those inquests where the Article 2 procedural obligation is engaged and requires the expression "how" the deceased came by his/her death to be read as meaning "by what means and in what circumstances". This is often referred to as the enhanced investigative duty.

The Factual Background

11. I am grateful to Mr Hough for the following summary of the factual background which I have taken from his skeleton argument, and which I do not understand to be in dispute. I acknowledge that it is based upon written evidence and records before the Coroner and that it does not reflect any predetermined views of the Coroner on the evidence she may hear in due course at the Inquest. The figures in square brackets are references to the trial bundle.

"Grace was born on 25 June 2003. She first came to the notice of the Council in 2010, when she was aged seven and she began exhibiting difficult and sometimes violent behaviour towards her family members. In June 2012, Grace disclosed that she had been abused by her mother's then partner, as a result of which she and her younger brother were made subject to child protection plans. In December 2015, following further allegations by Grace that she had been physically abused, she was made the subject of a child protection enquiry. Her behaviour remained challenging and she had become alienated from her mother and immediate family. At this stage, mental health services became involved with Grace and a full autism assessment was made. The conclusion was that Grace did not satisfy the ICD 10 criteria for a diagnosis of autism, but that she was suffering from an attachment disorder. See para. 3.3 of Dr Stanley's report **[404]**

Between February and May 2016, Grace was in the care of her maternal grandmother, Mrs Peers. She was placed in foster care in the latter part of 2016, while care proceedings were pursued. In February 2017, a care order was made under section 31 of the Children Act 1989 in favour of the council, after which Grace was again placed with her grandmother. She remained with Mrs Peers until May 2018, when Grace had to be moved because of an incident in which she assaulted her grandmother (who was in poor health and by this time was physically intimidated by Grace). By this point, Grace was known to be sexually active and to be using alcohol and cannabis regularly. See para. 3.4 of Dr Stanley's report **[404-5]**.

From 2 May 2018, Grace was placed in Baydale House, a residential children's home in Darlington. While there, she made a disclosure of sexual abuse by a former partner of her mother. Grace remained at Baydale House until 20 June 2018 when she was moved as a result of apparent sexual activity with a male resident. See para. 3.5 of Dr Stanley's report **[405-6]**.

With effect from 26 June 2018, Grace was placed at Farm House, a recently established small residential home for young people with complex behavioural needs. At this time, Grace was studying for GCSEs at Outwood Academy, Acklam, and was about to enter a new school year. The placement was always intended as a six-week interim measure while a longer-term placement was arranged. See para. 3.7.1 of Dr Stanley's report **[406-7]**. The referral document for the placement **[147-58]** contained modestly inconsistent references to risks of self-harm (with one section grading the risk as low to medium, with no evidence to date; and another putting the risk as medium). On the day of her arrival at Farm House, Grace and her social worker had a meeting with Daniel Johns, director of TVC. He asked specifically about any current or historical self-harm behaviour

or suicidal thoughts, and was told that there was no such history. See para's 10-19 of Mr Johns' statement **[229-32].**

Grace appears to have settled well into Farm House. She told social workers that she liked living there, and her behaviour was relatively good. While there, she was under the care of the Farm House clinical team of Dr Elizabeth Ashurst (forensic psychologist) and Lauren Grundy (trainee forensic psychologist). At the outset, Dr Ashurst administered several psychological questionnaire tests to inform risk management and care planning. These included the Strengths and Difficulties Questionnaire, the Beck Youth Inventories and the Children's Global Assessment Scale. They indicated that there was no material risk of self-harm or suicidal ideation. See paras. 7-20 of Dr Ashurst's statement **[124-29]**.

Later in the placement, on 30 August 2018, Ms Grundy administered a different questionnaire test, the Millon Adolescent Clinical Inventory. The responses indicated no mental health disorder and no self-harm ideation or planning. Dr Ashurst and Ms Grundy saw Grace regularly during the placement in clinical sessions. Neither considered Grace to present a risk of self-harm or suicide, and the clinical notes contain no reference to self-harm risks or behaviour: see the chronology in Dr Ashurst's statement **[129-41];** and the clinical notes **[182-225]**.

Grace returned to school for the new term on 5 September 2018. She had dyed her hair purple, which resulted in objections from teachers and a confrontation in school during which Grace was verbally abusive. She was excluded from school for three days. On 7 September 2018 (a Friday), she had a reintegration meeting at the school during which she again verbally abused teachers. This resulted in a further period of exclusion until 11 September 2018 (a Tuesday). See para 3.8.1 of Dr Stanley's report **[410]**.

On 7 September 2018, Grace asked Mr Johns what she needed to do to stay at Farm House. He referred her to the National Youth Advocacy Service (NYAS) and he tried to call NYAS himself that day, but without success. It was agreed that another call would be made on Monday 10 September. See para. 3.8.2 of Dr Stanley's report **[410];** paras. 22-24 of Mr Johns' statement **[236-37]**.

On Sunday, 9 September 2018, Grace went shopping with a member of staff from Farm House, who later reported the trip in positive terms. On her return to Farm House that evening, she watched television with another staff member and appeared to be enjoying herself. At around 10pm, she went to her bedroom. Later, staff members who brought her a night-time drink found

her in an apparently positive mood. See para. 3.8.2 of Dr Stanley's report **[410-11]**.

At around 9am on Monday, 10 September 2018, a staff member knocked on the door to Grace's room and received no reply. Since Grace did not need to attend school that day (due to her exclusion), the staff member decided not to go in and to let her lie in. At 11.20am and 11.25am other staff members knocked at the door. Shortly after 12.20pm, a decision was made to unlock the door. Grace was found hanging by a scarf in the shower cubicle in her room, and it was quickly determined that she had died. The post-mortem examination established that she had died from cerebral anoxia due to hanging. Toxicology findings indicated no use of medication, drugs or alcohol before death. See para. 3.8.3 of Dr Stanley's report **[411]**.

In the period after Grace's death, Farm House was subject to a number of Ofsted inspections which expressed criticisms of management, supervision, staff training and risk management procedures at the home **[109-20]**; **[361-74]**. The initial reports stated that the standard of care was generally inadequate and in particular that pro-forma risk assessment documents should have contained a specific section for risks of self-harm and suicide (when in fact such risks were only included as subcategories of risk within other categories, such as substance misuse). Those inspections and reports were general in scope and not focused upon Grace's case. There was also an independent review into risk assessments at Farm House which revealed that staff members had been asked to sign and backdate a risk assessment for Grace after her death **[97-107]**. …….

