Neutral Citation Number: [2013] EWHC 3055 (Admin)

Case No: CO/7495/2011

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 10/10/2013

Before :

LORD JUSTICE AIKENS
MR JUSTICE MITTING

- -

Between :

R (on the application of Antoniou)	**Claimant**
- and -	
(1) Central And North West London NHS Foundation Trust **(2) The Secretary of State for Health** **(3) NHS England**	**Defendants**

- -

(Transcript of the Handed Down Judgment of
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Official Shorthand Writers to the Court)

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Ben Hooper (instructed by **Treasury Solicitors**) for the **2nd Defendant**
Fenella Morris QC & Rose Grogan (instructed by **Capsticks Solicitors**) for the **3rd Defendant**

Hearing dates: 25-26/07/2013

- -

Judgment
Judgment
As Approved by the Court

Lord Justice Aikens :

1. This is the judgment of the court to which each of us has contributed.

I. The Questions

2. This claim for judicial review arises out of the suicide of Mrs Jane Antoniou, whom we shall refer to as JA, on 23 October 2010. At the time she was a patient detained in the Mental Health Unit of Northwick Park Hospital ("the hospital) under ***section 3*** of the ***Mental Health Act 1983*** ("MHA"). The hospital is part of the First Defendant NHS Foundation Trust ("CNWL"). The claimant, Dr Michael Antoniou, Reader in Molecular Genetics at King's College, London, is the widower of JA. At the time of her death at the age of 53, JA and the claimant had been married for 29 years, but they had separated.

3. Until the relevant provisions of the Coroners and Justice Act 2009 came into force, when a person who was detained under the MHA committed suicide or died as a direct result of self-harm, an "enhanced" inquest would take place, (ie one conducted on an expanded basis leading to a narrative verdict), pursuant to the "procedural obligations" of the state created by ***Article 2*** of the ***European Convention on Human Rights,*** ("ECHR"), as given the force of law in the United Kingdom by the ***Human Rights Act 1998*** ("HRA").[1] The principal question in this case is whether ***Article 2*** of the ECHR further obliges the State to conduct an *immediate* and *independent* investigation into the circumstances of the detained patient's death, prior to an inquest. Although there was an investigation into the circumstances of JA's death by the hospital and strategic health authority, there was no 'independent' investigation prior to the inquest, or, indeed, after it. Sadly, suicides of people detained under the MHA are not rare. The extent of the procedural obligation of State in relation to inquiries after such MHA deaths is therefore a matter of public interest and importance.[2]

4. The claimant raises three subsidiary questions that arise if the answer to the principal question raised is "yes". First, if the procedural obligations of ***Article 2*** do require an independent investigation prior to an inquest in a case where a MHA detained patient has committed suicide, then can the failure to have one be "cured" by having an appropriate inquest? Secondly, if the answer to that question is "no", then which defendant was in breach of its duty pursuant to ***Article 2*** of the ECHR and ***section 6*** of the HRA? Thirdly, if the answer is that the original defect can be "cured" by an appropriate inquest, was that achieved in this case, and, if not, which defendant was at fault?

5. The claimant also raises two further questions. The first is whether the absence of an independent preliminary investigation into the suicide of detained patients constitutes a difference in treatment compared with the treatment of other deaths in State custody,

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[1] See ***R (Middleton) v West Somerset Coroner [2004] 2 AC 182 at [3]-[4], [20] and [30] – [37].*** To be discussed further below.

[2] At para 27 of the claimant's Amended Details of Decision to be Judicially Reviewed it quotes the National (England and Wales) Confidential Inquiry into Suicide and Homicide by People with Mental Illness – Annual Figures (July 2012), which states that there were 1658 suicides by mental health in-patients between 2000-2010, ie. on average 150 per year. In the same period 501 self-inflicted deaths of detained patients in *secure* mental health settings were recorded in England and Wales: an average of 46 a year (Independent Advisory Panel on Deaths in Custody Secure Mental Health Deaths 2000 – 2010: October 2011).

such as a death in prison or probation custody[3] or one in police, immigration or Customs & Excise detention.[4] It is submitted that this difference in treatment amounts to unlawful discrimination for the purposes of ***Article 2*** taken with ***Article 14*** of the ECHR, for which discrimination the Secretary of State for Health (second defendant) and/or NHS London (now the NHS Commissioning Board, but known as NHS England – the third defendant) is said to be responsible under ***section 6*** of the HRA or ***section 19*** of the ***Equality Act 2010*** ("EA"). Allied to that question is a further issue: did the first and third defendants have "due regard" to the need to eliminate such discrimination for the purposes of ***section 149*** of the EA when deciding not to conduct an independent inquiry at the outset in JA's case?

II. The Facts

6. JA had long suffered from a mental disorder and had been diagnosed with borderline personality disorder and schizophrenia. Despite this she had had a successful career as a mental health trainer and advocate and was very well regarded in this sphere. JA was first admitted to a mental hospital in 1985. She was admitted subsequently on numerous occasions, both voluntarily and under ***section 3*** of the MHA.[5] From 1994 her condition improved and although JA was admitted to hospital from time to time, these admissions were voluntary. JA was admitted 16 times over a period of 10 years prior to September 2010. During the same period there had been some 28 occasions involving self-harm by JA, including 8 involving tying a ligature around her neck. The most serious relapse before the final admission occurred in May 2010, when JA was admitted to hospital for a month. The claimant took her there.

7. In September 2010 JA and the claimant were going through a very difficult time in their relationship. They were separated and the claimant was in a relationship with another woman. JA learnt of this fact and it precipitated a severe relapse of her condition and a dramatic increase in risk. JA was voluntarily admitted to the hospital on 29 September 2010. JA and the claimant were not in direct contact during the last two weeks before she died.

8. On 13 October 2010 JA was detained at the hospital under ***section 5(2)*** of the MHA.[6] On 15 October the detention was continued under ***section 3*** of the MHA. The period of "Close Watch" that had been instituted on 13 October was discontinued on 15 October. On 21 October 2010 JA was granted leave of absence from the hospital

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[3] These are referred immediately to the Prisons and Probation Ombudsman ("PPO").

[4] These are referred immediately to the Independent Police Complaints Commission ("IPCC").

[5] This provides in part: "(1) A patient may be admitted to a hospital and detained there for the period allowed by the following provisions of this Act in pursuance of an application (in this Act referred to as "an application for admission for treatment") made in accordance with this section.(2)
An application for admission for treatment may be made in respect of a patient on the grounds that—
(a)he is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and.. . . . .(d)appropriate medical treatment is available for him."

[6] ***Sections 5(1) and (2)*** provide: "(1)An application for the admission of a patient to a hospital may be made under this Part of this Act notwithstanding that the patient is already an in-patient in that hospital or, in the case of an application for admission for treatment that the patient is for the time being liable to be detained in the hospital in pursuance of an application for admission for assessment; and where an application is so made the patient shall be treated for the purposes of this Part of this Act as if he had been admitted to the hospital at the time when that application was received by the managers. (2)If, in the case of a patient who is an in-patient in a hospital, it appears to the registered medical practitioner or approved clinician in charge of the treatment of the patient that an application ought to be made under this Part of this Act for the admission of the patient to hospital, he may furnish to the managers a report in writing to that effect; and in any such case the patient may be detained in the hospital for a period of 72 hours from the time when the report is so furnished."

pursuant to ***section 17*** of the MHA.[7] On 22 October JA attended a professional conference in London. There she had a telephone conversation with her sister in law, Anne Antoniou, in which JA learned that the claimant was not going to return to live with JA. Upon her return to the hospital JA was distressed. At about 17.00 hours JA was seen and assessed by two staff psychiatrists Dr Alison Marr and Dr Janine Desforges. Their record states that JA was "…extremely upset and devastated, stating she does not want to live anymore" in the light of the fact that she and her husband were separated. JA also expressed suicidal ideas of jumping out of a high window. The doctors decided to put JA on "standard" observation (ie. once every hour), as opposed to the more frequent regime of "intermittent" or "close" observation. This direction to check JA every hour was given to the staff by Dr Marr and Dr Desforges. At 19.30 JA tried to leave her ward, Eastlake, but was prevented from doing so by Staff Nurse Rhoda Ogunjimini. She was the last person to speak to JA before her death. Her report stated that JA said she was "…fed up and lonely". The nurse also reported that JA was tearful.

9. At 21.00 hours on 22 October 2010 the night shift staff came on duty on Eastlake Ward. The team consisted of Staff Nurses Nazima Saimo and Winifred Mugo and Health Care Assistant ("HCA") Rachel Lambo. It is recorded that JA was observed at 3.30, 4.30, 5.30 and 6.30 hours on 23 October 2010. The last observation, which recorded that JA was asleep on her right side, was challenged at the Inquest held between 30 April and 16 May 2012. The observation sheet was not signed. At 07.00 hours the day staff came on duty. They included Staff Nurses Temple Diorgu, Winifred Mugo, Hyacinth Huie and Rhoda Ogunjimini.

10. At about 07.40 hours (10 minutes later than the scheduled observation time) SN Huie observed JA lying on her back on the floor of her room in the ward. SN Diorgu was called. She subsequently said in a statement that JA was "cold, stiff and blue". The "Crash Team" was summoned. This included Dr Shipway, the medical registrar. He attempted resuscitation of JA but this was unsuccessful. He pronounced JA dead at 08.12 hours. In a report that Dr Shipway prepared very shortly afterwards he noted that the morning staff had found JA's bed/mattress stacked against the door and that there was a ligature (actually a dressing gown cord) around her neck.

11. Staff Nurse Munteanu secured the medical records of JA almost immediately. The police were notified of JA's death and Detective Sergeant Woodham attended at 08.45 hours on 23 October 2010. He started an investigation and arranged for statements to be taken from SNs Huie and Diorgu and Dr Shipway. He took possession of exhibits, including the ligature, although that seems to have been lost at some time thereafter whilst it was in the custody of the police. The police took no statements from the night staff. On the same day the police notified the Coroner's Office and the claimant was informed of JA's death.

12. On 25 October 2010 the claimant was contacted by the Director of Operations of CNWL. On the same day the Care for Quality Commission ("CQC") was notified of JA's death, as was required under CNWL's "Serious Untoward Incidents Policy", ("SUI" and "SUI policy" respectively), which had been promulgated in January 2010. Under the CNWL's SUI policy there should be an "initial management review"

[7] ***Section 17(1)*** provides: "The responsible clinician may grant to any patient who is for the time being liable to be detained in a hospital under this Part of this Act leave to be absent from the hospital subject to such conditions (if any) as that clinician considers necessary in the interests of the patient or for the protection of other persons."

within 72 hours of a SUI, which is defined as having occurred where "an incident has serious outcomes" and so, plainly, covered this case. The SUI policy lays down[8] a template for the "Incident Report" that has to be prepared if a SUI occurs. The aim of the report and review is to identify any immediate clinical or managerial action necessary to ensure safety, such as ligature point removal; to highlight any necessary urgent changes to policies or procedures or to implement urgently required changes to local operational practice; and to provide details of the incident to the Chief Executive of the CNWL or his nominated officer. They will determine what steps are to be taken as a result of the report. In this case the Initial Management Review was completed by the Ward Manager, Mr Useya, on 25 October 2010.

13. On 26 October 2010 Mr Useya took statements from Temple Diorgu, (who saw JA's body at 07.40 am), Rhoda Ogunjimni (the last person to speak to JA) and also SN Winfred Mugo, one of the night staff team. On 27 October Mr Useya took an unsigned statement from HCA Rachel Lambo. In this Ms Lambo stated that Eastlake ward was "very busy and disruptive throughout the night" and she did not see JA. She said that she had taken her "break" between 5am and 6am and that after her break she remained on the ward corridor until hand over at 0730 hours. This statement was not disclosed to the claimant or his legal advisors until after the Inquest. On 28 October and 29 October Mr Useya conducted interviews with Care Team Leaders (CTLs) Marilena Munteanu, Ambrose Bvindi and Susan Adeleke and also Jane Chaudry. These interviews were typed up by Mr Useya.

