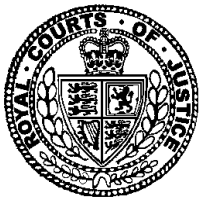

Neutral Citation Number: [2016] EWHC 1892 (Admin)

Case No: CO/3068/2015

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 26/07/2016

Before :

LORD JUSTICE BURNETT
And
MRS JUSTICE LANG

- -

Between :

Zifforah Tyrrell	**Claimant**
- and -	
HM Senior Coroner County Durham and Darlington	**Defendant**
- and -	
The Ministry of Justice	**Interested Party**

- -
- -

Matthew Stanbury (instructed by **Lester Morrill Solicitors**) for the **Claimant**
Peter Skelton QC (instructed by **Durham County Council**) for the **Defendant**
Louis Browne (instructed by the Government Legal Department) for the **Interested Parties**

Hearing dates: 12th July 2016

- -

Approved Judgment

Lord Justice Burnett :

Introduction

1. The issue in these judicial review proceedings concerns the question of what article 2 of the European Convention on Human Rights ("ECHR") requires of a coroner when a serving prisoner dies of natural causes. Michael Tyrrell, the claimant's father, died of pneumonia secondary to cancer on 30 May 2013. Although he was in hospital at the time, he remained in custody and under guard. An investigation followed by the Office of the Prison and Probation Ombudsman ("PPO") which concluded that the death was a natural one. It looked at the quality of care which had been afforded to the deceased. The coroner, with the benefit of that report, obtained evidence from a number of treating doctors. The claimant provided independent medical evidence reviewing the quality of her father's care, and in particular whether his cancer should have been diagnosed earlier. The evidence pointed irresistibly to the conclusion that the death was from natural causes. In those circumstances the coroner determined on 9 March 2015 that Article 2 ECHR did not impose upon him any obligation of further investigation. He expressed that by saying that "article 2 is not engaged" and proceeded to hold an inquest at which the medical evidence was taken through his coroner's officer, the only witness called. The coroner recorded a conclusion of death by natural causes. The coroner's reference to article 2 in this context was to the procedural obligation recognised by the Strasbourg Court to arise in some cases of death, rather than the substantive obligations which article 2 imposes on state parties to the ECHR.

2. The latest annual report of the PPO indicates that about 250 deaths occur in the prisons in England and Wales each year of which something over two thirds are from natural causes. A very small number result from violence, or are otherwise unnatural, and between a quarter and a third are from suicide.

3. The claimant submits that Strasbourg and domestic authority required the coroner to conduct what is described as a "Middleton inquest", a reference to the decision of the House of Lords in *R (Middleton) v West Somerset Coroner* [2004] 2AC 182. The claimant's argument is that the fact of the death having occurred in custody is sufficient to trigger an obligation to conduct an article 2 compliant inquest as described in the *Middleton* case. On her behalf, Mr Stanbury accepts that there is nothing in the factual circumstances of this case which suggests that there was any systemic failing on the part of the prison authorities to provide appropriate medical care to the deceased. He accepts that there is no support for the suggestion that the care provided by the National Health Service was sub-standard or that there was negligence on the part of treating doctors. He accepts that if the deceased had not been in custody but had received precisely the same care and treatment from the NHS as a patient at liberty, then there would have been no obligation under article 2 for the coroner even to hold an inquest. Indeed, Mr Stanbury was unable to identify any practical difference between the investigation in fact conducted by the coroner into this sad death, including the short inquest, and one which would have followed had the coroner decided that "article 2 was engaged" in the sense that the procedural obligation was triggered by the death.

4. A Middleton inquest, in the language of the coronial jurisdiction, is contrasted with a "Jamieson inquest" which is one conducted without the additional structure of the

article 2 procedural obligation. It is named after the case of *R v HM Coroner for North Humberside ex parte Jamieson* [1995] QB 1. Neither *Middleton* nor *Jamieson* was concerned with the scope of inquiry of an inquest but with the outcome, in the *Jamieson* case the availability of a conclusion including "neglect" and in the *Middelton* case whether article 2 ECHR required an expansion of the conclusions with which the inquest should culminate. The House of Lords concluded that the only change required to the coronial regime was the inquest "ought ordinarily to culminate in an expression, however brief, of the jury's conclusion on the disputed factual issues at the heart of the case." (para 20). This would be achieved by interpreting the words "how the deceased came by his death", which was and is the relevant statutory formulation, to mean not simply "by what means" but "by what means and in what circumstances." (para 34).