However ….it should be noted that monthly audits carried out on Farm House by the NYAS had been generally positive **[283-360]**."

Ground 1: Procedural Obligation

12. This Ground asserts that the Coroner should have concluded that an Article 2 inquest was automatically triggered on the basis that Grace was in state detention. There is no dispute that Article 2 extends to all violent deaths and suicides of persons in state detention, such that a full Article 2 inquest would follow automatically. The Claimant's case is that as a child in the care of the local authority, Grace's position is analogous to that of a person who commits suicide whilst in state detention.

13. It is common ground that the leading recent authority on the circumstances in which the Article 2 procedural obligation will be found to be automatically engaged, thus requiring a full Article 2 inquest, is the case of *R (Morahan) v HM Asst Coroner for West London* [2021] EWHC 1603; [2021] 3 WLR 919 ("*Morahan*"). In *Morahan* the issue of when the enhanced investigative duty arises automatically was considered, and previous case law was reviewed in detail. This is a decision of the Divisional Court

which counsel advised me is under appeal. However it is plainly binding upon me until such time, if any, as it is overturned on appeal.

14. In *Morahan* the issue was whether the automatic enhanced duty to investigate death arose in circumstances where the deceased was a voluntary in-patient in a psychiatric rehabilitation unit. She had left the unit with the agreement of her physician, but failed to return. Whilst at home in the community, she took a fatal overdose of recreational drugs.

15. Having reviewed the existing case law, at Paragraph 122, Popplewell LJ derived the following principles as applying to the enhanced investigative duty and when it arises automatically:

> "(4) The circumstances in which an enhanced investigative duty, as a procedural parasitic duty, arises are twofold:
>
> (a) whenever there is an arguable breach of the state's substantive article 2 duties, whether the negative, systemic or positive operational duties; and
>
> (b) in certain categories of circumstances, automatically.
>
> (5) The categories in which it has been identified as arising automatically include killings by state agents, suicides or attempted suicides and unlawful killings in custody, suicides of conscripts, and suicides of involuntary mental health detainees. These have been identified by a developing jurisprudence and these categories cannot be considered as closed.
>
> (6) The underlying rationale for the categories of case which automatically give rise to the enhanced investigative duty is that all cases falling within the category will always, and without more, give rise to a legitimate suspicion of state responsibility in the form of a breach of the state's substantive article 2 duties. The justification for the automatic imposition of the duty is not the wider rationale identified in *Amin* and *Middleton*, associated with the framework duty, of learning lessons with a view to protecting against future deaths
>
> (7) The touchstone for whether the circumstances of a death are such as to give rise to an automatic enhanced investigative duty is whether they fall into a category which necessarily gives rise, in every case falling within the category, to a legitimate ground to suspect state responsibility by way of breach of a substantive article 2 obligation.
>
> (8) In this context legitimate grounds for suspicion connotes the same threshold of arguability as has to be satisfied in cases where the enhanced investigative duty does not arise automatically.

> (9) In addressing whether a category of death automatically attracts the enhanced investigative duty, the type of death is important. Deaths from natural causes are not to be treated in the same way as suicides or unlawful killings. This follows from (6) and (7)."

16. In *Morahan* the court did not think it legitimate to equate the deceased's position to that of a detained patient. At paragraph 137 Popplewell LJ said

> "I would not accept that a voluntary psychiatric patient is to be treated in the same way as an involuntary detainee for these purposes. As I have observed the extent to which they are in the same position is fact specific. The threat of detention may render them involuntary patients in all but name, as Melanie Rabone was. At the other end of the spectrum they may be genuinely voluntary patients. The determination of whether the enhanced investigative duty arises automatically is a category exercise, and the automatic imposition of the duty can only be justified if the circumstances *necessarily* engage the justification for *all* persons falling within that category. The justification, as I have endeavoured to show, is a sufficient ground for suspicion of a breach of a substantive obligation by the state. That does not arise for those whose residence in the psychiatric unit is genuinely voluntary."

17. Mr Hough submitted that it cannot be said that the suicide of a 15 year old capable of independent living but subject to a care order "will always, and without more, give rise to a legitimate suspicion of state responsibility in the form of a beach of the state's substantive article 2 duties" as per Paragraph 122(6) of Popplewell LJ's Judgment in *Morahan*. He submitted that the Claimant needs to show that it would be impossible for a child in care under a Section 31 care order to commit suicide without there being an arguable basis for a breach of high level systemic duties or a breach of operational duties. He submitted that the tragic reality is that a 15 year old in care can commit suicide even though subject to a regime of perfectly adequate systems and practices and without anyone foreseeing a real and appreciable risk of imminent death.

18. There is obvious force in that submission. Dr Van Dellen sought to address it by arguing that Grace was effectively detained by the state, and that the fact of her detention is what gives rise to the enhanced investigative duty arising automatically as a category exercise. The categories where there is a legitimate ground to suspect state responsibility by way of breach of a substantive Article 2 obligation include cases of detention such as those in custody, conscripts and involuntary mental health detainees (Para 122(5) per Popplewell LJ as set out in paragraph 15 above). Dr Van Dellen submitted that on its facts this case is on the cusp of where a person is or is not detained. He described this as the "grey zone".

19. Dr Van Dellen submitted that the extent of control and supervision over Grace on the facts of this case is such as to equate her position to that of a person detained by the state. He reminded me that Popplewell LJ said that the categories where an Article 2 is automatically engaged are not closed, and that the type of death being a suicide is important (Paragraph 122(5) and (9); set out in Paragraph 15 above). He submitted that

the key case is *Rabone v Penine Care NHS Foundation Trust* [2012] UKSC 2; [2012] 2 AC 72 ("*Rabone*"). The deceased, Melanie Rabone, hanged herself from a tree in a park when she was on 2 days home leave from a hospital in Stockport where she was being treated as an informal patient, in other words someone not detained under the Mental Health Act 1983 ("the MHA"). It is noteworthy that the Court of Appeal had ruled that there was no operational duty, but held that had there been such a duty, there would have been a breach of it. Thus the case went to the Supreme Court on the issue of whether an operational duty could be owed to a hospital patient who is mentally ill but not detained under the MHA. It was not considering whether there was detention for the purposes of Article 2.