14. On 1 November 2010 an SUI team or panel was appointed by CNWL under the provisions of its SUI policy. This was a so-called "NED led panel", that is to say a panel "led by a non-executive director [and] following RCA[9] methodology". The chairman of the panel was Mr Ian Holder (non-executive director of CNWL) and the members were Dr Graham Behr, (consultant psychiatrist), Ms Jackie Shaw, (service director of CNWL), Mr David Crinion (senior nurse advisor of CNWL) and Ms Christine Baldwinson, who acted as secretary to the panel. In the course of November 2010 interviews of various relevant members of the hospital's staff were conducted on behalf of the SUI panel.

15. On 16 December 2010 the police concluded their investigations and DS Woodham made a "Case Officer's Report". In this he did not consider the steps taken before the death of JA, but only the events following the discovery of her body.

16. In the course of December 2010 and January 2011 the SUI panel further interviewed various members of the staff of the hospital.[10] On 26 January 2011 the claimant met Mr Holder and Dr Behr of the SUI panel and was told that the SUI report would not be disclosed to him but it would be explained to him orally.[11] He was not at that stage provided with the terms of reference for the panel.[12] On 18 February 2011

[8] See Appendix 11 of the SUI policy document.
[9] RCA stands for "Root Cause Analysis". The scope of the work to be carried out by a panel using "RCA methodology" is set out in Appendix 4 to the CNWL's SUI policy document. It has to produce a "final report" which must be presented in accordance with a template produced by the National Patient Safety Agency ("NPSA"): see further the NPSA's Good Practice Guidance of February 2008 Appendix 3. This Guidance is discussed below.
[10] Sam Ude, Winifred Mugo, Temple Diorgu, Valerie Griffiths, Hyacinth Huie, Chucks Okomba, Marlena Munteanu and Naima Simoo; Dr Marr and Francoise Battin.
[11] After the claimant had begun the present proceedings he received a copy of the SUI report on 22 September 2011.
[12] They were subsequently given to him on 15 July 2011.

Professor Derrick Pounder, Professor of Forensic Medicine at the University of Dundee, was instructed by the SUI panel to prepare a report by CNWL for its benefit. This was done because of the remarks of the "Crash Team" that the body of JA was cold and had been dead for some time when first discovered. Professor Pounder produced a report on 28 February 2011 and his evidence to the SUI panel was that a "cold and possibly stiff body is consistent with a person being dead for 15 minutes or more". On that basis the SUI panel concluded, in its report, that JA had been alive at 6.30 the "time of the last observation" and that she had applied the ligature at some time thereafter up to 7.25am.[13] The SUI panel also interviewed Dr Shipway and, in May 2011, they obtained a report from Mr Stephen McCabe, a consultant in Emergency Medicine.

17. The SUI panel's report was produced on 6 July 2011. Its key conclusions were: (1) there were no factors that indicated that JA should have been placed on a higher level of observation on the night of 22/23 October. (2) The lack of fully documented risk assessments was not a contributory factor to JA's suicide. All the staff were well briefed on the level of risks she posed; nor was the lack of an unsigned observation chart a contributory factor. (3) There were no "Root Causes" of JA's suicide.[14] (4) There needed to be greater leadership and more individual responsibility in responding to the circumstances where a patient had apparently taken (or tried to take) her own life. [15]

18. Meanwhile, on 28 April 2011 the claimant, through his solicitors, had written to CNWL requesting that an independent review should be conducted. Unfortunately, the letter was misaddressed and only came to CNWL's attention on 4 May 2011, when the first of seven Pre-Inquest Reviews ("PIRs") was held.[16] On 5 August 2011 the current claim for Judicial Review was issued, naming the first two defendants only. It was stayed on 4 November 2011 pending the forthcoming inquest ("the Inquest"). Between November 2011 and the start of the Inquest on 30 April 2012, there was correspondence between the CNWL and the claimant's solicitors about the disclosure of statements of the hospital staff concerned with the care of JA and who were on duty before and at the time of her death. On 27 April 2012, that is three days before the start of the Inquest, the claimant's solicitors raised with CNWL their concern about the non-disclosure of proofs taken by or in the possession of CNWL's solicitors. These concerns about disclosure continued through the Inquest. At first CNWL's solicitors asserted that statements taken from hospital personnel were subject to legal professional privilege. However, on 3 May 2012 (the third day of the Inquest) CNWL's solicitors disclosed 14 transcripts of interviews that had been conducted by or on behalf of the SUI panel. The solicitors acting for the claimant also complained to CNWL about its failure to make voluntary disclosure of documents relating to the commission of expert reports by the SUI panel.

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[13] Page 15 of the SUI report of 6 July 2011.

[14] Under the RCA Guidelines "root causes" are defined as " the most fundamental underlying factors contributing to the incident that can be addressed". The Guidelines also note that there "should be a clear link, by analysis, between root cause and effect on the patient". It seems that the report did not consider that a "root cause" might have been JA's mental condition combined with the news that her husband had stated that he was not going to return to her.

[15] See pages 18-19 of the report.

[16] The other six PIRs were held on 4 July, 20 September, 8 November and 13 December 2011; then 14 February and 12 March 2012. The Inquest hearing itself began on 30 April 2012.

19. On 16 May 2012 the jury rendered a narrative verdict. The jury stated in the Inquisition that JA died in her room on Eastlake Ward at the hospital between the hours of 6.30 and 7.10 am on 23 October 2010. The jury also held:

> "We believe, beyond reasonable doubt, that Mrs Antoniou did not commit suicide. Her death was inadvertent following self harming by use of a ligature".

The jury elaborated on this conclusion and stated that it was unanimous in finding, "…based on the evidence and the balance of probabilities" that: (1) all relevant information was not passed on to the nursing team in a clear and concise manner following assessment by the doctors at 5 pm on 22 October 2010; (2) all relevant information was not passed on to the night shift "…because they did not have the relevant facts at their disposal"; (3) upgrading JA's level of observation at 5pm on 22 October would have been a "disproportionate response", although the information in the clinical notes should have been better communicated to the nursing staff; (4) nursing staff did not need to place JA on "close observation" after 7.30 pm on 22 October 2010, although "extra vigilance" should have been in place from 5 pm that day; (5) there was an "appropriate risk management policy in place" although the "alternative system" of monitoring and recording risk put in place was ineffective "…to the extent that there were key instructions missing from the plan on 22 October 2010 and the plan should have been better communicated to the nursing staff"; (6) there was "…insufficient emphasis placed on the need to respond to the risk of JA becoming more emotionally unstable and harming herself because of her marital crisis [and] this contributed more than minimally or trivially to her death". The jury was not asked to comment on whether JA was, in fact, checked every hour during the night of 22/23 October 2010, as had been directed by Dr Marr and Dr Desforges.

20. On 16 January 2013 the claimant's solicitors wrote to NHS London (the predecessor of NHS England, the third defendants) raising the possibility that it would be joined to the Judicial Review proceedings. On 1 February 2013 CNWL's solicitors served amended grounds of defence asserting that NHS London/England was responsible for commissioning any independent investigation if one was required. Eventually NHS England was joined by consent on 31 May 2013.

III. The Legal Framework and the Guidance of the Ministry of Health and National Patient Safety Agency Guidances.

The Coroners Act 1988

21. At the time JA committed suicide in 2010 and at the time the Inquest into her death took place in 2012, the ***Coroners Act 1988*** ("the 1988 Act") was in force. On the first day of the hearing of this case, 25 July 2013, ***sections 1*** and ***7*** of the ***Coroners and Justice Act 2009*** came into force, extending a coroner's duty to investigate and hold an inquest before a jury for deaths of persons in custody or otherwise in state detention. Under ***section 8(1)*** of the 1988 Act, when a coroner is informed that the body of a person is lying within his district and "there is reasonable cause to suspect that the deceased – (a) has died a violent or an unnatural death; (b) has died a sudden death of which the cause is unknown; or (c) has died in prison or in such a place or in such circumstances as to require an inquest under any other Act", then the coroner is to hold an Inquest into the cause of death, with or without a jury except in circumstances set out in ***section 8(3).*** That provides that where (either before or

during an Inquest) a coroner has reason to suspect that (a) the death occurred in prison "or in such circumstances as to require an inquest under any other Act", or (b) the death occurred whilst the deceased was in police custody or resulted from an injury caused by a police officer in the purported execution of his duty, or (d)[17] the death occurred in circumstances "…the continuance or possible recurrence of which is prejudicial to the health or safety of the public or any section of the public" then the coroner "shall proceed to summon a jury," as set out in ***section 8(2)*** of the 1988 Act.

22. Under the 1988 Act, therefore, there was no statutory obligation to carry out an Inquest in relation to a death in psychiatric custody, as opposed to a death in prison, or in the other circumstances set out in ***section 8(3)*** of the 1988 Act. However, in practice, self-inflicted deaths in legal custody, (including in a psychiatric hospital) were usually referred to a coroner for an Inquest either under ***section 8(1)(a)*** or ***(b)*** of the 1988 Act. There was no obligation to hold the Inquest with a jury, as there is in the circumstances set out in ***section 8(3).*** But the coroner had the power to conduct an inquest with a jury, as happened in this case. He had only to do so if the circumstances set out in ***section 8(3)(d)*** obtained.

Article 2 of the ECHR

23. ***Article 2(1)*** of the ECHR expresses the right to life. It provides: "Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law".[18] The European Court of Human Rights ("ECtHR") has interpreted Article 2 as imposing on states both "substantive" and "procedural" obligations. The substantive obligations, which are not in issue in this case, fall broadly into two categories: first, "…not to take life without justification" and, secondly "to establish a framework of laws, precautions, procedures and means of enforcement which will, to the greatest extent reasonably practicable, protect life".[19] So far as the latter category is concerned as it applies to detained patients, there are two aspects. First there is a general obligation to have in place proper systems for the prevention of self-harm and suicide by all detained patients, having regard to the risks that such patients present as a class. Secondly, there is an operational obligation to take reasonable steps to protect detained patients from any real and immediate risks of self-harm or suicide of which the relevant authority is aware or ought to have been aware.[20]

24. In issue in this case is the extent of the 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 of the state has been or may have been violated and it appears that agents of the state are, or may be, in some way, implicated".[21] The ECtHR has

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[17] Sub-paragraph (c) is immaterial to the present case.

[18] ***Article 2(2)*** , which relates to the use of necessary force in defence against unlawful violence and so forth, is not relevant to this case.

