Neutral Citation Number: [2016] EWHC 1796 (Admin)

Case No: CO/4941/2015

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 19/07/2016

Before :

LORD JUSTICE BEATSON
HHJ PETER THORNTON QC, THE CHIEF CORONER

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Between :

The Queen on the application of Maxine Hamilton-Jackson	**Claimant**
- and -	
HM Assistant Coroner for Mid Kent and Medway	**Defendant**

- -
- -

Ifeanyi Odogwu (instructed by **Hodge Jones and Allen LLP**) for the **Claimant**
Sian Davies (instructed by **Kent County Council Legal Services**) for the **Defendant**

Hearing date: 22 June 2016

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Approved Judgment

Lord Justice Beatson:

I. Overview

1. The claimant is the mother of Sean Joseph Jackson, a prisoner with a history of mental health problems and self-harm, who died at HMP Elmley on 10 January 2013 aged 26. The defendant is Ian Wade QC, HM Assistant Coroner for Mid Kent and Medway, who, with a jury, conducted an inquest into the death of the deceased between 6 and 15 July 2015. Because this was a death in custody apparently from self-harm, by section 5(2) of the Coroners and Justice Act 2009 ("the 2009 Act") the purpose of the investigation included ascertaining in what circumstances the deceased came by his death as well as how, when and where he did so. The scope of the investigation and inquest was thus required to reflect the requirements of Article 2 of the European Convention on Human Rights.

2. The claimant was an Interested Person in relation to the investigation and inquest (see section 47 of the 2009 Act). At the inquest, the main issue was whether the deceased ought to have been recognised as a risk of harming himself in the days and hours leading up to his death, and whether the response from the prison and healthcare staff to any risks that they were aware of or ought to have been aware of was appropriate. This involved consideration of Chapter 5 of PSI 64/2011, the Ministry of Justice's Instructions on "*Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*" containing the Assessment, Care in Custody and Teamwork process for supporting and monitoring prisoners at risk of harming themselves and the local policy at HMP Elmley for supporting and monitoring prisoners at risk of harming themselves; "*Suicide Prevention and Self-Harm Management*". I shall refer to these as respectively "the national ACCT policy" and "the local ACCT policy".

3. In August 2012 the deceased was charged with the assault of his then partner/girlfriend and remanded in custody. Throughout his time in prison he was located in the prison's inpatients healthcare unit. From 1 September until 30 December, ten days before his death, he was managed and monitored under ACCT policy procedures.

4. The deceased's ACCT plan was "closed" on 30 December 2012, two months after the last recorded incident of self-harm by him. Two important issues at the inquest were whether his ACCT plan should have been re-opened because of an act of self-harm on 8 January to which he drew the attention of a prison nurse, or on 9 January 2013 when he changed his plea to guilty and was remanded for sentence, so that his status within the prison changed. Other issues at the inquest were whether the ACCT plan should have been re-opened because of his low mood and the breakdown of his relationship with his partner/girlfriend.

5. The conclusion of the jury on the Record of Inquest as to the death was "accidental death" and that the medical cause of death was "suspension". Its conclusion as to the circumstances in which the deceased came by his death were that:

> "On 10 January 2013 at a time between 11:45 and 14:40 Sean Joseph Jackson suspended himself by a ligature made out of strips torn from a sheet that was tied to his cell light fitting in his cell at HMP Elmley and declared deceased at 15:42pm".

Mr Odogwu, on behalf of the claimant, stated at the hearing and in his post-hearing submissions (as to which see below) that these conclusions are not challenged in this judicial review. The challenge is to the answers to the questions on the jury questionnaire appended to the Record of Inquest about "closing" the deceased's ACCT and not reopening it, and the handwritten statement on that questionnaire relating to the ACCT policies. I set the questions out at [8] below and the answers and the handwritten statement at [36] below. The claimant seeks an order quashing the jury questionnaire. She does not seek an order for a fresh inquest. Mr Odogwu stated that the basis of her position is that the Record of Inquest complied with the statutory requirements under section 10 of the 2009 Act as to the determinations and findings to be made at an inquest, and that the procedural obligations of Article 2 of the European Convention on Human Rights are met by the inquest investigation itself together with a declaration by this court that the jury questionnaire was unlawful.

6. I accept the main thrust of Mr Odogwu's submission but in my judgment it is not necessary to make a declaration that the entire jury questionnaire, the answers to the questions and the handwritten note were unlawful. For the reasons given at [44] – [47] and [53] I consider that there was misdirection in relation to the matters relevant to question 2 of the jury questionnaire and the jury's answer to it. Accordingly, that question and the answer to it should be quashed. That, in my judgment suffices to mean that the Record of Inquest together with this application and the court's judgment, complied with the requirements of section 10 of the 2009 Act and those in Article 2.

II. The relevant policies

7. The national ACCT policy relevant to these proceedings, PSI 64/2011, came into effect on 1 April 2012. It replaced PSO 2700 *Suicide Prevention and Self-Harm Management* which had been in effect since 1 January 2003. The ACCT plan was introduced as of 1 June 2005 by PSI 18/2005 to replace the elements of PSO 2700 that referred to a specified form to be opened when a prisoner is identified as at risk of suicide or self-harm. At some stage thereafter, PSO 2700 was updated by replacing references to the old form with reference to the new ACCT plan.