20. Dr Van Dellen took me to paragraphs 27-30 of the Judgment of Lord Dyson in *Rabone.* He particularly relied on Paragraph 28 where, he submitted, Lord Dyson looked at the nature of the control over the voluntary patient, and referred to the fact that an informal patient can be detained temporarily under Section 5 MHA to allow an application to be made for detention under Section 2 or Section 3 MHA as appropriate. Dr Van Dellen submitted that this illustrates that the test is not whether there are bars and a lock and key, and that even in the case of an informal patient, there is the statutory power to detain. At paragraph 29 there is reference to the fact that although informal patients are not "detained" and are therefore, in principle free to leave the hospital any time, their "consent" to remaining in hospital may only be as a result of the fear that they will be detained.

21. At Paragraph 28 of *Rabone*, Lord Dyson said this:

> "The patient's position is analogous to that of the child at risk of abuse in *Z v United Kingdom,* where at paras 73 to 74 the court placed emphasis on the availability of the statutory power to take the child into care and the statutory duty to protect children."

Dr Van Dellen relies upon this passage as supportive of the fact that the power to take a child into care is comparable to detention. In response, Mr Hough pointed out that the case of *Z v United Kingdom* was also a case considering whether or not an operational duty arose and/or was breached and was not considering Article 2 detention. That is correct. In any event, it seems to me that there is an obvious difference between exercising the statutory power to take a child into care in order to protect the child, and the issue of whether the child once in care can be said to be detained.

22. In this case Grace was the subject of a care order under Section 31 Children Act 1989 placing her in the care of MBC. As a result MBC had parental responsibility for Grace. Dr Van Dellen submitted that the imposition of parental responsibility is important given the reference to state responsibility in paragraph 122(6) of Popplewell LJ's judgment (as set out in paragraph 15 above). I challenged this submission, pointing out to Dr Van Dellen that if he was correct, then any suicide by a child in care would automatically result in an Article 2 inquest. Dr Van Dellen agreed that was not attractive, but he submitted it is nevertheless the correct position. He pointed out that children are vulnerable compared to adults; that the state was effectively exercising its power by reason of its parental responsibility for Grace, and that Grace was controlled and supervised by MBC. Dr Van Dellen submitted that if Grace had left the home without permission, the police would have been called, and the state and the police would have tracked Grace down and returned her to the home. He pointed out that

Grace was not exercising any choice to live at Farm House of her own free will, but was placed there by the state saying "We control you and supervise you and you must live there". He submitted that this is stronger control over the individual by the state than simply a question of parental responsibility.

23. Dr Van Dellen relied on the decision of the Supreme Court in *P v Cheshire West* [2014] UKSC 19; [2014] AC 896. In paragraph 1 of her judgment Lady Hale described the case as being about the criteria for judging whether the living arrangements made for a mentally incapacitated person amount to a deprivation of liberty. He particularly relied upon that case insofar as it dealt with the cases of MIG and MEG. They were sisters who first became the subject of care proceedings in 2007 when they were aged 16 and 15 respectively. Both girls had learning disabilities and, if their living circumstances amounted to a deprivation of liberty, that deprivation had to be authorised either by the court or pursuant to the deprivation of liberty safeguards set out in the Mental Capacity Act 2005.

24. By the time of the first instance hearing MIG was 18 and was living with a foster mother. She had never attempted to leave the home by herself and showed no wish to do so, but if she did, the foster mother would restrain her. She attended a further education unit daily during term time and was taken on trips and holidays by her foster mother. MEG (then aged 17) had originally been placed with a foster carer who was unable to manage her aggressive outbursts and so she was moved to a residential home. The home was an NHS facility, not a care home, for learning disabled adolescents with complex needs. Her care needs were met only as a result of continuous supervision and control. She showed no wish to go out on her own and so did not need to be prevented from doing so.

25. At paragraph 46 of her judgment, Lady Hale said this:

> "…… what it means to be deprived of liberty must be the same for everyone, whether or not they have physical or mental disabilities. If it would be a deprivation of my liberty to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision, and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person. The fact that my living arrangements are comfortable, and indeed make my life as enjoyable as it could possibly be, should make no difference. A gilded cage is still a cage"

26. In paragraph 48, having asked herself whether there was an acid test for the deprivation of liberty in these cases, and noting that MIG and MEG were, for perfectly understandable reasons, not free to go *anywhere* without permission and close supervision, Lady Hale asked what are the particular features on which the court needed to focus. She continued as follows:

> "49. The answer, as it seems to me, lies in those features which have consistently been regarded as "key" in the jurisprudence which started with HL v United Kingdom 40 EHRR 761: that the person concerned "was under continuous supervision and

> control and was not free to leave" (para. 91). I would not go so far as Mr Gordon, who argues that the supervision and control is relevant only insofar as it demonstrates that the person is not free to leave. A person might be under constant supervision and control but still be free to leave should he express the desire so to do. Conversely, it is possible to imagine situations in which a person is not free to leave but is not under such continuous supervision and control as to lead to the conclusion that he was deprived of his liberty"

27. Dr Van Dellen submitted that Grace's arrangements under Section 31 of the Care Act were such that she was living in a "gilded cage". He submitted she was subject to close monitoring and control, could not decide to go and live somewhere else and that if she left, police would bring her back. He submitted that this therefore triggered an automatic Article 2 inquest.

28. Mr Hough referred me to the Court of Appeal decision in *R (Ferreira) v Inner South London Senior Coroner* [2017] EWCA Civ 31; [2018] QB 487 ("*Ferreira*"). In that case M, who had Downs syndrome and learning difficulties and was confined to a wheelchair, lived with her parents and her sister who provided most of her care. She was admitted to a hospital operated by an NHS trust suffering from shortness of breath and she underwent treatment for pneumonia and heart problems. Her condition worsened and she was admitted to the hospital's intensive care unit where she was sedated and intubated. Four days later she died. Throughout her stay in hospital M lacked capacity to make decisions on all aspects of her treatment and care. The claimant argued that M had died while in "state detention" within Section 7(2)(a) Coroners and Justice Act 2009, which by Section 48 of that Act meant "compulsorily detained by a public authority".

29. The Court of Appeal held that "state detention" in the Coroners and Justice Act 2009 was not exactly the same as deprivation of liberty for the purposes of Article 5 of the Convention although there was some overlap. The court concluded that when determining whether the administration of life-saving treatment deprived a person who lacked capacity of his liberty, it was not appropriate to apply the test of whether the person was under continuous supervision and control and was not free to leave which was the test usually applied to the living arrangements of persons lacking capacity in order to determine whether there had been a deprivation of liberty.