[19] See the considered opinion of the Appellate Committee of the House of Lords as expressed by Lord Bingham of Cornhill in (***R)Middleton v West Somerset Coroner [2004] 2 AC 182 at [1].*** The substantive obligations have most recently been considered by the Supreme Court, in the case of a voluntary psychiatric patient who committed suicide on a home visit, in ***Rabone v Pennine Care Trust [2012] 2 AC 72.***

[20] See: ***Savage v South Essex Partnership NHS Foundation Trust [2009] 1 AC 681*** and ***Rabone v Pennine Care NHS Trust [2012] 2 AC 72.***

[21] The words of Lord Bingham in the ***Middleton case at [2],*** where he summarised the effect of the decisions of the ECtHR on this topic.

repeatedly recognised that there are many different ways in which a state may discharge its procedural obligations under ***Article 2*** to investigate. In England and Wales that is usually in the form of an inquest.[22] In certain circumstances, which have been the subject of discussion and decision in a number of cases going to the House of Lords and the Supreme Court, which we will have to consider in more detail below, it has been held that the ***Article 2*** procedural obligation is to be fulfilled by an independent investigation apart from an inquest. These circumstances include the death of a person in custody where there was no inquest,[23] the attempted suicide of a person in a Young Offender Institution, where, obviously, there was also no inquest,[24] and in a case where an inquest will not be the appropriate vehicle for inquiring into state responsibility for loss of life.[25]

The Guidances

25. As already noted,[26] in England and Wales where a death occurs in prison or probation custody, the case is immediately referred for investigation to the PPO and where a death occurs in police, immigration or C&E detention it is immediately referred to the IPCC. There is no equivalent body to investigate MHA deaths. However, the Department of Health issued guidance in 2005 on ***Independent Investigation of Adverse Events in Mental Health Services*** ("the DoH Guidance"). This was supplemented by guidance issued by the National Patient Safety Agency ("NPSA")[27] in 2008: "the NPSA Guidance". The CNWL issued its own, local, guidance in 2010 in its ***Serious Untoward Incident Policy*** document ("SUI Policy"). Both sets of guidance are criticised by the claimant.

26. The DoH Guidance states that the investigation process following a death or some other serious incident (not involving death) in a mental health context may give rise to three stages of investigation. First, there will be an "initial management review", which will be rapid and usually within 72 hours of the "adverse event". One of its objects will be to safeguard notes or equipment as evidence. It is also meant to ensure communication with relevant individuals and organisations and initial contact with carers and families. This initial review will usually be followed by an "Internal NHS Mental Health Trust Investigation", using an approach such as "Root Cause Analysis". This second investigation should "establish a clear chronology of events leading up to the incident; determine any underlying causes and whether action needs to be taken with respect to policies, procedures, environment or staff". The third type of investigation is a "Strategic Health Authority Independent Investigation" or "SHA Investigation".

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[22] Per Lord Bingham of Cornhill at ***[20]*** in the ***Middleton case.*** That case went on to decide that, in the case of a prisoner serving a long custodial sentence who had hanged himself in prison, the inquest would discharge the state's ***Art 2*** procedural obligations, but to do so it ought normally to culminate in an expression of the jury's conclusion on the central, factual issues in the case. It was for the coroner to decide whether this was done in a particular case by a short form of verdict, a narrative form or in answer to questions put by him: see ***[34]-[38].*** This is sometimes referred to as a "***Middleton*** type Inquest" or "***Middleton*** type verdict": see eg per Lord Mance in ***R(Smith) v West Oxfordshire Assistant Deputy Coroner [2011] 1 AC 1*** at ***[208].***

[23] ***R(Amin) v Secretary of State for the Home Department [2004] 1 AC 653.***

[24] ***R(L (A Patient)) v Secretary of State for Justice [2009] 1 AC 588.***

[25] ***R(Smith) v Oxford Assistant Deputy Coroner [2011] 1 AC 1 at [81]*** in the judgment of Lord Phillips of Worth Matravers PSC.

[26] Footnotes 3 and 4.

[27] The key functions and expertise for patient safety were transferred from the NPSA to the NHS Commissioning Board Special Health Authority as from 1 June 2012. It is understood that the NPSA Guidance is therefore in the process of being rewritten.

27. The DoH Guidance advises that an SHA Investigation should be undertaken in the following circumstances:

> "- When a homicide has been committed by a person who is or has been under the care (i.e. subject to a regular or enhanced care programme approach) of specialist mental health services in the six months prior to the event.
>
> - When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is or may be responsible for a death or where the victim sustains life-threatening injuries, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate extent.
>
> - Where the SHA determines that an adverse event warrants independent investigation, for example, if there is concern that an event may represent significant systemic service failure, such as a cluster of suicides."

28. On behalf of the claimant it was submitted that the DoH Guidance is in error in limiting the applicability of the ***Article 2*** procedural obligation of the state to hold an "effective investigation" to circumstances where a State agent is or may be responsible for a death or where the victim sustains life-threatening injuries. The claimant's case is that the obligation is wider.

29. In Appendix 7 of the CNWL guidance of 2010 it adopts the terms of the DoH Guidance of 2005. The claimant therefore criticises this document also, as it is said to fall into the same error in requiring an independent investigation for ***Article 2*** purposes only where a State agent is or maybe responsible for causing death or life-threatening injuries.

30. The NPSA Guidance of 2008 endorses (at page 5) the DoH Guidance of 2005 but, in Appendix 1 the NPSA Guidance it expands upon the circumstances when ***Article 2*** requires an independent investigation, although it is not entirely consistent in what it states. At page 25 it says:

> "Article 2 imposes on States a procedural obligation to initiate an effective public investigation by an independent official body into any death or incident involving life-threatening injuries *occurring in circumstances in which it appears that Article 2 has been or may have been violated and it appears that agents of the State are in some way implicated*." (Emphasis added)

Then at page 26 it states:

> "Only a minority of deaths/near deaths being investigated under this guidance will trigger a duty for the investigation to be Article 2 compliant. On the one hand, the duty does not, for example, arise in every case where someone dies in hospital.

> On the other hand, *it will almost always arise where there is an unexpected death in custody <u>and</u> where there are real concerns that there were failures in care*. That duty arises as a consequence of the control and responsibility for the individual victim, so Article 2 may apply even if the patient is informal…" (Emphasis added)
>
> It is also important to note that any duty to carry out an Article 2 compliant investigation covers the whole span of investigations following death or incident, and not simply an investigation under this guidance in isolation. Normally, the coroner's inquest is going to be the best forum to ensure Article 2 compliance either on its own or coupled with a criminal trial and investigation carried out under this guidance. The SHA mental health independent investigation described in this document will probably not of itself have to be fully Article 2 compliant…"

31. On behalf of the claimant it is submitted that even the formula on page 26 of Appendix 1 of the NPSA Guidance is too narrow in stating that there is a duty to investigate where there is an unexpected death in custody *and* where there are real concerns that there were failures in care. It is argued that every self-inflicted death in custody requires an ***Article 2*** compliant independent investigation, quite apart from a properly constituted and conducted inquest.

32. The claimant also criticises the NPSA Guidance in other respects. First, because it envisages that, even with a death in MHA detention, the NHS Trust will be responsible at the first stage of investigation (the initial management review) for obtaining "…all relevant physical, scientific and documentary evidence", which is said not to be ***Article 2*** compliant. Secondly, because the second stage of investigation (the internal investigation) will be a precursor to any independent investigation thereafter. It is pointed out that this is not consistent with the DoH Guidance, which contemplates that a Strategic Health Authority ("SHA") independent investigation could start at any time, irrespective of whether the internal investigation has been completed. Moreover, if this procedure is followed, it would mean that any SHA independent investigation would be much delayed as it would have to await the outcome of the internal investigation.

33. It appears that, in practice, independent investigations by SHAs have rarely been commissioned and then only in cases where a homicide has been committed by an individual in contact with mental health services or where there has been a cluster of suicides or restraint-related deaths.[28] In 2012 the IAP recommended that the DoH Guidance should be rewritten to clarify when an independent investigation must be carried out and that consideration should be given to establishing a permanent investigation body to carry out inquiries into MHA deaths, prior to Inquests.

IV. The principal arguments of the parties, the relief sought by the claimant and the issues to be determined.

[28] See the second witness statement of Deborah Coles, who has been, since 1990, Co-Director of INQUEST, an NGO and charity founded to support the families of those who die in state custody. She represents INQUEST on the Ministerial Council on Deaths in Custody and on the Independent Advisory Panel on Deaths in Custody ("IAP").

The claimant

34. On behalf of the claimant, Mr Paul Bowen QC advanced five propositions of law, four of which he said were uncontroversial. First, under ***Article 2*** of the ECHR a substantive positive obligation is owed to all detained psychiatric patients to protect them against self-inflicted death.[29] Secondly, pursuant to ***Article 2*** there were two procedural obligations on the State when an individual dies, which are owed to the next of kin on behalf of the deceased and to them in their own right. The first duty was to establish and operate an effective independent judicial system so that the cause of any death can be determined and those responsible made accountable.[30] Secondly, in circumstances where it is at least arguable that the State is or may be responsible for the death, either following a State killing or in circumstances where one of the positive obligations under ***Article 2*** is in play, the State must provide an independent and impartial investigation which complies with minimum standards of effectiveness.[31] It is the extent of the latter duty that is in dispute in this case. Thirdly, these minimum standards of effectiveness require that (a) the initiative to begin the investigation must be taken by the State; (b) the State must take adequate steps to secure all relevant forms of evidence needed to establish the cause of death (or near-death); (c) the investigation must be independent of the institution involved in the death/near-death and "practically" independent.;[32] (d) it must be carried out with diligence and promptness; (e) there must be a sufficient element of public scrutiny for it to be "accountable"; (f) it must involve the next-of-kin effectively; (g) it must be able to able to achieve its objectives of establishing the circumstances of the death/near – death. Fourthly, an independent investigation must begin immediately, even though it may not then be clear whether or not the State has been in breach of its ***Article 2*** obligations.[33]

35. The fifth proposition of law advanced by Mr Bowen was that an independent investigation was necessary from the outset even where there would be an inquest. Mr Bowen argued that no distinction could be drawn between cases involving State killing, where he said it was well-established that there had to be an independent investigation from the outset, and death in custody cases and, by extension, MHA deaths. He relied in particular on statements by the House of Lords in ***R(L) v Secretary of State for Justice.***[34] Mr Bowen challenged the arguments advanced by the defendants, which we outline below, that there should be a distinction between MHA deaths and other custodial deaths.

36. Mr Bowen further submitted that any lack of independence at the evidence-gathering stage cannot be "cured" by there being independence at a later stage, for at least four reasons. First, an initial lack of independence may compromise the adequacy of the entire later investigation; secondly, the non-independent initial investigator may

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[29] He relied in particular on the ***Savage case [2009] 1 AC 681.***
[30] He relied on ***Silih v Slovenia (2009) EHRR 37 at [196]-[199].***
[31] He relied on ***R(Smith) v Oxfordshire Assistant Deputy Coroner [2011] 1 AC 1 at [98] per Lord Hope of Craighead DPSC*** and ***[211] per Lord Mance JSC.***
[32] He relied on ***Ramsahai v The Netherlands (2007) 46 EHRR 983 at [324]-[325].***
[33] He relied in particular on the statement of Lord Rodger of Earlsferry in ***R(L) v Secretary of State for Justice [2009] 1 AC 588 at [58].***
[34] ***[2009] 1 AC 568*** at ***[33]-[37] per Lord Phillips of Worth Matravers; [74]-[75] per Lord Rodger of Earlsferry and [94] per Lord Walker of Gestingthorpe.*** Mr Bowen also relied on the statement of Baroness Hale of Richmond in ***Savage v South Essex NHS Trust [2009] 1 AC 681 at [97].***

retain control of important material to the prejudice of the later investigation;[35] thirdly, the lack of independence at the first stages may compromise the independence of an otherwise independent body at a later stage. Lastly, two key purposes of an ***Article 2*** investigation, viz. to prevent the appearance of collusion in or tolerance of unlawful acts and to maintain public confidence in the State's monopoly on the use of coercive powers, will not be met where there is a lack of independence at the crucial evidence-gathering stage.

37. Mr Bowen submitted that there had been a breach of the claimant's rights to an independent and effective investigation, contrary to ***Article 2,*** because, first of all, the internal SUI investigation lacked independence. Secondly, there were operational failures at several points: (a) in securing evidence; (b) by not involving JA's family in the process; (c) in failing to follow CNWL's own policy and the DoH's own Guidance; (d) in the superficial nature of the SUI investigation and (e) in the failure to disclose evidence and the provision of misleading statements concerning disclosure. Thirdly, he submitted that these failings were not cured by the later involvement by the Coroner. The consequence of these failings, Mr Bowen argued, was that all three defendants acted unlawfully[36] in failing to commission an independent investigation.