The facts

5. Given the high level of legal abstraction at which the claimant's arguments have been advanced I shall trace the underlying facts relatively briefly. Mr Tyrrell, who was 65 years old when he died, had been sentenced to 26 years' imprisonment in 2002 for drugs importation. He moved to HMP Frankland in June 2005. In May 2012 he complained of a sore throat and was diagnosed with a dental infection which resulted in the removal of some teeth in June. Pain persisted. A specialist ear nose and throat investigation followed which found nothing abnormal. A biopsy revealed sialadenitis; but problems persisted. A maxillofacial specialist was next involved and he was referred for an MRI scan in February 2013. None of those who had seen Mr Tyrrell had suspected that he might be suffering from cancer. Before the scan was carried out Mr Tyrrell's condition deteriorated and so he was admitted to hospital. On 4 March 2013 an exploration under anaesthetic was performed which revealed a malignant tumour under the tongue. A CT scan followed which confirmed that the mass was four centimetres across. The lymph nodes were involved, as was confirmed on post-mortem.

6. Chemotherapy and radiotherapy were undertaken but Mr Tyrrell developed bilateral pneumonia which was the immediate cause of death.

7. Mr Tyrrell died in the University Hospital of North Durham. His death was notified to the coroner, Andrew Tweddle. An inquest was opened and adjourned. The death was also notified to the PPO. The PPO is a non-statutory body which operates pursuant to Memoranda of Understanding with the Ministry of Justice, under whose auspices it operates. It is functionally independent of the Ministry and of the Prison Service. One of its functions is to investigate any death of a person in custody. It did so in this case and produced a report in January 2014. The PPO examined the dealings of Mr Tyrrell with all clinicians who visited the prison, the prison medical and dental staff as well as reviewing the treatment he had received externally. The PPO was concerned with the way in which Mr Tyrrell was managed as a prisoner during his illness, including questions of whether he might have been released on temporary licence in the final stage of his illness and the conditions of security maintained at the hospital. Mr Tyrrell's family were engaged with the PPO investigation. A clinical review was commissioned by the PPO which examined the complete history of Mr Tyrrell's medical dealings since his imprisonment. The reviewers concluded that the diagnosis of the terminal illness was made appropriately and that the post-diagnosis treatment was conducted to an appropriate standard. The

result was that the PPO was satisfied that the clinical care provided to Mr Tyrrell was equivalent to that which he would have obtained in the community. It looked at a large number of detailed questions posed by his family concerning both the medical attention he received and documents and information management.

8. The report, including the clinical review, was provided to the coroner. The post mortem examination report established the cause of death, which was uncontroversial. The coroner did not rest upon the PPO investigation without more. He commissioned medical evidence with a view to exploring further the question whether the diagnosis of Mr Tyrrell's cancer had been timely. He held two pre-inquest reviews. In May 2014 the claimant instructed Professor Christopher Nutting, Clinical Director and Head of Neck and Lung Cancer Units at the Royal Marsden Hospital, to conduct a complete review of the treatment received by Mr Tyrrell. He reported on 5 August 2014. He described the tumour as relatively rare and notoriously difficult to diagnose. Although the original throat pain was likely to have been caused by the early development of a tumour Professor Nutting was not critical of the various medical staff who dealt with Mr Tyrrell. It was not until mid-February 2013 that the symptoms were such that a diagnosis became feasible, although it was not suspected by the clinicians. Professor Nutting's report provides no foundation for any suggestion of negligence on the part of the many medical practitioners who examined or treated Mr Tyrrell in the year before his death, still less of any systemic failings in the medical care provided by or through the prison medical services or the NHS. The position adopted by Mr Tyrrell's family was that they wished to explore further whether there was negligence in the late diagnosis of the tumour.

9. It was in all these circumstances that the coroner decided that no further investigations were called for and that article 2 ECHR did not dictate any further action on his part.

The statutory regime

10. The functions and duties of coroners are now set out in the Coroners and Justice Act 2009 ("the 2009 Act"). By section 1(2) the coroner is under a duty to investigate three categories of death:

    (a) Those where the deceased died a violent or unnatural death;

    (b) Those where the cause of death is unknown; and

    (c) Those where the deceased died whilst in custody or otherwise in state detention.