30. At paragraph 39 of *Ferreira*, Arden LJ quoted the acid test as formulated by Lady Hale (and set out in Paragraph 26 above). At paragraphs 79 - 87 of her judgment she considered Strasbourg case law applicable to urgent medical care. Mr Hough referred me to paragraph 82 where she considered the case of *Austin v United Kingdom*, a case relating to the "kettling" of a crowd of demonstrators, and which was found to amount to a restriction on movement only, and not a deprivation of liberty. Mr Hough relied in particular on paragraphs 85 and 86 of the judgment in *Ferreira* where Arden LJ referred to the cases of *Nielsen v Denmark* and *HM v Switzerland.* In *Nielsen* a young boy of sound mind was admitted to a child's psychiatric ward where he was treated for a physical condition. The Strasbourg court held that the conditions in the ward did not limit the boy's liberty to any greater extent than if he had been treated on a non-psychiatric ward and that accordingly there was no deprivation of liberty. In *HM v Switzerland* an elderly lady whom the Strasbourg court did not describe as of unsound

mind, was placed in a care home in her own interests because she could no longer be looked after in her own home or elsewhere. She had freedom of movement and could make social contacts outside the home and the Strasbourg court held there was no deprivation of liberty

31. Mr Hough submitted that the boy in *Nielsen* was materially more restricted than Grace and other children the subject of a care order. The boy was confined to a psychiatric ward and enjoyed the freedoms of a child in his situation. Dr Van Dellen invited me to distinguish the *Ferreira* case on the basis that it is dealing with care in the medical context of a patient in an intensive care unit.

32. Mr Hough submitted that a child in care is obviously different to those detained within closed societies such as prisons, conscript cases or those involuntarily detained pursuant to the MHA. He pointed to the fact that Grace was free to leave Farm House to attend school. In response to that, Mr Van Dellen said that Grace was taken to and from school, only went into town with a staff member and was allowed no access to a phone on her own. I have received no evidence to support those points, although they were not challenged by Counsel for TVC. Regardless of how she got there, there is no suggestion that Grace was deprived of her liberty at school. Like all pupils she would be subject to school rules but the school could not prevent her leaving the school premises had she chosen to do so. No doubt attempts would have been made to find her and return her to the care of the local authority, but she was free to leave. There is no suggestion that she was any more restricted at school than any of the other students. Mr Hough made the further point that there was a lock on Grace's bedroom door. At the time of her death, Grace had locked that door from the inside. She was not locked into her room and by locking it from the inside, she had the liberty to exclude others. On the face of it, that is not consistent with Dr Van Dellen's submission that Grace was under constant supervision and control.

33. In this case, whilst Grace was the subject of a Section 31 care order, she was not the subject of a Section 25 secure accomodation order, nor had she been placed in secure accommodation pending the making of an emergency application for such an order. Nor is there any suggestion that she should have been in secure accommodation. Dr Van Dellen made the point that if Grace had left the home, she would have been found and returned. No doubt if that was a repeated occurrence, MBC might then have considered applying for secure accommodation order.

34. I am not persuaded that Grace's situation in care is analogous to state detention. When discussing the case of *Rabone* in his Judgment in *Morahan*, Popplewell LJ (at paragraph 49) pointed out that in *Rabone* the power to impose involuntary detention which the court held should have been exercised, meant that the difference for Ms Rabone between a voluntary and involuntary patient was, as Lord Dyson put it, one of form, not substance. That will not be the case for every voluntary psychiatric patient. Popplewell LJ rejected the submission that all voluntary psychiatric patients would fall into the same category for the purposes of the existence of the operational duty irrespective of their personal circumstances.

35. On this point Mr Faulks referred me to Mr Johns' Witness Statement ([55]: Paragraph 4). Mr Johns is the sole Director and 80% owner of TVC. He states that when a young person comes to stay with them, TVC has no powers of compulsion or detention. There is no care order in favour of TVC and they cannot order or make a young person do

anything under any care legislation. Mr Faulks submitted that if all care orders amounted to de facto state detention, there would be no need for secure accommodation orders, or for deprivation of liberty orders allowing residents to be observed through the night.

36. In my Judgment there is a very real and obvious difference between a child in secure accommodation who has thereby been deprived of her liberty, and a child in care who is free to come and go, notwithstanding that if she simply left the home, police assistance would have been sought to find and return her to the home. In my judgment the difference is one of substance, not merely one of form. I consider Dr Vallen goes too far when he describes Grace's living arrangements as meaning that she is living in a gilded cage. It follows that I reject the challenge in Ground 1. In my judgment there is no automatic Article 2 enhanced investigative inquest simply by reason of Grace being a child in care who sadly took her own life.

37. Whilst that is sufficient to dispose of Ground 1, I should also deal with the final point made by Mr Hough, and also by Mr Faulks on behalf of TVC. Each submitted that Farm House is a private institution controlled by TVC, and not a public authority Mr Hough submitted that even if Grace had been in a situation of detention at Farm House (which I have found she was not), she was not detained by the state or deprived of liberty by the state because TVC was not a public authority for the purposes of Convention law or Section 6(3) Human Rights Act 1998 ("HRA 1988"). Mr Faulks submitted that TVC cannot be seen as a hybrid authority and was not, therefore, a public authority. Both referred me to the case of *YL v Birmingham City Council* [2007] UKHL 27; [2009] 1 AC 681 ("*YL*").

38. By Section 6(3)(b) HRA 1988 a public authority includes "any person certain of whose functions are of a public nature". In *YL* the Claimant was resident in a care home provided by an independent provider of health and social care services. The care home accommodated both privately funded residents and those whose fees were paid by the council in full or in part. The Claimant's fees were paid by the council save for a small top up fee paid by her relatives. The claimant's case was that in providing accommodation and care for her, the care home provider was exercising public functions within Section 6(3)(b) HRA 1998. The court concluded that in providing the care and accommodation, the Defendant company in that case was acting as a private, profit earning company. Lord Mance did not regard the actual provision, as opposed to the arrangement, of care and accommodation for those unable to arrange it themselves as an inherently governmental function (Judgment para 115). Whilst the Defendant company was subject to close statutory regulation in the public interest, Lord Mance said that regulation by the state is no real pointer towards the person regulated being a state or governmental body or a person with a function of a public nature, if anything perhaps even the contrary. The private and commercial motivation behind the company's operations in contrast pointed against treating the company as a person with a function of a public nature (para 116).