38. Mr Bowen's argument on discrimination was that the case of JA was treated differently to cases of detainees in other settings, where there would be an automatic referral to the PPO or IPCC. This difference in treatment fell within the ambit of ***Article 2*** and was on a proscribed ground (mental disorder) which was a "status" within ***Article 14,*** which related to the enjoyment of JA's rights under ***Article 2.*** There was, he submitted, no objective or reasonable justification for this discrimination. Therefore, the second defendant had unlawfully discriminated against JA for the purposes of ***Article 2*** and ***14*** and there had been indirect discrimination for the purposes of ***section 19*** of the EA. Furthermore, the need to eliminate such discrimination was a matter to which both CNWL and the third defendant should have given "due regard" under ***section 149*** of the EA when considering how to carry out the investigation into JA's death and they had failed to do so.

39. The principal relief sought by the claimant is a declaration that the investigation into the death of JA did not comply with ***Article 2*** in that (a) CNWL failed to conduct an independent investigation pre-inquest in breach of ***Article 2;*** (b) CNWL failed adequately to involve the claimant in the investigation; (c) CNWL failed adequately to preserve important witness evidence; (d) CNWL's investigation was not prompt; (e) the second defendant had not put in place an adequate system of independent investigation of MHA deaths pre-inquest that complies with ***Article 2;*** (e) the second defendant had not put in place guidance that correctly stated the circumstances in which ***Article 2*** requires an independent investigation to be carried out pre-inquest, viz. where the death has taken place in circumstances where there is or may be a possible breach of the substantive obligations of the State under ***Article 2.*** Damages against CNWL and the second defendant are also sought.

CNWL

[35] Mr Bowen alleged that this is what happened in this case when the CNWL claimed legal professional privilege for records of interviews of hospital staff, so refused to disclose them in the context of the Inquest.
[36] That is contrary to ***section 6*** and ***Schedule 1, Article 2*** of the HRA.

40. For CNWL, Mr Angus Moon QC indicated that he would not deal with the issue of whether the national system for investigation of MHA deaths complied with ***Article 2.*** He submitted that CNWL was not in breach of its obligations under ***Article 2*** on the facts of this case. Mr Moon accepted the following five propositions of law:[37] the State owes all persons detained in psychiatric hospitals under the MHA substantive positive obligations to take protective measures to safeguard them; those obligations require a proper system be in place to protect all detained patients; reasonable steps should be taken to protect an MHA detainee from real and immediate risks of suicide of which the State is or ought to be aware; there is a procedural duty upon the State where a positive obligation to safeguard life is at stake; the procedural obligation required by ***Article 2*** includes the provision of an independent and impartial official investigation which satisfies certain minimum requirements as to effectiveness. As to the last proposition, Mr Moon also accepted that the minimum standards were those identified by Lord Phillips of Worth Matravers PSC at [64] in ***Smith:*** [38]

> "The procedural obligation requires a state, of its own motion, to carry out an investigation into the death that has the following features: (i) it must have a sufficient element of public scrutiny of the investigation or its results. (ii) It must be conducted by *a tribunal*[39] that is independent of the state agents who may bear some responsibility for the death. (iii) The relatives of the deceased must be able to play an appropriate part in it. (iv) It must be prompt and effective. This means that it must perform its essential purposes. These are to secure the effective implementation of the domestic laws which protect the right to life and ensure accountability of state agents or bodies for deaths occurring under their responsibility".

41. However, Mr Moon took issue with Mr Bowen's submission that there has to be an independent investigation from the time of the death of the MHA detained patient. He submitted that the weight of authority supports the proposition that the totality of the investigations has to be examined to decide whether or not there the State concerned has been in breach of ***Article 2.*** Therefore the issue raised by the claimant as a second question, viz. whether a lack of independence or other short-comings in the investigation can be "cured" at a later stage, is a false one, because the process has to be examined overall.

42. In any event, Mr Moon submitted that if there were defects at the earlier stages, then, on the facts of this case, they were not the fault of CNWL and, moreover, any defects were effectively "cured" at the later stage of the Inquest. Accordingly, he submitted that there could be no question of CNWL, as a body, being in breach of ***section 6*** of the HRA because the ***Article 2*** obligation is one of the State, not a constituent body within the State that is only responsible for a part of the investigation overall.

43. As to the claimant's argument based on ***section 149*** of the EA, Mr Moon pointed out that this was not in force at the time that the decision was made to carry out an SUI investigation and when the SUI panel was appointed on 1 November 2010. Further,

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[37] Based on the ***Savage; Smith*** and ***Rabone*** decisions in the House of Lords/Supreme Court.
[38] ***[2011] 1 AC 1.***
[39] Mr Moon's emphasis.

(amongst other arguments), there was no discrimination against JA during her lifetime and the claimant himself has no protected relevant characteristics.

Secretary of State for Health

44. For the Secretary of State for Health, Mr Ben Hooper submitted, first, that there was no ***Article 2*** obligation on the State to conduct an independent "pre-inquest" investigation in the context of the present facts, viz. where a detained MHA patient has committed suicide in a psychiatric hospital. In this regard Mr Hooper relied particularly on statements of Lord Phillips of Worth Matravers PSC in the ***Smith case.***[40] He submitted that Lord Phillips' remarks were of wider application than the facts of that case, where a serviceman had died on duty whilst on active service in Iraq. Lord Phillips said, at [85] under the heading "Inquiries into the deaths of servicemen":

> "I have already referred to the fact that, whatever the requirements of the Convention may be, the United Kingdom has a staged system of investigation into deaths. Where death occurs in circumstances involving a public authority, an in-house investigation will often precede the inquest and provide valuable information to assist the inquest. In the present case the Special Investigations Branch of the Military Police carried out an investigation into Private Smith's death and two Boards of Inquiry made reports. It was because the first of these was not disclosed to the coroner that a second inquest is to be held. I would expect that in the case of every military death in service some form of internal investigation is held".[41]

45. In any event, Mr Hooper submitted, the coroner would be under the same ***Article 2*** obligations and he has all the necessary powers to ensure that the procedural requirements are fulfilled.

46. Mr Hooper submitted that the claimant's attempt to use ECtHR decisions in cases concerning the use of lethal force by agents of the State or involving death in custody to create an ***Article 2*** obligation to have an independent pre-Inquest investigation in the present case was misplaced. He emphasised that the ECtHR has not had to consider the application of the ***Article 2*** procedural obligations of the state to a case where a psychiatric patient detained in hospital under the MHA has committed suicide. He submitted the domestic courts should not go beyond the limits of the Strasbourg jurisprudence.[42] Furthermore, the policy arguments weighed against

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[40] ***[2011] 1 AC 1 at [85].*** There were two issues in the case. The first, on whether a British serviceman serving outside the UK was subject to the protection of the HRA, is not relevant to this case. The second was whether, assuming the serviceman had such protection, then would an Inquest into his death have to satisfy the procedures which ***Art 2*** of the ECHR implicitly required where there was reason to believe that the death might be attributable to fault on the part of a public authority.

[41] Lords Walker, Brown, Collins and Kerr agreed with Lord Phillips on this issue: see ***[131]; [149]; [309] and [340].*** Mr Hooper also relied on Simon J's rejection, in ***Rabone v Pennine Care NHS Trust [2010] PIQR P2*** at first instance, of the argument that the Trust had breached its procedural obligation under ***Art 2*** because there had been no independent pre-inquest investigation into the death of a voluntary mental patient. The CA refused to grant permission to appeal that conclusion: ***[2011] QB 1019*** at ***[78]-[85].***

[42] He relied on ***R(Ullah) v Special Adjudicator [2004] 2 AC 323 at [20]*** per Lord Bingham of Cornhill and ***R (Al-Skeini) v Sec of State for Defence [2008] 1 AC 153 at [106]*** per Lord Brown of Eaton under Heywood.

recognising a strict legal duty under ***Article 2*** to conduct independent pre-Inquest investigations.

47. In addition to the arguments advanced by Mr Moon in relation to the allegations of unlawful discrimination, Mr Hooper also submitted that, if (contrary to his case) there were differences in treatment, they were justified.

NHS England

48. On behalf of NHS England, Ms Fenella Morris QC submitted that neither of the two principal arguments of the claimant, viz. that an independent investigation from the outset was an inherent value required by ***Article 2*** in the present circumstances, or that there were practical reasons why an independent investigation from the outset were needed, withstood scrutiny. Ms Morris submitted that the claimant's attempt to apply principles applied in "state killing" cases to the suicide of a patient detained under the MHA in a psychiatric hospital was not warranted by the cases. Further, simply because there is an obligation in both cases to conduct an independent investigation does not mean that the State is required to adopt the same method of discharging this obligation. Neither can deaths in police custody or prison be put in the same position as MHA detained patient deaths. Unless an independent initial investigation was an inherent requirement of the ***Article 2*** procedural obligation in relation to the death of an MHA detainee, then in principle any earlier defects must be capable of cure at a later stage, although that would depend on the facts of the case.

49. Ms Morris submitted that the NPSA Guidance 2008 was lawful. First, properly interpreted, it did not compromise the requirement for an effective investigation at the initial stages and, if followed correctly, it did not prevent the State from complying with its ***Article 2*** obligations overall. Secondly, it is consistent with reliably securing evidence. Thirdly, it envisages both a prompt initial review and also involvement of relatives. Fourthly, the "Root Cause Analysis" or RCA that is used in a SUI investigation is a properly structured process. There are advantages, at that stage of the investigation, of having an internal investigation which is clinician – led rather than one which is independent but may, at that stage, be over legalistic.

50. Ms Morris also pointed out that the NPSA Guidance was being reviewed at present. Further, in the Care Bill presently before Parliament, clauses 81 and 82 were intended to protect against the dissemination of false or misleading information by an NHS provider.

51. It seems to us that, in the light of the arguments advanced by the parties, the principal issues for us to determine are:

i) What is the scope of the ***Article 2*** procedural obligation on the State in a case where a patient who has been detained in a mental hospital under ***section 3*** or ***5*** of the MHA commits suicide whilst in the care of the hospital?

ii) On the facts of the present case was there an ***Article 2*** procedural obligation to have an independent investigation, apart from the Inquest and, if so, from what point?

iii) On which of the defendants (if any) did that obligation fall and which defendant, (if any), was in breach of its ***Article 2*** procedural obligation?

iv) Did the DoH and/or NPSA Guidance mis-state the law?

v) If there was a breach of the ***Article 2*** procedural obligation by not having an independent investigation from the outset or apart from the Inquest, could that breach be "cured" by the Inquest?

vi) On the facts of this case, was the process of investigation, up to and including the Inquest, in breach of the State's ***Article 2*** procedural obligations?

vii) Was there any unlawful discrimination against JA or the claimant by any of the defendants in relation to the manner in which JA's death was investigated?

V. Issue one: What is the scope of the *Article 2* procedural obligation on the State in a case where a patient who has been detained in a mental hospital under *section 3* or *5* of the MHA commits suicide whilst in the care of the hospital?

52. We have already noted that in the ***Middleton case***, Lord Bingham of Cornhill, giving the considered opinion of the Appellate Committee, summarised the effect of the ECtHR decisions on the circumstances in which a procedural obligation is imposed by ***Article 2*** on member States to initiate an "effective public investigation by an independent official body into any death". At [3] in ***Middleton,*** Lord Bingham said that this obligation is triggered when the death occurs in circumstances:

> "[where]…it appears that one or other of [the substantive obligations under ***Article 2***] has been, or may have been, violated and it appears that agents of the state are, or may be, in some way implicated".