8. Section 2 of PSI 64/2011 contains the "specification outputs". Paragraph 23 deals with prisoners *inter alia* affected by incidents of self-harm. It states "*prisoners who self-harm must be managed using ACCT procedures*". Chapter 5 of PSI 64/2011 is concerned with the ACCT plan or process. In relation to identifying risk and opening an ACCT it is stated that:

> "*Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm, must open an ACCT by completing the Concern and Keep Safe form*".

The significance of the italics is that words in italics contain mandatory instructions. The national ACCT policy's procedures require the assessment of prisoners at risk, engagement with them and the completion of a Concern and Keep Safe form, an action plan to ensure that the prisoner is safe from harm including, within 24 hours, an assessment interview by a trained ACCT assessor and a case review attended and

chaired by the residential manager or equivalent, the case manager, the assessor, and other relevant members of staff.

9. The local ACCT policy is dated October 2010. The relevant provisions in these proceedings are to be found in Annex 3 under the heading "*Opening an ACCT Plan*". It is stated:

> "*In the event of any incident of self-harm, or whenever a member of staff believes a Prisoner is at risk of suicide or self-harm, they must (where there is not one open already) open an ACCT Plan*".

It is then stated that the person opening the ACCT Plan must take a number of specified steps to ensure that the opening of the plan is known by relevant prison and healthcare staff, including completing a "Concern and Keep Safe" form; ensuring the prisoner is safe and passing the ACCT Plan to the prisoner's unit manager or the night orderly officer in person; ensure C-NOMIS is updated; and record (or ensure that the wing staff records) in the observation book and on C-NOMIS that an ACCT Plan has been opened.

10. The other relevant document is the Quick-Time Learning Bulletin, a clarification of PSI 64/2011, *Opening an ACCT*. It was issued in August 2012. It stated that the wording of the mandatory action in chapter 5 about opening an ACCT which I have set out at [8] above "has led some prisons to open an ACCT on all prisoners received into reception with information pertaining to self-harm, whether this is in the past or present". It also stated that it aimed to clarify the position and to allow prisons to manage prisoners deemed to be a risk to themselves in an appropriate manner. The key learning points are stated to be:

- The mandatory action "is intended to empower all staff to determine **current** risk and thereby, the appropriate action to take, based on the available information before them".
- The mandatory action "**is not** intended to prompt staff to open an ACCT on all prisoners based on historical information about risk to self unless a **current risk assessment/warning form, event or incident** has occurred which indicates they are presently at risk of harm to themselves".
- "Historical information should be used as part of the overall risk assessment conducted as per local procedures to make an informed decision on the most appropriate course of action".
- Where historical information becomes available when a prisoner has been at the prison for a lengthy period, "this does not mean that an ACCT document must be opened, however, the information should be considered in the current context of the prisoner's behaviour and mental state".

III. The factual background and the evidence

11. What follows is largely taken from the Assistant Coroner's summing up and the transcript of the evidence of Nurse Cortez. After the deceased was remanded in

custody on 16 August 2012, he was assessed as being in a low mood, floridly psychotic but without present suicidal thoughts, and mentally unwell. He was admitted to the healthcare inpatients unit. Because he was not assessed as posing a risk of self-harm and, when asked, had denied that he had thoughts of harming himself, an ACCT was not opened. On the next day, he was prescribed with an anti-psychotic drug, olanzapine, and was considered not to have capacity. Two psychiatrists, Dr Feeney and Dr Harding, assessed him during this period. They considered him to be extremely unwell and psychotic but not at risk of self-harm.

12. An ACCT on the deceased was opened on 1 September 2012 by a nurse to whom he had said he had felt like stabbing himself or hanging himself. At a review the next day, the nurse came to the view that he tended to use self-harm attempts manipulatively in response to indications which he perceived suggested that it was intended to move him out of the inpatients unit. On 6 September he was discovered tearing up a sheet. This was assessed as probably conduct to make a ligature, and he was put on constant watch. On the following two days he repeated his intention to kill himself and, on 10 September, he was observed apparently taking preparatory steps to harm himself. On 11 September his ACCT was reviewed and the level of watch was reduced. The deceased self-harmed on 21 September and it was recorded that he was hearing voices. Consideration was given to getting him admitted to the Maudsley Hospital.

13. On 29 October it was decided to close the ACCT. On 30 October, a prison officer reported that at regular lock-up time he had seen the deceased tie a ligature tight round his neck and preparing to tie the other end of it to the light fitting. In the light of this report a second ACCT was opened. On 31 October, the deceased was found by a prison officer on his bed making another ligature. An entry in his record on 6 November stated that he appeared to make a ligature each time he was told he would be moved out of healthcare and onto an open wing.