39. Mr Faulks submitted that simply discharging a public function does not make a private body a hybrid authority (*YL* paras 30, 133, 140, 144 and 164); that payment by a local authority to a private body does not make it a hybrid authority (*YL* paras 27 and 142), and that regulation (for example by Ofsted or under the Care Act) does not make a private body a hybrid authority (*YL* paras 116 and 136). He further submitted

that the active test identified in *YL* is whether there is governance by the local authority. In his judgement in *YL* Lord Neuberger stated

> "In my judgment, it is of particular importance in relation to the issue which we have to decide that a proprietor of a care home is not given significant, or indeed (as far as I am aware) any, coercive or other statutory powers, over its residents, whether they are in the care home pursuant to an arrangement with the local authority or otherwise. If proprietors had such powers, that would be a powerful reason for justifying the conclusion that a function was "public in nature". Running a prison, discharging a statutory regulatory regime….. maintaining defence….. and providing police services, which are plainly functions falling within section 6(3)(b), carry with them such powers."

40. In response to these submissions , Dr Van Dellen invited me to distinguish YL on the basis that it relates to a care home, whereas in this case I am dealing with a children's home and an order made under section 31 of the Care Act. I reject that submission. Whilst the Supreme Court judges were considering a care home, the passages in their judgments are of general application as is clear from the paragraph from Lord Neuberger's judgment set out in paragraph 39 above. It follows that even if I had been of the view that Grace was deprived of her liberty and/or detained at Farm House, that would not be pursuant to any action by the state. Article 2 would not be engaged and there would be no automatic right to an Article 2 inquest .

Ground 2: Systemic Failing

41. Article 2 imposes a negative obligation upon the state not to take life save in certain specified situation. It also imposes positive obligations to protect life which fall into two categories known as the general or systems duty, and the operational duties. Ground 4 having been abandoned by the Claimant, in this case I am concerned only with the general/systems duty. There is no dispute between Counsel that this duty is a duty to establish a framework of laws, precautions and procedures, with means of enforcement, to protect the lives of citizens. It is not concerned with acts or omissions of individual state agents which would fall within the operational duty. Thus it is concerned at a relatively high level with systems and procedures.

42. By Ground 2 the Claimant argues that the Coroner was wrong to conclude that on the available material there was not an arguable case of a breach of the Article 2 general/systems duty in relation to Grace's death. Dr Van Dellen relies on *Morahan*, in particular at paragraph 122 where Popplewell LJ states that the circumstances in which an enhanced investigative duty, as a procedural parasitic duty, arises include

> "whenever there is an arguable breach of the state's substantive article 2 duties, whether the negative, systemic or positive operational duties"

In the light of Dr Stanley's reports, and the Ofsted Reports, I asked Counsel for the Interested Parties whether there was any dispute that each was arguably guilty of systemic failings in this case. Both Mr Walker and Mr Faulks accepted, for the

purposes of argument in the hearing before me, that there were systemic failures. They were plainly right to do so.

43. Both before the Coroner [66] and in her Grounds (at Paragraph 34) the Claimant argued that a systemic breach is not dependent on it being shown that there was a particular risk to a particular individual, as the breach arises from the systemic failings. The Grounds assert that the submission from Farm House that any systemic failings needed to be causative of Grace's death does not appear to accord with the ratio in *Savage v South Essex Partnership HNS Foundation Trust* [2008] UKHL 74 ("*Savage*").

44. On behalf of the Coroner, it was submitted that this is a mis-statement of the law. In his skeleton Mr Hough cited Lord Rodger in S*avage* indicating that a causal connection is in fact required:

> "31. If the authorities failed to put in place appropriate general measures to prevent suicides among the prisoners in a particular prison and, as a result, a prisoner was able to commit suicide, there would be a breach of article 2.
>
> 69…… Failure to perform these general obligations may result in a violation of article 2. If, for example, a health authority fails to ensure that a hospital puts in place a proper system for supervising mentally ill patients and, as a result, a patient is able to commit suicide, the Health Authority will have violated the patient's right to life under article 2"

Both extracts clearly indicate a causal link by reference to the words "..and, as a result…". In response to a question from me, Dr Van Dellen conceded that there has to be a causal link and that it has to relate to the particular death.

45. There is no dispute that the causal link is the test laid down in *Van Colle v Chief Constable of Hertfordshire* [2008] UKHL 50; [2009] 1 AC 225 ("*Van Colle*") at 138, namely whether the deceased lost a substantial chance of surviving because of the breach. That is a lower threshold than the tortious test. There is no requirement to show, on the balance of probabilities, that the relevant failure caused the death.

46. Thus by the time of the hearing in front of me, the dispute on Ground 2 was whether the Coroner was wrong to conclude that there was no evidence that it was arguable that Grace lost a substantial chance of surviving because of the systemic failings. Dr Van Dellen submitted that Grace did lose a substantial chance of surviving as risk assessments were not tailored to individual needs and there were only generic strategies in place to address self-harm behaviour, which took no account of individual circumstances or history.

47. Dr Van Dellen relies upon the fact that an Ofsted Report [109-120] following an inspection on 13 and 14 September 2018 (just three days after Grace's death) was, in his words, "damning in the extreme". The Report found Farm House inadequate, including an inadequate finding of how well children and young people are helped and protected, and an inadequate finding of the effectiveness of leaders and managers [109]. The Report contained 13 statutory requirements which were subject to a compliance notice [110 -115]. The Report also noted that records held about children were of poor

quality and at times were incomplete and contradictory. Farm House was restricted from admitting any further children until practice had improved.

48. Dr Van Dellen relies in particular on the following taken from the first Ofsted Report:

> "Risk assessments are not tailored to individual needs and in some cases known risks have not been sufficiently recognised, addressed and reduced. This leaves children at risk of harm."[115]
>
> "Admissions have not been managed effectively since the home opened in May 2018." [115]
>
> "Arrangements for ending children's placements are ineffective." [116]
>
> "There are generic strategies in place to address behaviours of self-harm, but they take no account of individual circumstances or history. This means that health outcomes for children are poor." [116]
>
> "Records are not always updated when risks change." [117]

Dr Van Dellen submitted that the failure to update records when risks change is linked to this case, as Grace was excluded from school twice in the week in the run up to her death.

49. Ofsted carried out a further inspection on 16 and 17 April 2019 [361-374], and whilst some improvements were seen, further improvements were required overall to be found good, and the effectiveness of leaders and managers was still found to be inadequate [361].