53. This summary was repeated, without comment or modification, by Lord Phillips of Worth Matravers PSC in ***R(Smith) v Oxfordshire Assistant Deputy Coroner.*** Lord Hope of Craighead emphasised that the procedural obligation depends on the existence of the substantive "right" and so substantive obligation on the State. The procedural obligation cannot exist independently.[43] None of the other seven law lords sitting on that appeal dissented from this summary. We must follow this interpretation of the ECtHR decisions.

54. It is necessary to bear in mind the context in which the ECtHR has been called upon to rule on the nature and extent of member States' procedural obligations under ***Article 2.*** At the end of the hearing we asked Mr Hooper to ascertain whether any other member States operated a system of coroners and inquests similar to that in the UK. His response, on behalf of the Secretary of State for Health was that, so far as he was aware, only the Republic of Ireland and Cyprus operated a system of coroners and inquests. The civilian system is summarised in ***Jervis on Coroners***[44] and Mr Hooper told us in a note dated 8 August 2013 that, so far as the DoH is aware, having consulted within the UK government, this account remains accurate. Very shortly, the civilian system is to assign responsibility for investigating deaths to prosecuting authorities. In France, Spain and Germany, at least, the prosecuting authorities may in turn assign investigative functions to an examining magistrate.[45] We think that it

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[43] See: respectively ***[2011] 1 AC 1 at [63]*** per Lord Phillips and ***[97]*** per Lord Hope of Craighead.

[44] 12th Ed 2002, 4th Cumulative Supplement 2011.

[45] ***Jervis*** at 22.25-35. It is noted by the editors that in France (said to be in "some ways a model of the civilian approach") certain deaths, including violent deaths, those in custody, or resulting from police action, but not

is important to have these differences in mind when analyzing decisions of the ECtHR on other member States' systems of investigation into deaths and whether they fulfil the Article 2 procedural obligations imposed.

55. We were referred in detail to the following ECtHR decisions in particular: ***Jordan v UK,***[46] ***Ramsahai v The Netherlands,***[47] and ***Silih v Slovenia.***[48] In the ***Jordan case*** the ECtHR noted that there were, at the time of the hearing before it, two domestic procedures for investigating the facts surrounding the shooting of Pearse Jordan by an officer of the RUC: the civil proceedings brought by his family for death by unlawful act and the inquest. The ECtHR refused, itself, to examine the factual evidence. It held that there was "little substance" of the criticisms of the police internal investigation.[49] But the court did regard the fact that there was an hierarchical link between the officers in the investigation and the officers subject to the investigation as indicating the investigation procedure was insufficiently independent.[50] It also criticised the fact that the Northern Irish DPP had not given any reasons for the decision not to institute any criminal proceedings against the officer responsible for Jordan's death. So far as the inquest was concerned, the Court gave general approval to the system operating in Northern Ireland,[51] but criticised particular procedural matters, such as the fact that the key soldier involved, Sergeant A, did not give oral evidence[52] and that the verdict in Northern Ireland was limited in scope so that it could have no effective role in the identification or prosecution of any criminal offences which may have occurred.[53] In those respects the inquest fell short of the requirements of ***Article 2.*** The civil proceedings, being a process initiated by the parents, not the State and not being able to lead to the identification or punishment of any alleged wrongdoer, could not be taken into account in the assessment of the State's compliance with its procedural obligations under ***Article 2.***[54] This decision therefore demonstrates that, even in a case of State killing, the ECtHR examined all aspects of the domestic procedures, the internal investigation, the inquest and the civil procedure, to see whether there was, overall, a compliance with the State's ***Article 2*** procedural obligations. It did not rule that an inquest was incapable of fulfilling the state's Article 2 procedural obligations.

56. In ***Ramsahai v Netherlands*** the Grand Chamber of the ECtHR reiterated at [321] – [322] the general principles it had previously set out in ***Nachova v Bulgaria***[55] on the

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suicide, are reportable to the *Procureur de la République* and will give rise automatically to an *enquête judiciare.*

[46] ***(2003) 37 EHRR 2,*** which concerned the death of an unarmed man by an officer of the Royal Ulster Constabulary, where there was then an internal RUC inquiry and no subsequent criminal proceedings but there was in inquest, albeit much delayed.

[47] ***(2008) 46 EHRR 43,*** which concerned the death of a 19 year old man by the police when resisting arrest and the public prosecutor decided not to institute criminal proceedings against the police.

[48] ***(2009) 29 EHHR 37,*** which concerned the death of a boy in hospital after two injections as part of medical treatment. The public prosecutor dismissed the parents' criminal complaint following an investigation and a medical report. Subsequently the investigation was reopened but an attempt by the parents to make the public prosecutor take over criminal proceedings was rejected and all further attempts to bring criminal, civil and administrative proceedings over many years all failed.

[49] [118]

[50] [120].

[51] [125]. It had done so in relation to inquests in England and Wales in ***McCann v UK [1996] 21 EHRR 27,*** the case concerning the inquest into the deaths of 3 IRA suspects shot in Gibraltar.

[52] [127]

[53] [129]

[54] [141]

[55] ***(2006) 42 EHHR 43 at [110]-[113].***

Article 2 procedural obligations of a State when individuals have been killed as a result of the use of force by a state agent, which might be unlawful. There must be an "effective official investigation" whose essential purpose is to "secure the effective implementation of domestic laws safeguarding the right to life" and, in cases involving State agents or bodies, "to ensure their accountability for deaths occurring under their responsibility". It also reiterated both the need for a "sufficient element of public scrutiny" although the degree of public scrutiny required might well vary from case to case,[56] and also the need for promptness. It repeated the need for the investigation to be "effective" in two senses. First, in the sense of being "adequate", ie. capable of leading to the identification and punishment of those responsible, when there was a death "that engages the responsibility of the Contracting Party" under ***Article 2;***[57] secondly, in the sense of the investigation having not only no "hierarchical or institutional" connection with those implicated in the events, but also having a "practical independence" as well.[58] The court then examined the facts in relation to both the "adequacy" of the State Criminal Investigation and its independence. The ECHR found there were "lacunae" in the way the investigation had been carried out and an unreasonable delay in its start so as to amount to a violation of ***Article 2.*** But it also held that the fact that the investigation was carried out under the supervision of the Amsterdam Public Prosecutor, which had some links with the Amsterdam police force, one of whose officers had shot the deceased, was not a violation of ***Article 2.*** The Court took account of the degree of independence of the Netherlands Prosecution Service, the fact that the ultimate responsibility for the investigation was borne by the Chief Public Prosecutor and that the investigation could be the subject of review by an independent tribunal.[59]

57. We think it important to note that, in the case of the Netherlands, there is apparently no equivalent of an inquest as in England and Wales. Even so, the ECtHR did not regard an investigation by the State Criminal Investigation Department as being ineffective or inadequate in principle. The violations of the procedural obligations of ***Article 2*** concerned operational defects in the investigation.

58. In ***Silih v Slovenia*** the Grand Chamber of the ECtHR drew a distinction between two particular situations and when the ***Article 2*** obligation to hold an "effective official investigation" of a death arose. In the first case, that of an intentional taking of life (by a State agent), the fact that the authorities had been informed that a death had occurred triggered the obligation. In the second case, where the death was caused unintentionally "and in which the procedural obligation is applicable", the obligation to hold an "effective official investigation" may come into play upon the institution of proceedings by the deceased's relatives.[60] The court reiterated the principle that where there had been a death of a patient in the care of the medical profession (whether in the public or private sector) there was a procedural obligation under ***Article 2*** that required the State to "set up an effective independent judicial system so that the cause of death…can be determined and those responsible made accountable".[61] This may, and under some circumstances, must, include a "recourse to criminal law."[62] The ***Article 2*** obligation requires that there be a prompt

[56] The Court quoted its decision in ***Anguelova v Bulgaria (2004) 38 EHRR 31 at [140].***
[57] [324]
[58] [325].
[59] [343]-[345].
[60] See [156].
[61] [192].
[62] [194]

examination of the case without unnecessary delays. Promptness is particularly necessary in cases concerning death in a hospital setting for the future safety of all users of health services.[63]

59. We note that the emphasis in this decision was on whether there was an "effective independent *judicial* system" which could and did investigate the allegations and enable the parents to obtain redress. The Court found that the Slovenian *judicial* system had failed to fulfil this ***Article 2*** obligation. But, apart from reiterating the general principles, it seems to us that this decision of the Grand Chamber has little relevance to the present case at all.

60. Much more relevant, in our view, are the decisions of the House of Lords in ***R(Amin) v Secretary of State for the Home Department,***[64] and ***R(L) v Secretary of State for Justice***[65] and that of the Supreme Court in ***R (Smith) v Oxfordshire Assistant Deputy Coroner.***[66] In ***Amin,*** a prisoner serving a custodial sentence in a Young Offender Institution (YOI) was murdered by his cellmate, who had a history of violent and racist behaviour. There were a number of investigations into the death of the young man. An inquest was opened, but it was adjourned pending the trial of the murderer and never resumed after his conviction. The Home Secretary refused demands of the deceased's family to hold a public inquiry. The uncle of the deceased sought judicial review on the grounds that none of the inquiries held[67] satisfied the minimum standard of the State's ***Article 2*** procedural obligations. The House of Lords, agreeing with the judge and disagreeing with the Court of Appeal, held that there should be a declaration that, to satisfy the ***Article 2*** procedural requirements of the State, there must be an independent public investigation, with the deceased's family being legally represented and with other procedural safeguards.

61. At [16] – [17] of his speech, Lord Bingham of Cornhill stated that for centuries the law of England had required a coroner to investigate the deaths of one who died in prison and he noted that the procedure was by an independent judicial officer, that the family of the deceased could be represented and the proceedings were in public.[68] At [20] of his speech, Lord Bingham summarised the ECtHR case law to date on the scope of the State's ***Article 2*** procedural duty and the reasons for the duty. At point (10) he noted that the ECtHR had not required that any particular procedure be adopted to examine the circumstances of a killing by state agents nor was it necessary to have one. He stated that these principles had been developed mostly in cases concerning killings deliberately carried out or allegedly carried out by agents of the state. However, at [21], Lord Bingham pointed out that the ECtHR had applied similar principles in ***Edwards v United Kingdom,*** [69] another case where two young men, both suffering from mental illness, shared a cell in prison and, on the first night, one kicked the other to death. Lord Bingham said, in the same paragraph,

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[63] [195]-[196]
[64] ***[2004] 1 AC 653***
[65] ***[2009] 1 AC 588***
[66] ***[2011] 1 AC 1***
[67] There had been one by a serving official of the Prison Service, but his report was not published; a police investigation; and an inquiry by the Commission for Racial Equality, which concerned itself solely with race-related issues. The first did not recommend any member of staff be disciplined and the second concluded that no charges should be brought against the Prison Service. The third, for the most part, was held in private and the family of the deceased were not permitted to participate.
[68] At ***[33]*** of his speech, Lord Bingham noted that in ***McCann v UK (1995) 21 EHRR 97,*** the ECtHR had accepted that a properly constituted inquest could discharge the State's "investigative obligation".
[69] ***(2002) 35 EHRR 487.***

that a "systemic failure to protect the lives of persons detained may well call for even more anxious consideration and raise even more intractable problems" than cases of deliberate killing (or alleged killing) by agents of the state.

62. In his conclusions, at [31], Lord Bingham stated that the procedural duty imposed on the State by ***Article 2*** was discharged by an inquest. The purpose of the investigation of a death by an inquest was clear:

> "to ensure that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of public wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others".