11. Section 4 requires the coroner to discontinue the investigation if a post-mortem examination reveals the cause of death and the coroner considers that it is unnecessary to continue the investigation. However, that requirement does not apply to deaths which were violent or unnatural or when the deceased died in custody or otherwise in state detention. Thus the effect of section 4 is that there must always be an inquest into the death of someone who has died in custody or otherwise is state detention. That is not a new provision. In its modern statutory form the requirement to hold an inquest into the death of somebody in prison can be traced back to section 3 of the Coroner's act 1887, which itself was a consolidating Act. The rationale is clear. There is a need for independent public scrutiny of any such death, whether it is the

result of violence or not, to expose to public scrutiny the full circumstances. That enables any wrong doing or failures to be exposed and otherwise provides proper reassurance that nothing untoward has occurred. For centuries the common law and then Parliament recognised that when an individual dies whilst in the custody of the state there must be a public accounting to explain how the deceased came by his death.

12. Section 5 of the 2009 Act identifies the matters which must be ascertained at an inquest. It provides:

> "(1) The purpose of an investigation under this Part into a person's death is to ascertain –
>
> (a) who the deceased was;
>
> (b) how, when and where the deceased came by his death;
>
> (c) the particulars (if any) required by the 1953 Act to be registered concerning the death.
>
> (2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998 (c. 42), the purpose mentioned in subsection 1(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.
>
> (3) Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express an opinion on any other 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).
>
> This subject to paragraph 7 of Schedule 5."

The reference to paragraph 7 of schedule 5 relates to action to prevent other deaths. It enables coroners to make a report to a person with power to take action which, in the coroner's opinion, might prevent deaths.

13. The purpose of the investigation identified in Section 5 of the 2009 Act is in precisely the same form as appeared in the antecedent legislation, save for subsection 2. Subsection 2 reflects the conclusion of the House of Lords in the *Middleton* case that the only adjustment needed to the statutory scheme to secure compliance with the procedural obligation of article 2 ECHR was to enable the coroner or jury state their conclusions on the circumstances in which the deceased came by his death.

Article 2 ECHR

14. Article 2(1) ECHR provides that "[e]veryone's right to life shall be protected by law". It imposes substantive obligations on the state. The first is a negative obligation

which prohibits the intentional and unlawful taking of life by agents of the state. Secondly, it imposes a positive obligation upon the state to safeguard life. This requires the state to put in place a legislative and administrative framework which protects the right to life. That includes the need for criminal and civil laws and an effective law enforcement and judicial system, including a system that investigates death. The positive obligation includes an operational duty which requires the state to take reasonable steps to protect life when it knew or ought to have known of a real and immediate threat to life. This is known as the *Osman* duty: see *Osman v United Kingdom* (2000) 29 EHRR 245 at para 116.

15. Article 2 also gives rise to a procedural obligation in certain circumstances. In the *Middleton* case, Lord Bingham encapsulated the procedural duty at para 3:

> "The European Court has also interpreted article 2 as imposing on member states a procedural obligation to initiate an effective public investigation by an independent official body into any death occurring in circumstances in which it appears that one or other of the foregoing substantive obligations has been, or may have been, violated and it appears that agents of the state are, or may be, in some way implicated. See, for example, *Taylor v United Kingdom* (1994) 79-A DR 127, 137; *McCann v United Kingdom* (1995) 21 EHRR 97, para 161; *Powell v United Kingdom*, *supra* p 17; *Salman v Turkey* (2000) 34 EHRR 425, para 104; *Sieminska v Poland* (App No 37602/97, unreported, 29 March 2001); *Jordan v United Kingdom* (2001) 37 EHRR 52, para 105; *Edwards v United Kingdom*, *supra*, para 69; Öneryildiz *v Turkey*, *supra*, paras 90-91; *Mastromatteo v Italy* (App No 37703/97, unreported, 24 October 2002)."