50. An independent review into risk assessment at Farm House was carried out by Bill Ashton. His report is dated 25 October 2018 [97-107]. He concluded that care staff members had been asked to backdate signatures on Grace's risk assessment. Dr Van Dellen submitted that this raises concerns about the weight to be attached to any records being kept at Farm House. Various explanations have been provided. One is that care staff are wrong about this. Another is that risk assessments were originally created and were never signed. Whatever the position, Dr Van Dellen submitted there is a very real question over the risk assessments and, in particular, whether anything has been added in the interim. He submitted that the court should place little if any weight on the risk assessments. He submitted that then feeds directly back into the *Van Colle* question of whether Grace lost a substantial chance of surviving because of the systemic breach which has been admitted for the purposes of these proceedings.

51. Dr Van Dellen further relied upon Dr Stanley's findings which raised concerns as to the proposals to move Grace from Farm House notwithstanding the positive placement outcomes which had been achieved there. In relation to that point at paragraph 10.2.6 Dr Stanley stated

> "I cannot therefore state on the basis of the evidence available at this latter point (i.e. during August 2019) of Grace's journey as a child looked after by the local authority that Middlesbrough Borough Council had suitable systems of working in place for identifying an appropriate placement for Grace Peers while she was the subject of a care order at that time" [429]
>
> At paragraph 10.3.1 he continued
>
> "I do not have sight of any Middlesbrough Borough Council written operational policies that describe how social workers and social work teams identify family or residential care placements that might address the needs of specific children." [429]
>
> At paragraph 10.10.1 he continued
>
> "In my opinion the major systemic flaw that manifests itself operationally was a lack of a focus on planning Grace's care over the summer of 2018…… There appears to have been no straightforward mechanism whereby Grace's opinions could be taken into account by the local authority and she could be reassured that her opinions would be heard by those making placement decisions on her behalf." [439]

52. Dr Van Dellen submitted that there is evidence outside Dr Stanley's expertise and which gives rise to the possibility that problems in other areas were affecting Grace. In particular he relies on the evidence that her proposed relocation to a placement other than at Farm House was impinging on Grace's mental state.

53. More generally in relation to provision in Farm House, Dr Stanley concluded as follows

> "10.5.6 in my opinion, while the clinical team (Dr Ashurst and Lauren Grundy) at the farmhouse residential care home did have a well-developed and personalised psychological understanding of Grace Peers' needs and requirements during her stay at the Farm House, the residential care home more generally and the residential care team did not have suitable systems of working in place for identifying and reviewing the care needs and requirements for Grace Peers; in particular, there was no risk review instrument that would afford the care staff at the Farm House residential care home oversight of Grace Peers' direct risk of harm to self as a category in and of its own right." [433]

54. Dr Stanley furthered noted the inadequacy of the systems whereby the risk status of residents was communicated to the wider care team (Para 10.6.3 [435]), and that it cannot be concluded that the home had a system for ensuring competent staff were involved with Grace Peers' and her fellow residents' care and supervision (Para 10.7.3 [437]).

55. Mr Hough on behalf of the Coroner submitted that Dr Van Dellen's argument fails to address the point that on the available evidence there was competent clinical assessment

of Grace's self-harm risk and she received care and support of high quality. Whilst Dr Stanley did make significant criticisms of the systems of both MBC and Farm House, he also made a number of positive findings. He found that MBC had acted reasonably in placing Grace at Farm House (paras.10.3.6-10.3.7 [430]); that her psychological needs had been consistently identified and reviewed at Farm House (para 10.5.4 [432]); that Farm House had not had proper risk assessment documentation, but that any documented assessment of Grace's self-harm risks at material times would have graded it as low (paras. 10.5.6 -10.5.7 [434]), and that the actual clinical assessment and care of Grace at Farm House actually exceeded the level Dr Stanley would expect even of a specialist NHS mental health service (para. 10.14.3 [443]).

56. Dr Stanley did raise concerns as to whether Grace had received sufficient support concerning the prospective change of placement, and he considered it likely that Grace was preoccupied in the weeks and days prior to her death by whether or not she would be able to stay at the Farm House residential children's home (para 11.7 [451]). He noted that many young people who go on to seriously harm themselves present prior to the event with self-harm thinking, evidence of planning self-harm and acts of actual self-harm. He stated that in Grace's case credible evidence is available that strongly suggests that Grace was not thinking or acting in this way as late as the Thursday prior to her death or indeed had been thinking or acting in this way for the duration of her placement at Farm House (para. 11.8 [451]).

57. I agree with Dr Van Dellen that Dr Stanley was clear to point out those areas in which he did not have appropriate expertise. At paragraph 11.16 of his report he states that, whilst he is a health services professional with experience in the clinical and managerial interface between health and social care organisations, he does not have a detailed in-house knowledge of local authority children's social care decision-making systems and their operational policies. He states he would therefore defer to other informed professionals with the requisite knowledge base if views contrary to those he has expressed in relation to the local authority systems and how they are executed/applied are raised in the course of the forthcoming inquest touching the death of Grace Peers.

58. In her decision [66 -69] the Coroner stated that it is not sufficient to simply identify the existence of systemic failings and that she must consider whether there was a causal connection between those failings and Grace's death. She acknowledged that in the days before her death Grace was experiencing a range of emotions and fluctuations in mood and behaviour, noting the exclusions from school and that she had advised her social worker that she wanted to stay at Farm House as she was happy there. The Coroner noted Dr Stanley's report and his belief that despite the Ofsted reports, staff at Farm House were able in practice to identify Grace's needs and requirements and were able to supervise and care for her. Whilst accepting there were clearly issues with the systems and procedures on the part of both MBC and Farm House, the Coroner stated that in the light of the documentary evidence, she could not conclude that Grace lost a substantial chance of survival because of them. She said it does not appear arguable that there was a real and substantial chance that improved systems and procedures would have saved Grace's life. Whilst recognising one cannot be sure what result better systems and procedures would have had, the Coroner stated that she could not say that the systemic and procedural breaches resulted in a failure to protect Grace's life, given the care and support given to her at Farm House.

59. In my judgment the Coroner was entitled to come to that conclusion based on all the evidence before her, notwithstanding the apparently serious systemic breaches disclosed. Dr Van Dellen submited that the court cannot rely on the risk assessments created at Farm House. I would accept that submission, but it ignores the evidence that the psychological care and support provided by the clinical team is not the subject of those criticisms. Given the high standard and high level of that care which was inevitably addressed to Grace's individual circumstances and history, in my judgment it was open to the Coroner to conclude that it was not arguable that improved systems and procedures would have presented Grace with a real and substantial chance of survival.