14. On 9 November, the day of the deceased's first appearance at the Crown Court, he stated that he felt suicidal but that he did not have any intention to commit suicide at the time. An assessment by a consultant from the Maudsley Hospital and Dr Harding on 12 November concluded that the deceased's psychotic presentation had been managed and that when seen he did not appear to be in an acute psychotic crisis. On 9 December, the nurse updating the care plan assessed the deceased as well and not demonstrating psychosis. Entries on 11 and 17 December expressed no concerns. Entries on 21 and 29 December were respectively that the deceased denied having thoughts of self-harm and assessed him as having no thoughts of self-harm. On 30 December, the position was reviewed and it was decided to close the ACCT.

15. On 8 January 2013, the deceased's trial started and was adjourned part-heard. That evening, he sounded the bell in his cell and Nurse Claire Cortez responded. He showed her that he had self-harmed by superficially cutting his wrist and she observed that he was low in mood. She also learnt from him that his former partner/girlfriend had unexpectedly given evidence against him and that he might be facing a sentence of four years imprisonment.

16. At the inquest, Nurse Cortez and Mr Harry Clarke, the Safer Custody Manager, were asked about the policies. There is no transcript of Mr Clarke's evidence, which is not referred to in the summing up. Mr Odogwu stated that Mr Clarke had confirmed that

the local ACCT policy was based on the relevant parts of the national policy but had been tailored to the needs of the prison. Mr Odogwu also stated that Mr Clarke confirmed without any challenge that it was mandatory to open an ACCT in the event of a prisoner deliberately harming himself. Ms Davies, on behalf of the Assistant Coroner, accepted that Mr Clarke's evidence was to the effect that there was no difference between the local and national policy.

17. There is a transcript of Nurse Cortez's evidence. She was asked about the ACCT process. There were questions about what must have been the local ACCT policy because of Mr Odogwu's reference to the words "any act of self-harm". Asked about the national policy, Nurse Cortez stated she had not heard the term "a PSI document" and could not recall whether she had heard the term when she had worked at the prison. Responding to a question by the Assistant Coroner, she stated that she might have seen the document she had been shown, but found it difficult to recall "because we're governed by so much as nurses as well, to recall all of them". She stated that she considered the risk of self-harm posed by the deceased and increased the observations. She stated that her view of the risk of self-harm was that, looking at historic evidence, the deceased would superficially self-harm in response to stresses or triggers. She recommended higher observations for that reason and because he had come to the prison staff for support. She stated that was a good way of giving him extra support. She drew a distinction between self-harm and suicide, and also made a distinction between suicidal intent and a "coping mechanism". She also stated that the deceased was demonstrating self-harm but she considered there was no evidence of suicidal ideation.

18. Nurse Cortez was asked whether she accepted that, under the ACCT policy, it was appropriate as a form of active self-harm had occurred to open an ACCT on that day, i.e. 8 January. She stated she believed "that an ACCT can be opened". In an exchange with the Assistant Coroner, Mr Odogwu stated that the use of the word "any act" in the policy meant that it followed that after any act of self-harm an ACCT must be opened. Nurse Cortez then said:

> "Yes, but the ACCT document itself doesn't protect the prisoner or patient, it's what level of observation, and obviously the ACCT document could be opened at any time during a 24 hour period. So that's why I would also bring in my second colleague, which would either be a nurse on duty at that time, possibly, so it's always good to liaise with colleagues because obviously one observation isn't necessarily correct, and that's why I refer back to, you definitely need a team approach, especially with such risks."

19. Nurse Cortez also accepted that, according to the policy, staff had to open ACCTs when self-harm occurred. When asked whether she accepted that on 8 January an ACCT plan should have been opened on the deceased, she replied:

> "I don't know how that would have changed the situation. Sorry, I'm unable to really comment. Obviously I can only … apologise for what's happened".

In response to a question from the Assistant Coroner as to whether there were circumstances in place which could have initiated her into opening an ACCT, she stated that from her judgment at the time she felt it was not necessary, and that she had considered whether to open an ACCT. When asked what judgment she brought into play to decide not to open the ACCT, she replied "the evidence at the time, obviously linking with the policy, obviously I'd agree that that wasn't correct. Sorry."

20. There were further questions about what happens in the first 24 hours after an ACCT is opened, and how this informs other members of staff that a prisoner is at risk of self-harm. Nurse Cortez stated:

> "Yes, but also our nursing assessment which would also be on System One would also have the triggers, the protective factors etc. So it's not just the ACCT document that we have for guidance on these key points".

21. Mr Irwin, who represented NOMS and/or the prison authorities at the inquest, asked whether she thought that, if the self-harm concerned was really minimal, there was no need to open an ACCT. Nurse Cortez replied: "Yes, also in the content of what he was actually discussing with myself, I take many factors into consideration including his history". She also stated that a deliberate scratch to the back of a hand which barely broke the skin might be called deliberate self-harm, but that if somebody did that she might not expect to open an ACCT. She said that was because she took into account the degree of harm, the intent, the history, and the risk factors. In answering a further question by Mr Irwin as to what she meant by her understanding of the intent of the person concerned, she said:

> "So obviously he reported his self-harm, so and also handed me the object so was quite futuristic in his thinking. This was behaviour which he had displayed many times. So I'm looking at them type of factors. I wouldn't have considered that he was a high risk, obviously I was concerned because of the stresses such as he was in court, which is why I raised the level of observation, also the relationship with the girlfriend, that's another stressor, I hope that is an answer to your question".