63. Lord Steyn emphasised the fact that in ***Edwards*** the ECtHR had applied the same minimum standards of effective and independent investigation to a case of death (in custody) resulting from negligence as to cases involving death caused by acts of state agents.[70] Lord Hope of Craighead said that there was a "strong case" for saying that an even more rigorous investigation was needed "if those who are responsible for … failures [by the prison service which led to a prisoner's death at the hands of another prisoner] are to be identified and made accountable and the right to life is to be protected by subjecting the system itself to effective public scrutiny".[71] He too noted that the ECtHR had accepted that the choice of method for conducting an independent and prompt and effective inquiry was "essentially a matter for decision of each contracting state within its own domestic legal order".[72]

64. ***Amin*** is important for two reasons. First, it demonstrates that, in principle, an inquest is the means by which, under the domestic law of England and Wales, [73] the State's procedural duty under ***Article 2*** to provide an independent and effective investigation of deaths in custody is to be discharged. Secondly, given the decision of the coroner not to reconvene the inquest once the deceased's murderer had been convicted,[74] and given the fact that the three other investigations had not fulfilled the minimum standards as established by ECtHR case law and domestic law, the State's procedural duty could not therefore have been discharged. This case is not, in our view, authority for the proposition that there must be an independent and prompt and effective inquiry in addition to an inquest, assuming that, in the circumstances of the case, the inquest itself discharges the State's ***Article 2*** procedural duty.

65. In ***L,*** a young man, L, had attempted suicide in a YOI whilst in custody awaiting trial and this had left him with long term brain damage. An internal report was conducted by a retired prison governor, which found that the treatment and care provided to L was consistent with national standards. The report was not published and the relatives were not involved in the investigation. The Secretary of State refused to conduct an investigation that "complied with ***Article 2"*** and L brought

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[70] [50].
[71] [62]
[72] [63]
[73] This must now include the broader approach to the scope of an inquest following ***Middleton.***
[74] As Lord Bingham makes clear at [35], the trial was concerned only with the defendant's mental responsibility for the killing which he admitted he had carried out.

judicial review proceedings challenging that decision. The House of Lords, dismissing the appeal of the Secretary of State against the decisions of the judge and the Court of Appeal, held that the procedural obligation under ***Article 2*** was automatically triggered by an attempted suicide of a prisoner in custody which had resulted in long term injury, so that the Secretary of State was obliged to hold an ***Article 2*** compliant investigation.

66. In his speech Lord Phillips of Worth Matravers stated that it was common ground that, in the case of a suicide in prison, the current practice in England of an investigation and report by the PPO, then an inquest with a jury under ***section 8(3)*** of the 1988 Act were sufficient to comply with the procedural obligations under ***Article 2.***[75] But at [31] he emphasised that the duty to investigate imposed by ***Article 2*** covers a wide spectrum of situations and that "…different circumstances will trigger the need for different types of investigations with different characteristics". He noted that the ECtHR had underlined the need for flexibility and it had also stated that it is for the individual member State to decide how to give effect to the "positive"[76] obligations imposed by ***Article 2.*** However, Lord Phillips was clear that, in the case of an attempted suicide of a prisoner in custody that resulted in serious injury, whether or not at that stage there is an arguable case of fault on the part of the authorities, it was necessary to have an initial investigation that constituted what he called an "enhanced investigation". [77] He summarised the ingredients of such an investigation as being that: (i) the initiation of the process by the state itself; (ii) it is prompt and carried out with reasonable expedition; (iii) it is effective; (iv) it is conducted by a person who is independent of those implicated in the events being investigated; (v) there must be a sufficient element of public scrutiny of the investigation or its results; (vi) the next of kin of the victim must be involved in the procedure to the extent necessary to safeguard their legitimate interests.[78] These characteristics are, essentially, the ones that the ECtHR has stated (in **Ramsahai)** as being necessary for any investigation, whether initial or "full" in order that it be compliant with ***Article 2.***

67. There are, essentially, five steps in Lord Phillip's reasoning as to why such an "enhanced" initial investigation was triggered and necessary in the case of a near-suicide in custody which resulted in serious injury. First, because those imprisoned posed a high suicide risk. Secondly, because ***Article 2*** imposed on the prison authorities a positive duty to take reasonable care of those in custody and, in particular, to take reasonable steps to ensure that they did not commit suicide. Third, this meant putting in place systemic precautions against suicide in prison. Fourth, if, despite these precautions, a suicide did take place, then it was necessary to have an investigation to open up the circumstances of the death to public scrutiny and to ensure that those at fault would be made accountable for their actions. Fifthly, the same reason for an enhanced investigation applied to cases of unsuccessful suicide attempts, although a full public inquiry might not be needed.[79] Effectively, Mr Bowen argued that the same reasoning applied to the circumstances of the present case.

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[75] [18]-[19]. Lord Phillips said that in some cases, it did more than was necessary to comply with ***Article 2.***
[76] We take the word "positive" to mean here both the State's obligation to give effect to a person's substantive right to life under ***Article 2*** and the procedural obligation of the State under ***Article 2.***
[77] See [37] and [42].
[78] [35]
[79] See [38]-[41].

68. Lord Phillips indicated that a further investigation might be necessary, even after such an "enhanced" initial investigation. But he left open for debate the precise circumstances in which one would be needed.[80] In ***L*** the investigation by the retired prison officer did not fulfil the requirements of ***Article 2,*** largely because he was not independent (criterion (iv) above) and also, because his report was not published.[81]

69. Lord Rodger of Earlsferry underlined the point that an independent investigation was needed in the case of a suicide in custody precisely to determine whether the substantive obligations of the State under ***Article 2*** had been violated, because the very fact of such a suicide made that inherently possible.[82] Lord Rodger was also careful to point out that not all attempted suicides in custody required an ***Article 2*** type investigation.[83] But if there was to be an independent investigation, then "the sooner it starts work the better".[84] Lord Walker of Gestingthorpe made the same point, whilst accepting that the initial steps in an investigation had to be done by the prison authorities "because of time constraints".[85] Lord Brown of Eaton under Heywood stated that a full independent public inquiry went "…far beyond what can reasonably be judged necessary to satisfy the ***Article 2*** procedural duty arising in any save the most exceptional near-suicide case".[86] He was particularly concerned about the cost aspects of holding such an inquiry, noting that it was "…idle to pretend that money is no object" even in such cases.[87]

70. What conclusions can be drawn from their lordships' speeches in ***L***? Lord Phillips went the furthest in requiring an ***Article 2*** compliant "initial investigation". The others were more circumspect, although all expressed the view that the need for an ***Article 2*** compliant investigation was triggered on the facts of that case. The appeal was academic in a sense because the Secretary of State had conceded that there should be an "enhanced investigation" in that case even before the hearing. In our view the case is helpful in identifying the ingredients of an ***Article 2*** compliant inquiry and in identifying the kind of reasons why such an inquiry might be necessary. But it is obvious that their Lordships did not have the present circumstances in mind when considering that case.

71. In ***R(Smith) v Oxfordshire Assistant Deputy Coroner***[88] there were two issues. The first was whether a soldier who died on active duty in Iraq was protected by the HRA. The second issue assumed the answer "yes" to this first question. The second question was whether, and if so, when, the State's procedural obligation under ***Article 2*** arose if the soldier was protected by the HRA. The majority of the panel of nine Justices answered the first question in the negative, so that all the statements on the second issue were *obiter*. Various statements of the Justices are helpful, however, because of the light they throw on the proper approach to the general problem of when the procedural duty arises under ***Article 2*** and how it is to be

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[80] [44].
[81] [48].
[82] [58]-[60].
[83] [64]-[73]
[84] [74]
[85] [94] – [95]
[86] [104]. He regarded the case on which this approach was founded, ***R(D) v Sec of State for the Home Dept [2006] 3 All ER 946,*** a decision of the CA, as having been wrongly decided. The other law lords, apart from Lord Phillips, were cautious about that decision and Lord Mance expressly agreed with Lord Brown on this issue: see [114].
[87] [106]
[88] ***[2011] 1 AC 1***

discharged. Thus, at [64], Lord Phillips of Worth Matravers PSC effectively repeated, albeit in a slightly altered order, the requirements he had set out at [35] in ***L*** for what he had there called an "enhanced investigation" and in ***Smith*** he called an "***Article 2*** investigation". At [70] Lord Phillips stated the general proposition that: "Any effective scheme for protecting the right to life must surely require a staged system of investigation of deaths, under which the first stage takes place automatically in relation to every death, whether or not there are grounds for suspecting that there is anything untoward about the death". He added that the requirement for an ***Article 2*** investigation "…will only arise if the preceding stage of the investigation discloses that there is a possibility that the state has not complied with the substantive ***Article 2*** obligation". These statements appear to imply that even in suicide in custody cases there may not have to be a preliminary investigation that is ***Article 2*** compliant. Whether or not that is so, these statements do not support the proposition that there has to be an *immediate* ***Article 2*** compliant investigation in the case of every death where there may or may not be grounds for suspecting that there was something "untoward about the death", or the involvement of State Responsibility.

72. This conclusion is reinforced by [71] of Lord Phillips' judgment, where he summarises the "staged system" of investigating deaths in the UK, which may culminate in an inquest with a jury. At [72] Lord Phillips states that an inquest "…is being used as the appropriate process for determining whether there has been a violation of the State's ***Article 2*** obligations". That could be done as a result of the broad interpretation that was given to ***section 11(5)(b)(ii)*** of the 1988 Act and ***Rule 36(1)(b)*** of the ***Coroners Rules 1984*** as a result of the ***Middleton case*** so that the inquest's ascertainment of "how" the deceased came to his death was to be interpreted as requiring that the inquest ascertain "by what means and in what circumstances" he came to his death.[89] Lord Phillips returned to what he called the UK's "staged system of investigation into deaths" at [85]. We agree with Mr Hooper's submission that Lord Phillips was not there confining the notion of the "staged system" to the deaths of servicemen; it was intended to be a general analysis.

73. Lord Phillips posed the question: "how suitable is an inquest for the discharge of ***Article 2*** procedural obligations"? His answer, at [81], is that it may be so in certain circumstances but there are others when it will not be.[90] He elaborated this at [86], where he stated that it would often only be in the course of an inquest that the issue as to whether there had been a breach by the state of its "positive"[91] ***Article 2*** duties can be considered. Only then can it be ascertained whether an ***Article 2*** investigation is needed and whether the inquest can successfully fulfil that role. In other words, each case has to be considered on its facts.

74. At [98], Lord Hope of Craighead identified certain situations where the ***Article 2*** procedural obligations of an investigation were automatically triggered. First, the suicide of a person in custody and, secondly, an attempt to commit suicide which resulted in brain damage. He said that in those cases "a ***Middleton*** inquest was

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[89] See [75]-[76] of Lord Phillips' judgment where he quotes from the CA decision in ***R v Coroner for North Humberside and Scunthorpe, ex p Jamieson [1995] QB 1,*** as considered and not followed, after the passing of the HRA, in ***Middleton's case [2004] 2 AC 182.*** See now ***section 5(2)*** of the ***Coroners and Justice Act 2009,*** in force since 25 July 2013.

[90] Lord Brown of Eaton under Westwood expressly agreed with this at [151].

[91] In this context we think Lord Philips equated "positive" with "substantive" duties, although, with respect, we would regard the "procedural duties" under ***Article 2*** as being just as "positive" in nature.

required". The reason for this was the fact that they were under the "care and control of the authorities" and this gave rise to the "automatic obligation to investigate the circumstances". Lord Hope extended the requirement to have a ***Middleton*** inquest to "suicides committed by others subject to compulsory detention by a public authority such as patients suffering from mental illness who have been detained under the MHA". [92] But it is clear that Lord Hope was not suggesting that there should be an additional ***Article 2*** compliant investigation prior to or in addition to a ***Middleton*** inquest in such cases. The other judgments (save to the extent that they agreed with points we have mentioned) do not further assist on the present issue.