60. Insofar as the issue of Grace's concerns about the ending of her placement at Farm House are concerned, Dr Van Dellen submitted that they were relevant to the extent to which they may have impacted on Grace's mental state. Indeed that is expressly referred to by Dr Stanley in Paragraphs 11.14 and 11.15 of his report (in particular his footnotes 11 and 12 to Paragraph 11.14 which show the relevance of these matters in the context of Grace's mental health and well being) [453-454]. The high level psychological care and support was directed to Grace's mental health and well-being. In my judgment the Coroner was entitled to reach the conclusion she reached notwithstanding these apparent systemic breaches by MBC.

61. Finally, insofar as Farm House is concerned, the points I made in relation to Ground 1 at Paras 38 -40 above apply equally to this Ground. In my judgment any systemic failings by Farm House would not give rise to an Article 2 breach of duty as it was not exercising a public function.

Ground 3: Effect of Article 2 on the Scope of the Inquest

62. By this Ground the Claimant argues that the Coroner was wrong to hold that the only material effect of the inquest not being an Article 2 inquest is on the conclusions that may be returned, rather than upon the scope of the inquest. In Section 7 of the Claim Form the challenge is to the decision of the Coroner that the inquest shall not be an Article 2 inquest [3]. The first point that Mr Hough made was that the claim form contains no challenge to the ruling on the scope of enquiry, and he suggested, therefore, that Ground 3 requires no decision from me. This point was not made in the Coroner's written submission which engaged with Ground 3, although in the final paragraph responding to Ground 3, the Coroner asserted that any error that might be revealed by the Ground would appear to be immaterial. Similarly neither of the Interested Parties in their responses suggested that the court could not deal with this on the basis that it formed no part of the challenge. The First Interested Party simply stated that Ground 3 is not an appropriate Ground for seeking judicial review [61], and the Second Interested Party said that it did not fully follow how Ground 3 provides a basis for judicial review [52]. Neither expressly suggested that Ground 3 was outside the scope of the claim form. Foster J granted permission on all Grounds, and in those circumstances, in my judgment, the Claimant is entitled to pursue Ground 3 and to seek a ruling from the court on Ground 3.

63. Dr Van Dellen submitted that there is inevitably a difference between the scope of the two types of inquest. He referred me to section 5 CJA 2009 which provides as follows:

> "(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), 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."

Dr Van Dellen submitted that Section 5(2) makes it clear that an article 2 inquest including "in what circumstances" the deceased came by his or her death, is inevitably wider than the non-article 2 inquest set out in section 5 (1). I accept that the natural reading of the statute would tend to suggest that one is wider than the other since subsection (2) describes the earlier subsection as being read to include ascertaining in what circumstances the deceased came by his or her death, the inference being that would not otherwise be included.

64. Dr Van Dellen submitted that in a non-Article 2 inquest, the circumstances in which the deceased came by his or her death are not necessarily going to be looked at. He told me that the common rejoinder is to say that a non-Article 2 inquest will be very broad in scope and will effectively look at the same issues and, therefore, the coroner can keep an open mind on this issue. That is precisely the stance the Coroner took in this case. She recognised that she was still likely to need to consider issues regarding procedures and systems when considering her duty under PFD (the prevention of future deaths report) [69], and indicated that she would keep an open mind and if it becomes appropriate, the matter of engagement of Article 2 can be reconsidered at the conclusion of the inquest. Dr Van Dellen submitted that the difficulty with this approach is that by then the inquest has been held and matters have already been determined. He submitted it is legally incorrect to say there is no difference in scope between the two types of inquest.

65. Dr Van Dellen referred me to Jervis on Coroners (14th edition) which states at 6-20 and 6-21:

> "Yet it is hard to deny that the difference in interpreting the word how in the statutory question must mean that there are things potentially within the scope of the enquiry in the Middleton case which would not be in a Jamieson case. And the legislation has now enshrined the distinction in meaning in primary legislation, which makes it impossible for judges to ignore.
>
> It is submitted that there is a difference in scope. Jamieson itself was a death in custody before the Human Rights Act, where the Court of Appeal held that the scope of the inquest was restricted

> to the means by which the deceased came by their death….. A Jamieson inquest is limited to a fact-finding exercise and should focus on the answers to the four statutory questions. A Middleton inquest into the Jamieson death now probably would need to look in addition to the general regime then in operation, the reception of the deceased into the institution, the communication of information between staff, and the events surrounding the discovery of the deceased, amongst other things. These are now described for the purposes of article 2 inquest as the central issue, a necessary part of scope."

Dr van Dellen accepts that Jervis is commentary rather than law, but he submitted that it is persuasive.

66. Dr Van Dellen referred me to the decision of the House of Lords in *R (Hurst) v London Northern District Coroner* [2007] UKHL 13; [2007] 2AC 189 ("*Hurst*"). That case concerned coronial proceedings under the Coroners Act 1988 into a death as a result of a stabbing attack, which death occurred prior to the coming into force of the Human Rights Act 1998 on 2 October 2000. In those circumstances the result and that decision has no bearing on the issues before me. However Dr Van Dellen referred me to paragraph 51 in the judgment of Lord Brown where he stated as follows:

> "Of course, the scope of the enquiry is ultimately a matter for the coroner. The "verdict" and findings, however, are not. The *Jamieson* construction of "how" severely circumscribed these. But where the *Middleton* construction applies, the verdicts and findings are not merely permitted, but *required* to be wider: section 11 [Coroners Act 1988] dictates that the inquisition "shall set out so far as such particulars have been proved… how… the deceased came by his death". If in every case that means "in what circumstances" as well as "by what means", the coroner will inevitably in many cases have to widen the scope of the enquiry beyond that which, under the *Jamieson* approach he would otherwise regard to be appropriate."

Dr Van Dellen submitted that Lord Brown recognised that the scope of an Article 2 inquest was inevitably wider than the scope of the Jamieson inquest. He also submitted that extract from the judgemnt of Lord Brown illustrates his submission that by embarking on a Jamieson inquest, the Coroner has exercised a discretion to narrow down the scope of the inquest, in effect making it difficult or impossible to convert it to an Article 2 inquest at a later stage.