22. The deceased returned to court on 9 January and decided to change his plea and to plead guilty to all the charges he faced. When he returned to HMP Elmley, now a convicted prisoner, he was seen by another nurse, Selva Jebamany. He told her that he had pleaded guilty and expected to be sentenced in four weeks time and to receive a term of four years imprisonment. Her evidence was that the deceased did not show any signs of distress about this or demonstrate mental illness, but appeared calm, made good eye contact, and specifically denied suicidal thoughts in response to her direct question. She concluded that there was no risk of self-harm and did not open an ACCT, but informed colleagues that the deceased's circumstances had now changed because he was now guilty and awaiting sentence.

23. There was also evidence from another prisoner who spoke to the deceased. That prisoner stated that in the evening of 9 January the deceased was upset, but the prisoner did not think he was suicidal.

IV. The summing up

24. The Assistant Coroner's summing up was in two parts. First he gave the jury directions in law and then he reviewed the evidence and drew the jury's attention to what appeared to him to be the most important issues. At the outset, he gave what are standard directions as to the respective roles of the jury and himself, that the facts are for them and it is they who decide what evidence is relevant and significant, what is accepted and what is rejected, and what weight to give to particular pieces of evidence. He stated that they should reject any view of the facts with which they did not agree and take into account any evidence which they consider important but which he did not refer to. There was no criticism of this, but it was submitted that did not mean defects elsewhere in the summing up were not operative.

25. The Assistant Coroner reminded the jury that this was an inquest into a death, a fact-finding investigation, not a trial and not a mechanism for apportioning blame. He stated that the law stated that the function of the coroner's jury is to answer four important but limited questions: who the deceased was, when he came by his death, where he came by his death, and how he came by his death. He stated that "how" means by what means and in what circumstances and the medical cause. He told them that they must not express an opinion on any other matter or make recommendations, because "the law prevents you from making any findings which appear to determine a question of criminal liability of some named individual or any question of civil liability by any person or organisation". He continued:

> "However, because this [is] an inquest which requires you to examine not simply by what means Sean died, but additionally, in what circumstances, you are required to examine wider issues of the death, in order to establish whether there have been or may have been failures of system, failures of system which caused or might possibly have caused Shaun's death."

26. After stating that it was important that the jury appreciated the difference between a system failure and an operational issue within what is otherwise a proper and working system, the Assistant Coroner stated that, if there is evidence that allowed them to reach a view as to whether there was a proper system in place, they may indicate that, but that:

> "If you think that there was an appropriate system in place but that there was an error of judgment or a wrong decision taken within it, then be sure to indicate that by as neutral a statement as possible, without naming names or apportioning blame. Equally, if your view is that there was a proper system and it was operated appropriately, then you will not be troubled to declare anything at all."

27. The jury were taken through the "Record of Inquest" document. Before doing so, the Assistant Coroner stated he would provide them with copies of his guidelines and a questionnaire. As to the guidance, he stated that the jury was "free to reflect your findings in the way that you think best". He also stated that, if no single word encapsulated their conclusion, they could "set out [their] essential findings in a short or brief history … and this is called a narrative conclusion". As to section 3, in which

they had to answer the question how, when and where, and in what circumstances the deceased came by his death, the Assistant Coroner stated that they had to agree the factual circumstances which gave rise to the death on the basis of the evidence and in the light of his directions. He stated that "when describing those factual circumstances, you should be brief, neutral, factual, expressing no judgment or opinion and making no recommendation". He then took them through the remainder of the document. No criticism is made of his directions on section 4, conclusion as to the death, and the various possible conclusions; suicide, accidental death, misadventure. I, however, observe that there is some contradiction between his direction that the jury should express no judgment or opinion and make no recommendation and the passage I summarise at [29] below which reflects the written directions he gave permitting a judgmental conclusion. Since this was an Article 2 inquest subject to section 5(2) of the 2009 Act the latter direction is correct: see the terms of the paragraphs 31 to 34 and 51 to 53 of the Chief Coroner's *Guidance No 17, Conclusions: Short Form and Narrative*.

28. There were three questions on the jury questionnaire:

> "1. Was the decision to close Sean's ACCT on 30 December 2012 a reasonable one in all the circumstances?
>
> Yes/No/Can't Say
>
> 2. Should the inpatient department staff have opened an ACCT on 8 January 2013 after Sean drew attention to his deliberate act of self-harm?
>
> Yes/No/Can't Say
>
> 3. Should the inpatient department staff have opened an ACCT on 9 January 2013 on his return from court after Sean's circumstances changed when he became a convicted prisoner?
>
> Yes/No/Can't Say".

29. The Assistant Coroner stated:

> "You do not have to comment on the questions [on the questionnaire], however you may expand on them or explain your answers should you so wish. You are not confined to answering these questions alone, and you may comment on any matter which you deem relevant to the death."