75. What conclusions can be drawn from ***Smith***? First, that the system in England and Wales consists of a "staged investigation" of death. Secondly, this "staged investigation" will culminate in an inquest if the statutory requirements for one are met and, if applicable, the inquest will take place with a jury. Under the 1988 Act the inquest will be a ***Middleton*** inquest (with the possibility of a narrative verdict) if there has been or may have been a breach of the State's ***Article 2*** substantive obligations. Fourthly, in certain types of case, including a suicide by a patient detained in hospital under the MHA, the State's ***Article 2*** procedural obligations and so an investigation leading to a ***Middleton*** inquest will be triggered "automatically". Fifthly, in some cases even a ***Middleton*** inquest will not be an appropriate medium for discharging the State's ***Article 2*** procedural duties to enquire into state responsibility for loss of life. Whether it is or not will depend on the circumstances of the particular death (or deaths) under investigation. Sixthly, in the case of a death (as opposed to an unsuccessful attempt at suicide leading to serious injury), there is no suggestion in any of the judgments that there must be an automatic triggering of an ***Article 2*** compliant "initial investigation" or that such an investigation should take place alongside a ***Middleton*** inquest.

76. **Conclusions on Issue one:** Our first conclusion is that no domestic authority requires that, in order to fulfil the State's ***Article 2*** procedural requirements, there must be an independent investigation from the outset into the death of a patient who has been detained under the MHA and who dies whilst in the hospital's care. ***L*** is Mr Bowen's highpoint, but that was a near suicide case and so there could be no inquest of any type. If the law were that an independent investigation was required from the outset when the State's ***Article 2*** procedural obligations are triggered "automatically", then the Supreme Court would have said so in ***Smith*** but it did not. Moreover, none of the ECtHR decisions indicates that this is required when a member State has a procedural system for investigating deaths which includes an inquest.

77. Therefore Mr Bowen has to argue for an extension of the existing law. As already noted, he deployed much the same arguments as Lord Phillips raised in ***L*** for reaching his conclusion in that case that an independent investigation was needed from the outset in the case of a suicide attempt. We accept that those detained in mental hospitals under the MHA pose a high suicide risk and we accept that, in those circumstances, the hospital authorities (to be regarded for these purposes as agents of the State) will be bound by the ***Article 2*** substantive obligations to take reasonable care to ensure that such patients do not commit suicide, by putting in place systematic precautions against it. We also accept (as we must given Lord Hope's remark in ***Smith*** at [98] and Lord Mance's similar statement at [210]) that if those precautions fail then the State's ***Article 2*** procedural obligations will be triggered. But the

[92] Lord Mance makes the same analysis at [210]

investigation into the circumstances of the death will be opened to public scrutiny by a ***Middleton*** inquest and that will, in our view, generally fulfil the State's ***Article 2*** procedural obligations. Such an inquest meets the minimum standards identified by Lord Phillips in ***L*** at [35] and reiterated by him in ***Smith*** at [64]. We are not persuaded that there are any particular characteristics of the present case that mean that a ***Middleton*** inquest would be an inappropriate means to discharge the State's ***Article 2*** procedural obligations, as Lord Phillips envisaged might be the case in certain circumstances.[93]

78. Mr Bowen emphasised the lack of independence of the prior, SUI, investigation. We accept that it was an internal investigation that was not hierarchically or practically independent of the NHS Trust "implicated" in the circumstances of JA's suicide. But, as Lord Phillips emphasised in ***Smith,*** that is only a part of the "staged investigation" that constitutes the framework in England and Wales for investigating deaths. The Inquest was opened in the normal way. The coroner and his officer have extensive powers and the coroner is an independent judicial officer. The investigations in an inquest are not limited to the fruits of any prior internal investigation.[94]

79. Mr Bowen also emphasised the fact that in the cases of deaths in custody and detention, the UK has instituted independent investigation systems under the PPO and IPCC. That is true, but it does not follow, in our view, that the State must, as a matter of law, institute the same system to investigate suicides of detained MHA patients. We have concluded that it does not have to do so as a matter of the existing law. Whether the UK wishes to create such a system on grounds of public policy is a different point. It is not bound to do so as a matter of either domestic or ECHR law as it stands.

VI. Issue Two: on the facts of the present case was there an *Article 2* procedural obligation to have in independent investigation apart from the Inquest and, if so, from what point?

80. Given our conclusion under Issue One, our answer to this question must be that there is no obligation to have an independent investigation apart from the Inquest at any point, for the reasons already stated.

VII. Issue Three: on which of the defendants (if any) did that obligation fall and which defendant (if any) was therefore in breach of its *Article 2* procedural obligation?

81. Again, given our conclusions under Issue One, the answer to this question must be that none of the defendants was under such an obligation and so none were in breach. The question of whether, overall, the investigation, including the Inquest, failed to be "effective" in the sense contemplated by Lord Phillips at [35] in ***L*** and [64] in ***Smith,*** is a different issue and we consider that under Issue Six.

VII. Issue Four: Do the DoH and NPSA Guidances mis-state the law?

82. Part of the relief sought by the claimant is a declaration that MoH has not put in place guidance that correctly states the circumstances in which ***Article 2*** requires an

[93] ***Smith* at [85]**
[94] As Lord Phillips noted at [85] of ***Smith.***

independent investigation to be carried out pre-Inquest. We assume that the relief sought relates to both the DoH and NPSA sets of Guidance.

83. The DoH Guidance of 2005 is not just concerned with deaths in the context of health care; it covers "all adverse health care events". Mr Bowen's criticism focuses on the criterion which we have set out above (at [27] above) and it is submitted that this is contrary to the statement of Lord Rodger at [59] in ***L.*** We do not accept that submission. Lord Rodger was dealing with a specific circumstance, that is where a prisoner has been killed or has committed suicide or (although not specifically stated in that paragraph) where there has been an attempted suicide by the prisoner. In those circumstances the ***Article 2*** procedural obligations are automatically triggered. To those situations can now be added the death (including suicide) of a mental patient detained in hospital under the MHA, following Lord Hope and Lord Mance's statements at [98] and [210] in ***Smith.*** But the criterion in the MoH Guidance is more general. It covers other possible circumstances in which a death has occurred, eg. as a result of clinical negligence. As Lord Hope of Craighead reiterated in ***Smith*** at [97], the procedural obligations imposed by ***Article 2*** (including the need for an independent investigation) are triggered when the substantive obligations imposed by ***Article 2*** "have been, or may have been violated in circumstances in which it appears that the agents of the state are, or may be in some way implicated".[95] That is precisely the way it is put in the Guidance.

84. Appendix 1 of the NPSA Guidance of 2008 also deals with both deaths and "incidents". We have quoted the relevant passage at [30] above. Our sole criticism of the wording is the use of the qualifying word "well" in the phrase "where an individual's ***Article 2*** rights *may well have been breached.…"* in the second paragraph. That degree of probability is not required. The correct test is stated in the previous paragraph in which it is stated that the ***Article 2*** procedural obligation to initiate an effective public investigation by an independent official body is triggered when it "appears that ***Article 2*** has been or may have been violated and it appears that agents of the State are or may be in some way implicated".

85. Mr Bowen also criticised the statement on the following page of Appendix 1 of the NPSA Guidance where it states that the ***Article 2*** procedural obligation to hold an independent investigation "will almost always arise where there is an unexpected death in custody and where there are real concerns that there were failures in care". His interpretation of that sentence is that two conditions have to be fulfilled: an unexpected death *and* real concerns that there were failures of care. We do not so read it. The paragraph is dealing with both "death" and "incident" and we read the sentence Mr Bowen criticises as covering both those situations. It could perhaps be better phrased but it is not erroneous in point of law.

VIII. Issue Five: If there was a breach of the State's *Article 2* procedural obligations by not having an independent investigation from the outset or apart from the Inquest, could that breach be "cured" by the process up to and including the Inquest?

86. Given our conclusions on Issues One to Three above, this issue does not arise. However, we will comment briefly on the issue. It seems to us that if, as a matter of law, there were an ***Article 2*** obligation on the State to initiate an independent investigation from the outset in the case of a suicide of a detained MHA patient such

[95] Citing ***Middleton at [2] and [3].***

as JA, then, logically, a failure to carry out that obligation cannot thereafter be "cured" by having another, later, independent investigation such as an inquest. Similarly, even if the obligation on the State is not to have an independent investigation from the very outset but to have one before and separately from the inquest, then if that is not done, it cannot logically be "cured" by a continuing failure to have one thereafter, claiming that the inquest cures all.

87. The only situation in which the question of "cure" might arise, in our view, is when there are criticisms of the effectiveness of the whole investigation system as it operated in the present case. As we interpret the domestic and ECtHR case law, the whole investigation process must be examined to see if is independent and "prompt and effective". It may be that there are operational faults in an early "stage" of the several stages of investigation into a death (to use Lord Phillips' phrase) which were so fundamental that the investigation as a whole could never be "effective" and so fulfil the ***Article 2*** procedural duty. Alternatively, there may be operational faults in the early "stage" that might potentially mean that the State has not fulfilled its ***Article 2*** procedural duty, but those errors were capable of rectification at a later stage of the investigation and they were rectified, so that, overall, the investigation process is independent, prompt and effective. In that sense, an earlier failure might or might not be "cured". We think that this is the better way to examine the submissions of Mr Bowen that the whole process in this case was flawed because earlier failures could not be or were not cured by what happened up to and at the Inquest. That is why we have phrased Issue Six in the way we have.

IX. Issue Six: On the facts of this case, was the process of investigation, up to and including the Inquest, in breach of the State's *Article 2* procedural obligations?

88. The first argument of Mr Bowen is that the lack of independence of the initial investigation and the SUI investigation fatally compromised the effectiveness of the whole process, including the Inquest. The second argument is that there were fundamental flaws in the SUI process which meant the whole process could not be "effective" and was incapable of "cure" by the later process including the Inquest. The principal flaws alleged are: (i) a failure to secure evidence and collect it promptly; (ii) the failure of the SUI report to deal with events before JA's death and its general superficiality; (iii) the failure of CNWL to disclose statements and notes of interviews to the claimant until a very late stage and, in the case of the interview note of Ms Lambo, not until after the Inquest; (iv) the generally obstructive nature of CNWL towards the claimant at all stages so that he could not be properly involved, and (v) a lack of promptness in the process overall.

89. **Lack of independence in SUI process.** We accept that the members of the SUI panel, who were all employees of CNWL, were not (indeed could not be) hierarchically or practically independent of CNWL. If that had been the only inquiry into JA's suicide, this lack of independence would have been a fatal flaw in the procedure. But it was not. The Coroner and his officer, who are undoubtedly independent, were involved from the outset. The Coroner was involved thereafter. All the "fruits" of the initial and SUI investigations (save the statement of Ms Lambo and the proof of Dr Marr) were available to the Coroner and jury and the claimant at the Inquest. As already noted there were seven PIRs leading up to the full and thorough Inquest with a jury. Overall, the requirement of independence of the investigation process was fulfilled.

90. **Fundamental flaws in the SUI process and thereafter.** The first allegation is that there was a failure to secure evidence, starting with the ligature and a failure to collect all necessary evidence. The ligature was removed from JA's room by DS Woodham and taken to the police station. It appears to have been lost thereafter. That is a flaw in the process; it should not have been lost. But the loss of the ligature was not fundamental. Its physical absence did not create difficulties at any stage.