67. Dr Van Dellen submitted that a coroner needs to ensure a wide scope of investigation which will then inform the decision that the coroner has to make as to whether the findings need to extend to the additional conclusions required by an Article 2 inquest. In response to a question from me, Dr Van Dellen accepted that it would be open to a coroner to embark on a Middleton type inquest and then decide that was unnecessary. However he suggested the opposite was not the case, precisely because it circumscribed the ambit of the enquiry at a time when it is impossible or inappropriate to determine what that ambit should be, precisely because the investigation has not been carried out. He pointed out that during the course of an inquest the coroner will have to rule on the

relevance of questions and decide whether a particular question is or is not within the scope of the inquest. That, he submitted, illustrates both why determining the scope is important, but also illustrates the importance of not making the decision at an inappropriately early time. Dr Van Dellen did not put it in these terms, but in essence he was suggesting that the Coroner here had put the cart before the horse. He pointed out that a coroner's decision on scope informs issues of disclosure, the relevance of questions, as well as the findings made at the inquest.

68. Dr Van Dellen also submitted that shortcomings in the regulatory system may potentially give rise to the need to make a PFD Report (Prevention of Further Deaths Report). The coroner has a legal power and duty to write such a report if it appears there is a risk of other deaths occurring in similar circumstances. Dr Van Dellen gave as an example that if there had been no fire extinguishers in Farm House, whilst that would be irrelevant to Grace's death, it would nevertheless be relevant to a prevention of future deaths report. Thus he submitted non-causative matters can fall within the scope of an Article 2 inquest. Thus, he submitted that once there is a properly convened Article 2 inquest it must also cover any shortcomings in the regulatory system even if they are not causative of death. He submitted therefore that the scope between the two types of inquest must be different.

69. Mr Hough drew my attention to Baroness Hale's Judgment at paragraphs 21 and 22 in *Hurst* where she states that the scope of the inquiry at an inquest is almost always going to be wider than the verdict eventually reached. He also drew my attention to the judgement of Lord Mance at paragraphs 74 and 74 where he states

> "Like my noble and learned friends, Lord Rodger and Baroness Hale, I am not persuaded that the distinction between a Middleton inquest and a Jamieson inquest is as stark as I believe Lord Brown to be suggesting in paragraphs 51, 56, 57."

Lord Mance goes on in paragraph 75 to say that the nature of the verdict and the scope of the coroner's investigation are different matters.

70. Mr Hough submitted that the Coroner's position reflects the observation of the Court of Appeal in two recent cases as follows. In *R (Sreedharan) v Manchester City Coroner* [2013] EWCA Civ 181, Hallett LJ (with whom Lord Dyson MR and Maurice Kaye LJ agreed) said at paragraph 18(vii):

> "There is now in practice little difference between the Jamieson and Middleton type inquest insofar as inquisitorial scope is concerned. The difference is likely to come only in the verdict and findings""

In *R (Maguire) v HM Senior Coroner for Blackpool and Fylde* [2020] EWCA Civ 738; [2021] QB 409 at para. 77, Lord Burnett of Maldon CJ (giving the judgment of the court) said:

> "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….[T]he peculiarity of the

> article 2 question for inquests is that in statutory terms it concerns the product and not the content of the investigation"

71. Both counsel referred me to the Supreme Court judgments in *R (Smith) v Secretary of State for Defence* [2010] UKSC 29; [2011] 1 AC 1 ("*Smith*"). In his skeleton, Dr Van Dellen states that in *Smith*, four justices considered there was no difference in scope, two justices took the view there was a difference, one justice expressly sat on the fence and two justices expressed no view. Mr Hough took me to the judgments. Having acknowledged at paragraph 77 that the decision in Middleton has been given statutory effect by section 5(2) CJA 2009, at paragraph 78 Lord Phillips (with whom Lord Collins and Lord Kerr agreed) stated:

> "It seems to me that the only difference that the decision of the House in Middleton would have made to either the Jamieson inquest or the Middleton inquest would have been to the form of verdict. In each case the coroner appears to have permitted exploration of the relevant circumstances despite the fact that he did not permit these to be reflected in the verdict. I question whether there is, in truth, any difference in practice between a Jamieson and a Middleton inquest, other than the verdict. If there is, counsel were not in a position to explain it"

72. Lord Brown agreed with Lord Phillips that in practice the only real difference between a Jamieson inquest and the Middleton inquest is likely to be with regard to its verdicts and findings, rather than its inquisitorial scope (paragraph 52). At paragraph 208 Lord Mance felt unable to go as far as Lord Phillips due to what he described as his relative ignorance as to the extent to which a distinction between the two types of inquest is in fact meaningful in day-to-day practice (as, he said, the courts in Jamieson, Middleton and Hurst must on the face of it have thought). However, he considered it unnecessary to pursue the aspect further on the appeal as:

> "Everyone agrees that coroners have a considerable discretion as to the scope of their enquiry, although the verdict that they may deliver differs according to the type of inquest being held. The practical solution is no doubt for coroners to be alert to the possibility that a Middleton type verdict may be, or become, necessary and to be ready to adapt the scope of their investigation accordingly"

73. Mr Hough relies on that practical solution. He submitted that a competently conducted inquest will address all the circumstances of death, thus leaving open the possibility of reverting to an Article 2 inquest verdict if it becomes necessary to do so. He referred me to the judgement of Garnham J in *R (Grice) v HM Senior Coroner of Brighton and Hove* [2020] EWHC 3581 (Admin), and Mr Hough reminded me that Garnham J was an inquest lawyer of substantial practical experience. At paragraph 58 of his judgment Garnham J stated that a decision that the Article 2 procedural obligation is engaged will have little if any effect on the scope of enquiry or conduct of the hearing, adding this is because any properly conducted inquest will consider the circumstances surrounding and events leading to the death. He noted that the key effect of Article 2 engagement is upon conclusions at the inquest.

74. It is plain from analysis of the authorities that notwithstanding that the natural reading of sections 5(1) and 5(2) tends to suggest there is a difference in scope of the two types of inquest, in practice that is not the situation. Recent decisions in the Court of Appeal (*Sreedhan* and *Maguire* set out in paragraph 70 above) make that clear. I accept Mr Hough's submission that the practical solution is for inquests to address the broad circumstances especially if there is a possibility that Article 2 may become relevant in the future. In those circumstances the enquiry should be broad enough to cover the ground for the coroner or jury to make the necessary conclusions. In this case the Coroner has expressly recognised that possibility and that will inevitably feed into her decisions as to scope generally, whether in relation to the scope of questions, disclosure or verdicts. Accordingly I reject Ground 3.

75. It follows that the Claimant's claim for judicial review must be dismissed.