He also stated that the jury should not record any act, omission or failure unless it had caused or contributed to the death on the balance of probabilities. If they chose to make further comment, their conclusions should be expressed in brief, factual and neutral language and must not include any indication of criminal liability on behalf of a named individual or any indication of civil liability but they "may come to a judgmental conclusion and may describe acts or omissions in more neutral terms as 'failures' and use such words as 'inappropriate', 'inadequate', 'omission', 'insufficient' or 'lacking'".

30. This language is close to that in paragraphs 51 and 53 of Guidance No. 17 issued by the Chief Coroner in January 2015 and revised in January 2016. The Assistant Coroner also stated:

> "You may choose to use the accompanying questionnaire as a prompt to focus your further deliberations, and draft your own concise comments, or you might simply select one of the optional answers and attach an answered questionnaire to the record of inquest".

31. He explained that the reason they were given the questionnaire was that the inquest was one which invited the jury to consider not simply by what means the deceased died, but in what circumstances, and that this was a part of law which was brought into play because of the effect of the Human Rights Act. It was, he stated, an opportunity, in effect imposed on the jury by law, to consider these wider circumstances because of the particular operation of the law in the context of a death in prison. He stated that whether the jury answered it one way or another was entirely a matter for them.

32. I now turn to the parts of the summing up which are criticised by Mr Odogwu. In describing Nurse Cortez's meeting with the deceased on the evening of 8 January, when he had shown her that he had self-harmed, the Assistant Coroner stated:

> " … and he summoned a nurse in order to show that nurse that he had scratched himself. The evidence seems to be that it was a superficial scratch and that it was undertaken with some metal implement, like a paperclip, something like that."

33. In relation to questions 2 and 3 of the questionnaire, which addressed the question of whether or not an ACCT ought to have been opened either when the deceased cut himself or when he returned to the prison as a convicted person, the Assistant Coroner stated:

> "the questionnaire is posed in this way so that you may, if you think it right, reflect in your announcements whether there was in effect a failure of system. Not was there an operational failure, I stress, was there a failure of system, by polarising the dichotomy between: is it mandatory to open an ACCT when a particular event occurs or is it mandatory to open an ACCT when the relevant official considers there is a risk of suicide or self-harm? If it's mandatory to open an ACCT simply on the event of self-harm, or perhaps change of circumstance, then there doesn't seem to be any opportunity for the relevant member of staff to assess risk, but if it's not mandatory because of the event, but is mandatory if the event, considered in the round, suggests to the observer a real risk of harm or suicide, then it may be that an ACCT should be opened. But in this way, this dichotomy represents, you might think, a system failure, or you might not, entirely a matter for you. You can reflect that, I daresay, in response to the questionnaire."

34. Towards the end of his summing up, the Assistant Coroner stated:

> "You will have to consider whether the circumstances were in place which required an ACCT to be opened on the 8th January or whether one was required to be opened on the 9th of January, what your view is about that. You will have to ask yourself, is the essence of the ACCT policy that it calls for an assessment of risk of self-harm or risk of suicide, is it the risk which has to be looked at, and is it the risk which leads a person to decide, well I think there's a risk so I must open an ACCT.
>
> Or is it, as Mr Odogwu has explored with all of the witnesses, that there are circumstances, at least as they prevail in Elmley, contrary to the spirit of both the national policy and its quicktime learning clarification, it's not so much risk which has to be assessed, but an event which must be responded to.
>
> If it's the event, it would seem that it doesn't matter how slight or how trivial in itself that event is, it dictates that an ACCT must be opened. If that is the correct interpretation, then you may think that the way in which you answer one or other of the questions posed is effectively set by that conclusion."

V. The jury's conclusion

35. I set out the jury's conclusions as to the death at [5] above. As to the questionnaire, the jury answered the first question "yes", and the second and third questions "no". Underneath their answers they added:

> "We suggest, having looked at the local and national ACCT policy documents, that the amendments to the national policy need to be reflected in the local Suicide Prevention and Self-Harm Management policy document."

VI. The challenge

36. These proceedings were filed on 13 October 2015 and Holman J granted permission on the papers on 24 November 2015. The challenge is based on four grounds. They are:

(1) The Assistant Coroner's direction to the jury on questions 2 and 3 of the jury questionnaire was unclear, incomplete and inaccurate, and/or misleading;

(2) The Assistant Coroner's presentation of the key evidence of Claire Cortez to the jury was inaccurate and/or misleading;

(3) The jury's findings on the inquisition are perverse and demonstrate that they could not have understood, and certainly failed properly to apply, the law prohibiting findings of opinion and recommendations in section 5 of the Coroners and Justice Act 2009; and

(4) The Assistant Coroner's "misdirection" was a breach of the procedural obligation arising from Article 2 of the European Convention on Human Rights.

37. It is submitted by Mr Odogwu, on behalf of the claimant, that the Assistant Coroner's summing up and directions to the jury were materially inadequate. He does not submit that there should be a new inquest and, as I have stated, the challenge is not to the record of inquest and the conclusions in it. It is to the jury questionnaire appended to the record of inquest.