16. Violent deaths in prison, whether self-inflicted or otherwise, give rise to the procedural obligation so described. As Lord Rodger of Earlsferry put it in *R (L(a Patient)) v Secretary of State for Justice* [2009] 1 AC 588, at para 59:

> "Whenever a prisoner kills himself, it is at least *possible*, that the prison authorities, who are responsible for the prisoner, have failed, either in their obligation to take general measures to diminish the opportunities for prisoners to harm themselves, or in their operational obligation to try to prevent the particular prisoner from committing suicide. Given the closed nature of the prison world, without an independent investigation you might never know. So there must be an investigation of that kind to find out whether something did indeed go wrong. In this respect a suicide is like any other violent death in custody. In affirming the need for an effective form of investigation in a case involving the suicide of a man in police custody, the European court held that such an investigation should be held "when a resort to force has resulted in a person's death": *Akdogdu v Turkey, para 52"*

17. The link between the procedural obligation and a possible breach of the substantive obligations of article 2 was restated by the House of Lords in *R(Gentle) v Prime*

Minister [2008] 1 AC 1356, paras 5, 27, 39-40. The procedural obligation that arises in such cases was summarised by Lord Bingham in the *Middleton* case at para 10 by reference to paras 105 and 107 of *Jordan v United Kingdom* (2001) 37 EHRR 52:

> "*Jordan v United Kingdom* arose from the fatal shooting of a young man by a police officer in Northern Ireland. The Court found a violation of article 2 in respect of failings in the investigative procedures concerning the death. The Court held:
>
> > "105 The obligation to protect the right to life under Article 2 of the Convention, read in conjunction with the State's general duty under Article 1 of the Convention to 'secure to everyone within [its] jurisdiction the rights and freedoms defined in [the] Convention', also requires by implication that there should be some form of effective official investigation when individuals have been killed as a result of the use of force. The essential purpose of such investigation is to secure the effective implementation of the domestic laws which protect the right to life and, in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility. What form of investigation will achieve those purposes may vary in different circumstances. However, whatever mode is employed, the authorities must act of their own motion, once the matter has come to their attention. They cannot leave it to the initiative of the next-of-kin either to lodge a formal complaint or to take responsibility for the conduct of any investigative procedures . . .
> >
> > 107 The investigation must also be effective in the sense that it is capable of leading to a determination of whether the force used in such cases was or was not justified in the circumstances and to the identification and punishment of those responsible. This is not an obligation of result, but of means. The authorities must have taken the reasonable steps available to them to secure the evidence concerning the incident, including *inter alia* eye witness testimony, forensic evidence and, where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death. Any deficiency in the investigation which undermines its ability to establish the cause of death or the person or persons responsible will risk falling foul of this standard." "

18. This is the procedural obligation for which the claimant contends, submitting that the same reasoning which the Strasbourg Court has applied in cases involving violent deaths in custody should apply to any death in custody, whatever its cause.

Deaths from natural causes and in consequence of medical error

19. The Strasbourg Court has considered the positive obligation to protect life under article 2 in the context of deaths in custody attributable to poor medical facilities or treatment. The relevant cases were collected together by Lang J in *Daniel v St George's Healthcare NHS Trust* [2016] EWHC 23 (QB); [2016] 4 WLR 32 between paras 22 and 27. So, for example, in *Tarariyeva v Russia* (2009) 48 EHRR 26 the Strasbourg Court said, when discussing the general principles applicable to the protection of the right to life:

> "73 The Court reiterates that … art.2 … requires the state not only to refrain from the "intentional" taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction. In the context of prisoners, the Court has already emphasised in previous cases that persons in custody are in a vulnerable position and that the authorities are under a duty to protect them. It is incumbent on the state to account for any injuries suffered in custody, which obligation is particularly stringent where the individual dies.
>
> Those obligations apply in the public-health sphere too. The positive obligations require states to make regulations compelling hospitals, whether private or public, to adopt appropriate measures for the protection of patients' lives. They also require an effective independent judicial system to be set up so that the cause of death of patients in the care of the medical profession, whether in the public or the private sector, and those responsible made accountable. Furthermore, where a hospital is a public institution, the acts and omissions of its medical staff are capable of engaging the responsibility of the respondent State under the Convention."

20. The applicant, who was the mother of the deceased, complained that her son had died in custody in consequence of inadequate and defective medical treatment. The treatment afforded to the deceased in that case, who suffered from chronic ailments and was in custody for two years before his death, was subjected to detailed scrutiny by the Strasbourg court and was considered to be seriously wanting. A violation of article 2 was found on that basis. In a separate section the court considered the "adequacy of investigation" at para 90 and following. But it did so not by reference to the procedural obligation discussed in the *Jordan* case but as part of the positive obligation:

> "The Court has also to examine whether the respondent Government discharged their obligation under art.2 to put at the applicant's disposal an effective judicial system, enabling liability for the loss of life to be established and any appropriate redress to be obtained."