91. It is also alleged that there was a failure timeously to take statements from Dr Marr and Dr Desforges, who saw JA at 5pm on 22 October 2010. The SUI panel interviewed Dr Marr on 19 January 2011, three months after JA died and 2 ½ months after the SUI panel had been set up. Dr Marr gave a further witness statement and gave evidence at the Inquest. It could be said that there was a delay in having the initial interview, but there was no suggestion at any stage that Dr Marr's ability to give effective evidence of events was marred by that fact. This was not a "fundamental flaw". Nor was the fact that a statement was not taken from Dr Desforges until shortly before the Inquest.[96]

92. The suggestion that Rachel Lambo was not interviewed is incorrect. She was interviewed on 27 October 2010, 4 days after JA's death. It is clear that she was not involved in the observation of JA during the night of 22/23 October 2010. It was not disclosed until after the Inquest had finished, but this had no consequences because of her lack of involvement with the care of JA on 22/23 October.

93. Mr Bowen also argued that CNWL failed to comply with its own relevant Guidance and SUI policy and that this may have contributed to what he says were failures to secure and preserve evidence. We are satisfied that, on a correct reading of the Guidance and the policy, this is not the case, for the reasons set out at paragraph 30 of CNWL's "skeleton argument" which we do not need to repeat here.

94. Secondly, Mr Bowen submitted that the SUI procedure was fundamentally flawed because it failed to report on matters before JA's death and the report was generally superficial. He relied on the conclusions of the jury and the Rule 43 recommendations made by it. In our view the fact that the Inquest did go into such matters as hospital procedures, (including risk assessment policy), and the lack of co-ordination between medical staff shows how thorough the Inquest was. Even if the SUI investigation could have been deeper or even if it lacked independence, that was not a fundamental flaw to the investigation process as a whole, which must include the Inquest itself. The Coroner instructed Dr Lord, a consultant psychiatrist, who considered in detail events prior to JA being discovered at 7.40 on 23 October.

95. Thirdly, Mr Bowen made a great deal of the allegation that CNWL had failed to disclose witness statements and other evidence until very late and that two documents (Ms Lambo's statement and a proof of Dr Marr) were not disclosed before the Inquest.[97] CNWL accepts that misleading statements were made to the Coroner and to the claimant about what statements had been taken and when, but that this was unintentional. We accept that. We are not going to go into the question of what statements might be subject to legal professional privilege; it is unnecessary to do so. Although there may have been flaws in the disclosure process, they were far from "fundamental" and certainly did not mean that the whole investigation process,

[96] The claimant refused to permit the statement of Dr Desforges to be read at the Inquest.
[97] A witness statement, based on Dr Marr's proof of evidence, was disclosed prior to the Inquest.

including the Inquest, failed to fulfil the minimum requirements of the ***Article 2*** procedural/investigation duty.

96. Fourthly, it is alleged that CNWL was generally obstructive towards the claimant at all stages and that it acted in an "adversarial" manner which was unwarranted. Mr Bowen raised the issue of legal professional privilege again under this heading. As CNWL points out, this is an academic point now as the privilege originally asserted (we will not go into whether this was properly claimed) was waived.

97. We regard as unfounded the assertion that the claimant and JA's family were unable properly to be involved at all stages. The claimant was promptly notified of JA's death. He was interviewed by the police prior to DS Woodham's case report on 16 December 2010. The claimant met two members of the SUI panel on 26 January 2011. It is true that the panel did not take a statement from him prior to their report and that, initially, the panel stated that it would not give him a copy of the report. However he was offered a meeting after the report had been made, which was not taken up, and in September 2011 the report was disclosed to him. That was several months in advance of the Inquest at which he gave evidence, as did Ann Antoniou. There is no suggestion that their recollection of events was impaired by that time. The claimant and the family of JA were represented at the Inquest.

98. The last allegation under this heading that is advanced by Mr Bowen is that the whole procedure overall lacked promptness. We also reject this criticism. The initial investigation was very prompt. The SUI *investigation* itself was prompt enough, even if the production of the report was not within the timescale set out in the NPSA Guidance, which stipulated 90 days. The interlocutory stages of the Inquest itself were quite drawn out, but this was understandable in the circumstances and the time-scale was not inordinately long. The whole investigation process, from beginning to end, took 19 months. We regard that as prompt.

99. **Conclusion on Issue Six:** For these reasons we conclude that the investigation process, taken overall, was not in breach of the State's ***Article 2*** obligations.

X. Issue Seven: Was there any unlawful discrimination against JA or the claimant by any of the defendants in relation to the manner in which JA's death was investigated?

100. ***Article 14 of the ECHR.*** This provides:

> "The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status."

101. Disability is an "other status", so that discrimination based on disability is within the scope of Article 14: see ***Glor v. Switzerland***. [98] Given the nature of the procedural obligations imposed on the State under ***Article 2,*** which we have discussed at some length above, we accept in principle that the obligation of the state to investigate the death of a detained mental patient must be discharged without discrimination on the ground of disability. As far as we know, the ECtHR and Commission have held that

[98] Application Number 13444/04 6/11/2009, see [80].

a state's obligation under the procedural aspects of ***Article 2***, taken together with ***Article 14***, has been breached by reason of discrimination in one case only: ***Nachova v. Bulgaria***[99]. The facts are not in point. The breach in that case occurred because Bulgaria failed to take all possible steps to investigate whether or not race discrimination may have played a role in the events which led to the unjustified killing, by a member of the military police, of two Bulgarian nationals of Roma origin: see [168].

102. If, without considering ***Article 14***, the State is under an obligation to conduct an investigation into the suicide of a detained mental patient which is in all respects independent from first to last, Article 14 adds nothing to that obligation, because (by definition) it must exist in all cases. It is only if the State is not under such an obligation for reasons independent of ***Article 14*** that the latter, arguably, has a part to play. Self-evidently, ***Article 14*** could only be determinative if its effect would be to convert what was otherwise a lawful investigation into an unlawful investigation because of the existence of discrimination on the ground of disability.

103. Superficially, it might seem as if there is a difference of treatment if the State's investigative obligation into a suicide is more stringent in the case of a prisoner of sound mind than in the case of a detained mental patient. However, upon reflexion it will be clear that this difference does not arise from the mental patient's disability; it arises from the circumstances in which each person is detained. In the case of the prisoner of sound mind, he will be detained within the prison estate for reasons of punishment, deterrence, protection of the public and rehabilitation. He will be under the supervision of a prison staff composed mainly of prison officers. In the case of the detained mental patient, he will be detained principally for his own health, well-being and protection in a hospital staffed mainly by clinicians, nurses and hospital assistants. If the requirement to investigate suicide in the former case is more stringent than in the latter, it arises because of the difference in the circumstances of the detention of the two individuals, which is reflected principally in the actual place and in the nature of the place in which they are detained. It does not arise from the fact that one does, and the other does not, suffer from a disability. So the more stringent obligation would continue to apply in the case of a prisoner detained, by reason of a psychiatric condition or physical disability, in the hospital wing of a prison. The reason why the more stringent obligation would continue to apply in those circumstances is because he was and remained a prisoner. There would be no difference in the obligation of the State to investigate his death by comparison with that of a prisoner of sound mind and body who was not in the hospital wing.

104. The claimant himself does not suffer from any disability. ***Article 14*** is irrelevant so far as his rights are concerned.

105. For those reasons, we are satisfied that ***Article 14*** does not convert what would otherwise be a lawful investigation into an unlawful investigation by reason of the disability of a detained psychiatric patient.

106. **Indirect discrimination: *section 19* of the *Equality Act 2010*.** Unlike ***Articles 2*** and ***14*** of the ECHR, as interpreted by the ECtHR, the domestic legislation is tightly drawn. Section 19 provides,

[99] Application Numbers 43577/98 and 43579/98 6/07/2005

"(1) A person (A) discriminates against another (B) if A applies to B a provision, criterion or practice which is discriminatory in relation to a relevant protected characteristic of B's.

(2) For the purposes of sub-section (1) a provision, criterion or practice is discriminatory in relation to a relevant protected characteristic of B's if –

(a) A applies, or would apply, it to persons with whom B does not share the characteristic,

(b) it puts, or would put, persons with whom B shares the characteristic at a particular disadvantage when compared with persons with whom B does not share it,

(c) it puts, or would put, B at that disadvantage, and

(d) A cannot show it to be a proportionate means of achieving a legitimate aim.

(3) The relevant protected characteristics are –

…

disability…"

Disability is defined by ***section 6*** as follows:

"(1) A person (P) has a disability if –

(a) P has a physical or mental impairment, and

(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to- day activities.

(2) A reference to a disabled person is a reference to a person who has a disability.

(3) In relation to the protected characteristic of disability –

(a) A reference to a person who has a particular protected characteristic is a reference to a person who has a particular disability…"

107. It is plain, as a matter of language, that a disability as defined by ***section 6*** can only be suffered by a living person. Hence, the reference to "a person", "who has a disability" which "has a substantial and long-term adverse effect on P's ability to carry out normal day to day activities". It cannot sensibly be said that a deceased person "has a disability". Once a person has died, his "ability to carry out normal day to day activities" is wholly extinguished. In our view, it is not possible to apply a "provision, criterion or practice" to a deceased person which would not apply to a living person and so indirectly discriminate against the former. We accept, of course, that a claim can be maintained by the Executor of a deceased person in respect of discrimination that occurred during the lifetime of the deceased person. However, it would be a different thing altogether to say that Parliament has prohibited indirect

discrimination in the manner in which investigations are conducted into the death of two deceased persons – one who, when alive, was a detained mental patient and the other who was a prisoner of sound mind and body. The 2010 Act sensibly recognises that death eliminates all differences based on disability.

108. Once again, there can be no question of indirect discrimination against the claimant because he suffers from no disability.

109. **The public sector equality duty – *section 149* of the *Equality Act 2010.*** Again, the statutory duty is more tightly drawn than obligations under ***Articles 2*** and ***14*** ECHR. ***Section 149*** provides:

> "A public authority must, in the exercise of its functions, have due regard to the need to –
>
> (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
>
> (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
>
> (c) foster good relations between persons who share a relevant characteristic protected characteristic and persons who do not share it…
>
> (3) Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to –
>
> (a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
>
> (b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
>
> (c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low…
>
> (7) The relevant protected characteristics are –
>
> …
>
> disability…
>
> (8) A reference to conduct that is prohibited by or under this Act includes a reference to –
>
> ….

(b) A breach of a non-discrimination rule."

110. As a matter of language, it is plain that ***section 149*** also relates only to living persons. Two duties are relied upon by the claimant: the obligation to have regard to the need to "eliminate discrimination" and to "advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it". "Discrimination" is exclusively defined by ***sections 13 – 19, 21*** and ***108***: ***section 214*** and ***Schedule 28***. For reasons similar to those we have identified in relation to ***section 19***, all of these provisions can only, as a matter of language, apply to living persons. Self-evidently, equality of opportunity "between persons who share a relevant protected characteristic and persons who do not share it" can only apply as between the living.

111. Accordingly, and for those reasons, differences in the manner of investigation into the death of a person who had and who did not have a protected characteristic cannot give rise to a breach of the public sector equality duty in ***section*** 149.

112. The claimant does not have a protected characteristic so ***section 149*** is irrelevant to his position.

XI. Conclusion and disposal

113. For the reasons given above, we have concluded that, given all the circumstances of this case, in particular the fact that there was a properly constituted and conducted Inquest, there was no obligation under ***Article 2*** of the ECHR to have, in addition, a separate independent investigation into the death of JA, either from the outset or from any time thereafter. We have also concluded that, taken as a whole, the investigation process into the death of JA was independent, effective and prompt. Lastly, we have concluded that there was no unlawful discrimination against JA or the claimant by any of the defendants in the way that JA's death was investigated.

114. Accordingly, this claim for judicial review must be dismissed.