VII. Analysis

38. There was substantial agreement between the parties as to the applicable principles. Both relied on *R (Anderson) v Inner North London Coroner* [2004] EWHC 2729 (Admin). Collins J (at [22]) stated that the summing up would not be subjected to a detailed analysis and the absence of a particular form of words or a particular direction would not be fatal, but "the absence of opening or closing speeches at inquests meant that the need for clarity when summing up became all the more important". He also stated that "the jury must know clearly what they must find as facts in order to justify any verdict" and reiterated the need for clarity later in his judgment: see [26].

39. The difference between the parties lay in relation to the application of these principles in considering the summing up and the jury questionnaire and the meaning of the national and the local ACCT policies and the relationship between them. Those policies are the responsibility of the Ministry of Justice, which did not participate in the proceedings and declined an invitation by those representing the Assistant Coroner to do so or to clarify its position in relation to the national and local policies.

Ground 1: Misdirection concerning ACCT policies

40. There are three limbs to this ground. The first is that the language in the excerpt from the summing up I have set out at [34] above was unclear. Particular criticism was made of what was said about "failure of system", the phrase "polarising the dichotomy", and the statement that the "dichotomy" was "between: is it mandatory to open an ACCT when a particular event occurs or is it mandatory to open an ACCT when the relevant official considers there is a risk of suicide or self-harm". It was a misdirection because the jury could not be clear from the direction what they were being asked to decide.

41. The second limb is misdirection in relation to the evidence of Mr Clarke, the prison's Safer Custody Manager, as to which see [16] above. Mr Clarke's evidence was that the local policy was based on the relevant parts of the national ACCT policy and he also stated, without challenge, that it was mandatory to open an ACCT in the event of a prisoner deliberately harming himself. Despite this, and what the Assistant Coroner has said about "the dichotomy", there was no reference to Mr Clarke's evidence in the summing up.

42. The third limb of this ground is that the statements (set out at [34] above) "if it's mandatory to open an ACCT simply on the event of self-harm … there doesn't seem to be any opportunity for the relevant member of staff to assess risk …" and that the

deceased's family had advanced the proposition (see [35] above) that it is "not so much risk which has to be assessed, but an event which must be responded to" were erroneous and misleading. This, submitted Mr Odogwu, was because both the policy and the undisputed evidence was that an immediate risk assessment was required once an ACCT was opened.

43. As to the first limb, the Assistant Coroner had earlier (see [26] above) told the jury that it was important that they appreciated the difference between a system failure and an operational issue within what is otherwise a proper and working system. But it is not clear whether in the later part of the summing up which is criticised the jury were being asked to consider whether there was a difference between the meaning of the national ACCT policy and that of the local policy, or whether they were being given directions about the implementation of the policies. Also, if the Assistant Coroner considered there was a dichotomy between the national and the local policy, he did not make that clear. In view of the way the case was presented before us, it may well be that any lack of clarity is in part a reflection of a failure by all at the inquest to make a distinction between the meaning of the policies and their operational implementation, and because both were regarded as questions of fact.

44. At the hearing in this court, Mr Odogwu's initial position was that the meaning of the ACCT policies was an issue of fact for the jury. Although in response to questions by the court, he stated that the meaning of the policies was a question of law, whereas whether they had been implemented was a question of fact, he nevertheless returned to the proposition that there was "no evidential basis" for a conflict or dichotomy between the national and local policies. The statement in paragraph 24 of the skeleton argument in support of the summing up by Ms Davies that "the policies themselves were items of evidence and the defendant acted consistently with his duties in raising the potential conflict" also fails to analyse the difference between determining the meaning of a policy and determining whether, on the particular facts of a case, there was a breach of that policy.

45. It also appears that, at the inquest, Mr Clarke's evidence was that the local policy was based on the relevant parts of the national policy. In fact, the local policy pre-dated PSI 64/2011 by some 18 months. Its language reflected that of the previous national policy, PSO 2700, and it may well have been based on that. It had not been revised in the light of the changes to the language of the national policy. I, however, agree with the Chief Coroner, a draft of whose judgment I have seen, that any difference between the two policies was not substantial.

46. In my judgment, it is clear, for example from *Tesco Stores Ltd v Dundee City Council* [2012] UKSC 13 at [18], [19] and [21], that if there is a dispute as to the meaning of words in a policy, the words "should be interpreted objectively in accordance with the language used, read always in its proper context", but not "as if they were statutory or contractual provisions". See also *R v Derbyshire County Council, ex p. Woods* [1997] JPL 958 *per* Brooke LJ and *R (Raissi) v Secretary of State for the Home Department* [2008] EWCA Civ 72, [2008] QB 836 at [118] – [123]. The meaning of a policy is not therefore a matter of fact to be determined by the jury.

47. I bear in mind that a coroner's summing up should not be subjected to a close forensic analysis, but the authorities show that in directing a lay jury the coroner must be clear. In this case, the Assistant Coroner failed to make a distinction in his summing up

between the meaning of the national and local ACCT policies and the way they were operated in the circumstances of the deceased's case. He did not direct the jury as to the meaning of the policies and in substance left it to them to decide whether there was a "dichotomy" between the national and local policies, and whether they were inconsistent. I consider that in these respects he fell into error. I have concluded that, on ground 1, the claimant's submissions are to be preferred.