The court continued by examining the criminal process that followed the death and the civil claim for compensation. The court concluded that the processes available did not establish the cause of death or make those responsible accountable. It considered

the criminal proceedings inadequate and that there was no accessible and effective civil remedy available, para 102. The conclusion in para 103 was that Russia had failed to discharge the positive obligation under article 2 "to determine in an adequate and comprehensive manner the cause of death of Mr Tarariyev and bring those responsible to account."

21. This approach is consistent with the way in which the Strasbourg Court has approached the question of investigation of "medical deaths" in general, which was fully discussed by Richards J in *R (Goodson) v Bedfordshire and Luton Coroner* [2006] 1 WLR 432 and by the Court of Appeal in *R (Takoushis) v Inner North London Coroner* [2006] 1 WLR 461.

22. A clear statement of the nature of the investigation required by the ECHR of a death in custody from medical causes is found in *Kats v Ukraine* (2010) 51 EHRR 44. The applicants were the parents and son of a prisoner who died in custody of an HIV related illness. The Strasbourg Court concluded that there had been a violation of the positive obligation under article 2 as a result of a failure to safeguard the life of the deceased. The prison authorities were aware of the deceased's HIV status and there was a striking failure to give her medical attention. Her death was the result of inadequate medical assistance. In addition the court found a violation of article 2 in respect of the lack of an adequate investigation into the circumstances of the death. It is instructive to see how the court described the investigative duties which arise as part of the positive obligations under article 2 and contrasted them with the procedural obligation which arises when the responsibility of the state for the death is "potentially engaged", as it was in this case as a result of the wholly inadequate nature of the medical facilities and treatment available.

23. In discussing the failure to protect the deceased's life the court noted, para 101 and 102, the different factual contentions of the parties: on the one hand the applicants said that the authorities were well aware of her condition which they failed to treat, and on the other the state suggested that the death resulted from an unpredictable development of the illness which had occurred before the deceased went into custody but of which she failed to inform the authorities. That issue was resolved in favour of the applicants, para 112. The Strasbourg court reiterated, para 103, that the state was under an obligation to take appropriate steps to safeguard the lives of those within its jurisdiction before continuing:

> "104 Persons in custody are in a particularly vulnerable position and the authorities are under an obligation to account for their treatment, Having held that the Convention requires the state to protect the health and physical well-being of persons deprived of their liberty, for example, by providing them with the requisite medical assistance, the Court considers that, where a detainee dies as a result of a health problem, the state must offer an explanation as to the cause of death and the treatment administered to the person concerned prior to his or her death.
>
> As a general rule, the mere fact that an individual dies in suspicious circumstances while in custody should raise an issue

> as to whether the state has complied with its obligation to protect that person's right to life."

24. The Strasbourg Court was making two different points in these sub-paragraphs. First, that whenever someone dies in custody an explanation of the cause of death must be provided, including (if it be the case) a narrative of medical treatment provided. The second point, which was echoed by Lord Rodger in the *L* cases quoted in [16] above, was that a suspicious death in custody inevitably raises the question of a breach of article 2 on the part of the authorities. The consistent jurisprudence of the Strasbourg Court is that in this second circumstance the procedural obligation arises of the sort considered in the *Jordan* case, and which was in issue in the *Middleton* case.

25. Because of the egregious nature of the failure of medical care in this case, the Strasbourg Court went on to consider whether there was a violation of the procedural obligation under article 2. The responsibility of the state for the death was potentially engaged and so the procedural obligation arose, para 117. The court had encapsulated the triggering principle as being "when a detainee dies in suspicious circumstances, an "official and effective investigation" capable of establishing the causes of death and identifying and punishing those responsible must be carried out of the authorities' own motion." The court went on to examine the nature of the investigation by reference to the *Jordan* criteria (although it referred to them through *Slimani v France* (2006) 43 EHRR 49).

26. In my judgment the reasoning of the Strasbourg Court demonstrates that the *positive* obligations under article 2 encompass a duty to account for the cause of any death which occurs in custody. The procedural obligation arises only in circumstances where the responsibility of the state is engaged in the sense that there is reason to believe that the substantive positive obligations (identified by Lord Bingham in the *Middleton* case) have been breached by the state. In the case of deaths in custody the procedural obligation will be triggered in the case of all suspicious deaths, including apparent suicides, for the reason given by the Strasbourg Court in the *Kats* case. The distinction between these two types of case is principled. The essence was captured by Lord Bingham in para 6 of the *Middleton* case:

> "The death of any person involuntarily in the custody of the state, otherwise than from natural causes, can never be other than a ground for concern."