48. Ms Davies submitted that, to the extent that there was any lack of clarity in the summing up in relation to the national and local policies, relief should be refused on the basis that it would have made no difference to the outcome. She maintained that the Assistant Coroner had properly directed the jury to consider whether there was a different approach between the national and local policies and that the outcome properly reflected the legal position that the national guidance is applicable unless there is cogent or rational reason for departure: see, in particular, *R (Munjaz) v Mersey Care NHS Trust* [2005] UKHL 58, [2006] 2 AC 148. She also relied on the evidence of Nurse Cortez that she had exercised discretion in deciding whether to open an ACCT or whether to increase the observations. Ms Davies submitted that Nurse Cortez had in substance complied with the national ACCT policy.

49. Ms Davies's submissions have force in relation to the answers to questions 1 and 3. They might have had more force if the relief sought was to set aside the Record of Inquest and to order a new inquest. But in circumstances in which the relief sought is to set aside the answers in the jury questionnaire and/or the handwritten words underneath those answers but not to order a new inquest, in my judgment they do not justify refusing any relief.

50. The battleground in this case concerns the aspects of the summing up which are relevant in determining the answer to question 2, "should the inpatient department have opened an ACCT on 8 January 2013 after the deceased drew attention to his deliberate act of self-harm". Mr Odogwu's criticisms, as seen in the discussion of the errors identified above, concerned this question and did not really go to questions 1 or 3. I do not consider that the answer "yes" to question 1, "was the decision to close the deceased's ACCT on 30 December 2012 a reasonable one", or the answer "no" to question 3, "should the inpatient department staff have opened an ACCT on 9 January 2013 on the deceased's return from court when he had become a convicted prisoner", would have been different had there been no misdirections of the sort I have described above. I do not, however, consider that the same can be said of the answer "no" to question 2. For these reasons, I also reject Ms Davies's alternative submission on ground 1.

Ground 2: Misdirection concerning Nurse Cortez's evidence

51. The Assistant Coroner's treatment of the evidence of Nurse Cortez was criticised on the ground that her evidence was, in essence, that the threshold for opening an ACCT was not met because the deceased had summoned attention, given up the item with which he had cut or scratched himself, and was futuristic in his conversation. Mr Odogwu submitted that the Assistant Coroner misdirected the jury when summarising her evidence by stating that Nurse Cortez "did not fear that he would carry out any attempt at suicide or that there was any further risk of self-harm" because she had accepted that she was concerned about self-harm and had raised the observations, and

she had also accepted that the threshold under the policy for opening an ACCT was met.

52. The use of the word "scratched" to describe the injury was criticised by Mr Odogwu as misleading and trivialising the harm. The nurse had recorded it as a superficial cut. Mr Odogwu also submitted that the Assistant Coroner's statement that it was Nurse Cortez's view, "after taking a certain amount of time with [the deceased] in the cell, considering what he had done, considering what he was saying to her, she did not fear that he would carry out any attempt at suicide or that there was any further risk of self-harm" was a misdirection. This, he submitted, was because in her evidence Nurse Cortez confirmed that she considered there to be a risk of the deceased self-harming and that the policy required her to open an ACCT on 8 January, and she apologised. The direction is also criticised for mis-stating what is described as the clear and unequivocal language of both the national and local policies.

53. The word "scratched" is a possibly unfortunate paraphrase of what Nurse Cortez said, but it does reflect the tenor of her evidence, which was that the incident was not a serious incident of its type. This part of the summing up was consistent with her evidence, which was that she had evaluated risk, that evaluation had disclosed some risk, but she had exercised judgment that it was insufficient to trigger opening an ACCT. Notwithstanding that, I agree with the Chief Coroner that it was a deliberate act of self-harm which should have triggered the operation of the ACCT policies. The failure to direct the jury as to the meaning of the policies, or to remind them that Nurse Cortez had accepted that the threshold for opening an ACCT had been met was, in my judgment, also a misdirection.

Ground 3: unlawful opinion and recommendation in jury's conclusion

54. Section 5(3) of the Coroners and Justice Act 2009 provides:

> "Neither the Senior Coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than–
>
> (a) the questions mentioned in subsection (1)(a) and (b) (read with subsection (2) where applicable;
>
> (b) the particulars mentioned in subsection (1)(c)".

The particulars mentioned in section 5(1)(c) are those required by the 1953 Act to be registered concerning the death.

55. The jury were advised that they could set out their essential findings in a short story or brief history, i.e. in a narrative conclusion, and expand on the questions and comment on any matter relevant to the death. Mr Odogwu did not criticise those parts of the summing up. He also did not criticise the parts of the summing up (see [25] – [26] and [31] above) which directed the jury to consider if there had been failures of system which might have caused the death, and to consider the wider circumstances. The line between a narrative expression of a finding and a comment on a matter relevant to the death, and an expression of opinion on a matter prohibited by section 5(3), can be a fine one. It has been stated, albeit *obiter,* that a short comment on the operation of the

regulatory system is permissible even though it is not causative of the death: see *R (Lewis) v Midland North Shropshire Coroner* [2009] EWCA Civ 1403, [2010] 1 WLR 1836 at [11], [35], and [37]. It is, however, the duty of the coroner and not the jury to refer matters to an appropriate person to enable action to be taken to prevent similar fatalities in the future: see paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009.