27. Unless there is binding domestic authority which dictates a different outcome it follows that the Coroner was correct to decline to conclude that the procedural obligation under article 2 was engaged. The evidence showed unequivocally that the death of Mr Tyrrell was from natural causes. There was no reason to suppose that the state in the guise of the prison authorities had failed to protect his health and well-being. On the contrary, the indications were that he had received appropriate treatment both within the prison and from the NHS.

28. Mr Stanbury has drawn our attention to an observation of Smith LJ in the Court of Appeal in *R (Humberstone) v Legal Services Commission* [2011] 1 WLR 1460 at para 58 which he submits supports the broad proposition for which he contends. The case concerned the refusal of a grant of legal aid for representation at an inquest. Legal aid was generally granted only if the inquest was to be conducted in accordance with the

Middleton case to ensure compliance with the procedural obligation under article 2. The only reasoned judgment was given by Smith LJ. It was concerned, for the most part, with a discussion of deaths which were said to have been the result of a medical failure. That gave rise to consideration of both the *Goodson* and *Takoushis* cases. In summarising the reasoning of Richards J in *Goodson* her Ladyship said that "a specific obligation proactively to conduct an investigation [arises] where the death occurs while the deceased is in the custody of the state." This observation was not made in the context of a discussion of a death from natural causes and was, in any event *obiter*.

29. Mr Stanbury also relied upon a sentence in the judgment of Lord Hope of Craighead in *R (Smith) v Oxfordshire Assistant Deputy Coroner* [2011] 1 AC 1 at para 98 where he said:

> "Some situations in which the procedural obligation is triggered are now well recognised. The suicide of an individual while in the custody of the state is the prime example. It has been extended to the case where a prisoner attempted to commit suicide while in custody and suffered brain damage: *R (L (A Patient)) v Secretary of State for Justice (Equality and Human Rights Commission intervening)* [2009] AC 588. This is because it has been recognised that prisoners as a class present a particular risk of suicide and because those who have custody of them, as agents of the state, are or may be in some way implicated. A *Middleton* inquest is required in all these cases, because it is at least possible that the prison authorities failed to take the steps to protect the prisoner's life that the substantive right requires. As Lord Rodger of Earlsferry said in *L's* case, para 59, suicide is in this respect like any other violent death in custody. **The procedural obligation extends to prisoners as a class irrespective of the particular circumstances in which the death occurred.** The fact that they are under the care and control of the authorities by whom they are held gives rise to an automatic obligation to investigate the circumstances. The same is true of 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 Mental Health Acts: *Savage v South Essex Partnership NHS Foundation Trust (MIND intervening)* [2009] AC 681. This approach has the merit of clarity. Everyone knows from the outset that the inquest in these cases must follow the guidance that was given in *Middleton*, paras 36-38."

30. The *Smith* case raised two issues. The first concerned the jurisdictional reach of the ECHR. The second concerned whether there should be a Middleton inquest on the basis that there was reason to believe that the death of Private Smith gave rise to a possibility that the United Kingdom was in breach of its article 2 obligations. He died on duty at a British Army base in Iraq from hyperthermia whilst working in extreme heat. This passage from Lord Hope's judgment forms part of his discussion of the second issue. He, along with all members of the court concluded that the

circumstances of the death triggered the procedural obligation because of the potential responsibility of the state. The sentence in bold, if read out of context, provides support for the claimant's contention. But it is no more than a reflection of the position adopted by Lord Rodger in the *L* case (which Lord Rodger quoted from and repeated in his judgment in *Smith*) to the effect that any suspicious death in custody (including one apparently the result of suicide) gives rise to the procedural obligation. On this aspect of the case Lord Phillips gave a judgment with which Lord Walker, Lady Hale, Lord Brown, Lord Collins and Lord Kerr agreed. Lord Hope, Lord Rodger and Lord Mance all reached the same conclusion, namely that the procedural obligation arose on the facts of the case, but gave their own reasons.

31. Lord Phillips of Worth Matravers encapsulated the difference between a preliminary inquiry to establish whether an article 2 investigation was called for on the facts surrounding any death, and an article 2 investigation itself, in para 70 of his judgment:

> "The duty to hold an article 2 investigation arises where there are grounds for suspecting that a death may involve breach by the State of one of the substantive obligations imposed by article 2. This raises the question of how the State is to identify that there are grounds for such suspicion. 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. Where the first stage shows that the death has not, or may not have, resulted from natural causes, there will be a requirement for a further stage or stages of the investigation. 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 a substantive article 2 obligation."

32. He continued by explaining that in England and Wales such a staged approach is embedded in the coronial jurisdiction. In my view Lord Phillips' explanation mirrors the approach of the Strasbourg Court in requiring the state to account for a death of someone in its custody as part of the substantive obligation arising out of the duty to set up laws and systems to protect the right to life with the procedural only arising if there are grounds to believe that the state may have breached its substantive obligations to safeguard life.

33. There is nothing in domestic authority which requires a different conclusion from that suggested by the Strasbourg jurisprudence. I am satisfied that the coroner was correct to rule that the procedural obligation under article 2 ECHR did not arise in this case. It would not arise in any case where it is established that the death arose from natural causes and there is no reason to believe that the state failed to protect the life of the prisoner in question. The Strasbourg authorities discussed in the *Daniel* case suggest that in the context of a natural death in custody the responsibility of the state for the purposes of the duty to protect life will arise only if there has been a failure to provide timely and appropriate medical care to a detainee obviously in need of it. The *Osman* test is applied in the context of the provision of medical care to those dependent upon the detaining authority to provide it.

The Chief Coroner's guidance

34. In coming to his conclusion that the procedural obligation under article 2 was not engaged the coroner had regard to guidance and advice issued by the Chief Coroner. Such guidance and advice is designed to assist coroners in the discharge of their duties and, in particular, to give a clear indication of the correct approach to a wide range of legal issues which they might be expected to encounter. It is not binding on coroners nor is it an authoritative statement of the law, as the guidance itself recognises, which may come only from the courts.

35. On 5 January 2015 the Chief Coroner published advice to coroners relating to the deaths in prison and the need for a post-mortem examination. He indicated that where "a death may be unnatural or suspicious the coroner should request a forensic post-mortem examination." He continued:

> "5. On the other hand where a patently natural death has occurred there may be no need to request a forensic examination. For example, where a member of the increasingly elderly prison population dies expectedly after a long illness, there may be no need for a forensic post-mortem examination. There may be no need for a post-mortem at all.
>
> 6. Obviously the death of a prisoner in custody must always be treated with special care and fully investigated. There will be an inquest in all cases. Therefore the coroner will err on the side of caution in exercising his or her discretion.
>
> 7. But where the death is clearly natural from the outset and where the police have attended early, made initial investigations and obtained the prisoner's clinical record, the coroner should be less ready to request a post-mortem examination, particularly a forensic examination. To do so may be unnecessary in the public interest (and also expensive)."

36. This advice was given in the knowledge that all deaths of custody provoke a police response, with a view to identifying whether there are any suspicious circumstances, and the certification in the case of a natural death by an independent medical examiner. I agree that there will be cases of natural death of those in state detention which do not require a post-mortem examination. The uncontroversial certification of the cause of death by a medical practitioner independent of the detaining authority will be sufficient to discharge the state's obligation to establish the cause of death in many cases.

37. There is no guidance directly on the question whether all deaths in custody attract the procedural duty under article 2 ECHR but the Chief Coroner has issued guidance (Guidance No. 16) for those who die subject to Deprivation of Liberty Safeguards ("DoLS"):

> "61. The mere fact that the inquest will be concerned with a death 'in state detention' does not mean that it will necessarily

> be an Article 2 inquest. In some cases it may be. But in many cases, particularly those where the death is from natural causes, there will be no arguable breach of the state's general duty to protect life. Nor will there be any arguable breach of the *Osman* test that the state knew or ought to have known of a real or immediate risk to the life of the deceased and failed to take measures within the scope of their powers: *Osman v UK* [1998] 29 EHRR 245."

38. I respectfully agree with this guidance from the Chief Coroner as regards those who die the subject of DoLS and endorse it as a correct statement of the law with respect to deaths in custody and state detention. It reflects both Strasbourg and domestic law.

Conclusion

39. Mr Tyrrell's death was, from the outset, one which was clearly from natural causes. The cause of death was established and then confirmed on post-mortem examination. There was no indication of state involvement in his death of the sort that would trigger the procedural obligation under article 2 ECHR. The coroner was right to conclude that the procedural obligation was not engaged. In those circumstances this claim for judicial review will be dismissed.

MRS JUSTICE LANG:

40. I agree.