56. In the circumstances of this case, where the purposes of inquest include the purpose of ascertaining in what circumstances the deceased came by his death and opinions on that are expressly permitted by section 5(3)(a), I consider the handwritten words may properly be regarded as a comment or a conclusion upon the questions or an aspect of them. I bear in mind Pill LJ's statement in *R (Scholes) v Secretary of State for the Home Department* [2006] EWCA Civ 1343 that the conclusions of the jury on policy issues are less helpful than those on factual issues. But the comment in that case dealt with the policy not to send young offenders straight into local authority secure units and referred to the level of resources. The words here are very different. They are not a conclusion on a policy issue and not, in substance, a recommendation, but are simply a comment on the matters concerning the national and local policies, a reflection on the difference in the wording of two policy documents about the same issue because the local policy had not been updated. All that is stated is that the amendments to national policy need to be reflected in the local policy. In the light of the information that emerged at the hearing before this court, that the local policy pre-dated the national policy and had not been updated as a result of the significant change in wording from the former policy, there is in my judgment much sense in what the jury said. But that comment was made in the shadow of the matters which have led me to conclude that the claimant succeeds on ground 1 and that the answer to that question should be set aside.

Ground 4: breach of Article 2 ECHR

57. In the light of my conclusion on ground 1, it follows that the narrative conclusion in the answer to question 2 is unsafe and to this extent the procedural obligations under Article 2 of the European Convention on Human Rights were not discharged by the inquest. It is accepted on behalf of the claimant (see [5] above) that they have been met by the inquest investigation and the decision and order of this court.

The Chief Coroner:

58. I agree. For the reasons set out by my Lord the claimant succeeds on Ground 1. In particular the Assistant Coroner could have done more to help the jury about the two ACCT policies, the national ACCT policy and the local ACCT policy. It was his duty to explain them, their meaning insofar as was relevant, and the effect of the differences, if any. He did not do so with sufficient clarity.

59. For my part, on the facts of this case, the difference between the two policies was not substantial. It is true that the wording was not precisely the same. That was because the local policy followed the wording of the earlier national policy and had not been updated. Nevertheless, both policies directed attention to the necessity of opening an ACCT statement in the event of an incident of self-harm. In this case there was such an incident.

60. It is true that the incident could be considered at the less serious end of the spectrum of self-harm. Whether described as a scratch or a cut or a scrape, it was not the most serious incident of its type. But it was still self-harm. It was a deliberate act of self-harm across the wrist. As such it was the duty of Nurse Cortez to take action under the ACCT policies. It would then be for others to decide on a full assessment of risk and how to devise and implement appropriate action.

61. In my judgment both the national and the local ACCT policies were triggered. Under the national policy, all that is required is that a 'member of staff "receives information" or "observes 'behaviour" which "may indicate a risk of … self-harm". Nurse Cortez had received such information and had observed the result of a self-harm incident for herself. It goes without saying that an incident of self-harm indicates a risk of self-harm. Self-harm, even if not serious, indicates a risk of self-harm.

62. Similarly, under the local policy an ACCT plan must be opened 'in the event of any incident of self-harm'. There was such an incident. The plan should have been opened. The differences between the policies, such as they were, were not significant. Both are mandatory. Both should be followed.

63. These are long-standing policies which are (or should be) well understood. They are in place for a very good reason, to protect the vulnerable who are at risk from themselves. The policies should therefore be followed in the absence of cogent reasons to the contrary: see *R (Munjaz) v Mersey Care NHS Trust* [2005] UKHL 58, [2006] 2 AC 148. In this case not only had self-harm occurred, a cut on the wrist with an implement, but the deceased had gone to the prison staff for support by reporting it. He was considered to be low in mood at the time. And he said that he had been taken by surprise at court that day when his former partner/girlfriend had unexpectedly given evidence against him and he felt that suddenly he was facing a four year sentence. It is not surprising that Nurse Cortez decided on those facts to increase observations. She should, in my judgment, have done more and followed the ACCT policies.

64. In these circumstances the Assistant Coroner should have done more to help the jury in the first instance with an objective view of the meaning of the policies (after hearing submissions from counsel in the event of differing views), rather than leaving to them what he called the polarity of the dichotomy. He could then have directed the jury that, although it was a matter for them on the facts as they found them on the evidence, they might wish to conclude that an incident of self-harm had occurred, as a result there was a risk of further self-harm, and that Nurse Cortez therefore had had a duty to follow the ACCT polices and open a plan but did not.

65. I would also add that coroners, however well intentioned, should do their best in directing a jury to avoid using language which is not in everyday use, language which may not be clearly understood. Words such as "polarising the dichotomy" and "descriptor" are not helpful.

66. The claimant does not ask for a fresh inquest. I agree that it would be unnecessary and serve no useful purpose. I also agree that sufficient relief is provided by the quashing of Question 2 and the jury's answer, together with the provision of these judgments which explain the reasons for it. The jury's additional handwritten words are not

unlawful. They do little more than draw attention to the fact that the local ACCT policy had not been updated, which was correct.