Art 2 Inquests: Local Authority care is not state detention – but having a wide scope whilst keeping an open mind is a good idea

written by Imogen Hildred | 25 January 2022

***R (Boyce) v HM Senior Coroner for Teesside and Hartlepool (and (1) Middlesbrough Borough Council (2) Tees Valley Care Ltd)* [2022] EWHC 107 (Admin)**

There can be no dispute that Article 2 procedural obligations will extend to all violent deaths and suicides of those in state detention, such that a full Article 2 inquest must automatically follow such a death. But it was a step too far to suggest that a child in care who had been placed in a care home by a Local Authority was in state detention. The child in this case had been placed in a *private* care home. The child was not detained at the care home, and that home was not, in the judge's view, a functional public authority that might owe ECHR obligations to its residents.

Furthermore, the Claimant's argument that the Coroner had erred in law when she suggested that there was no difference between the scope of this non-Art 2 inquest and an Art 2 inquest was not sustainable. The scope of Art 2 and non-Art 2 inquests were not necessarily different, a Coroner conducting a non-Art 2 inquest could choose to look at the same circumstances that an Art 2 inquest must cover.

The background

Grace Peers was 15 years old when she was found hanging in the shower cubicle of her bedroom. Grace was in the care of the Local Authority which had placed her in the private care home where she died. At Grace's inquest the Coroner determined that there was insufficient evidence that there had been a real and immediate risk to Grace's life and accordingly that there had been no breach of the operational duty under Article 2.

Notwithstanding her conclusion that there was no engagement of the operational duty under Article 2, the Coroner indicated that she remained open to considering whether there were flaws in higher level systems which gave rise to an arguable breach of the Article 2 general duty of the state. She directed that independent expert evidence be obtained into a number of specific matters. Having considered that expert evidence, the Coroner concluded that any systemic failure in care home policies and procedures had not caused or contributed to Grace's death. Given the level of care Grace in fact received, it was not arguable that there was a real and substantial chance that improved systems and procedures would have saved Grace's life.

Hence, the Coroner decided that the inquest conclusion need not engage s.5(2) Coroners and Justice Act 2009.

A care home is not state detention

After the inquest the Claimant, Grace's mother sought judicial review. It was asserted that the Coroner should have concluded that an Article 2 inquest was automatically required on the basis that Grace was in state detention. It was argued that the position of a child in the care of the local authority was analogous to that of a person who dies from suicide whilst in state detention. The

judge did not agree.

Relying on *Morahan*[1], HHJ Belcher[2] clarified that the touchstone for whether the circumstances of a death give rise to an automatic enhanced investigative duty is whether they fall into a category which necessarily gives rise, in every case within that category, to a legitimate ground to suspect state responsibility by way of breach of a substantive article 2 obligation. In *Morahan* the court did not think it legitimate to equate the deceased voluntary in-patient's position to that of a detained patient. Similarly, the judge was not persuaded by the Claimant's suggestion that there was a 'grey zone' where the extent of control and supervision over a person on the facts of the case might, equate her position to that of a person detained by the state.

There was an obvious difference between exercising the statutory power *to take a child into care* in order to protect the child, and the issue of whether the child *once in care* can be said to be detained.

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As the judge pointed out, if being provided with accommodation in a care home were sufficient to engage Art 5, then any suicide by a child in care would automatically result in an Article 2 inquest. The Claimant had to agree that this was '*not [an] attractive' argument*', (code for a barrister now on the back foot) but sought to argue on the basis of the Supreme Court decision in *P v Cheshire West*[3]that a child in care should be considered to be in detention, as such a child was not exercising any choice about where to live but had to live where social services placed her. The Claimant argued that her placement under of the Care Act meant Grace was living in a 'gilded cage', she could not decide to go and live somewhere else and that if she had left the care home then police would have brought her back.

The judge was not persuaded that an Art 2 enhanced investigative inquest was automatically required simply by reason of Grace being a child in care who sadly took her own life.

The Claimant's arguments had overlooked the determination of the Court of Appeal in *Ferreira*[4]that, 'state detention' in the Coroners and Justice Act 2009 was not exactly the same as deprivation of liberty for the purposes of Article 5 of the European Convention. A child in care is obviously different to those detained within closed units such as prisons and immigration centres or those involuntarily detained under the Mental Health Act.

Grace went to school like other children and was not restricted when she was there, at the care home there was a lock on the inside of Grace's bedroom door, she was not locked into it by others. Notably, Grace was not the subject of a more restrictive secure accommodation order, nor was there any suggestion that she should have been. Grace's situation in care was not at all analogous to state detention.

Any failure in systems must be arguably causative of death

The Claimant's second ground of challenge was that the Coroner was wrong to conclude that, on the available material, there was not an arguable breach of the Art 2 general/systems duty in relation to Grace's death.

For the purposes of argument in the hearing it was accepted that there had been systemic failures in the running of the care home. The issue between the parties was whether those systemic failings needed to be causative of Grace's death to engage Art 2 obligations.

The need for such a causal link had been made clear in a number of cases, including by the House of Lords in *Savage*[5]:

> *"If the authorities failed to put in place appropriate general measures to prevent suicides among the prisoners in a particular prison and, as a result, a prisoner was able to commit suicide, there would be a breach of article 2."*

In Grace's case there was ample evidence that (i) the care home's risk assessments were not tailored to individual needs and (ii) generic strategies in place to address behaviours of self-harm took no account of individual circumstances or history. However, what the Claimant could not show was that this had made any difference to Grace. On the available expert evidence there had been competent clinical assessment of Grace's self-harm risk and she received care and support of high quality.

As the Coroner had pointed out – it was not sufficient to simply identify the existence of systemic failings: she must consider whether there was a causal connection between those failings and Grace's death. The Coroner could not conclude that Grace had lost a substantial chance of survival because of the identified systemic weaknesses. The judge held that the Coroner was entitled to come to that conclusion based on all the evidence before her, notwithstanding the apparently serious systemic breaches disclosed.

The care home was not a public authority

Furthermore, the Claimant had not even established that ECHR obligations applied to this private care home. Even had the judge been of the view that Grace was deprived of her liberty and/or detained by the state at the care home, or that systemic shortcomings had led to her death, this *private* care home was not, in the judge's view, a functional public authority that might owe ECHR obligations to Grace.

Although Grace had been placed there by the Local Authority, the private home wielded no statutory powers of itself. If the care home had placed any detention on Grace that would not be pursuant to any statutory power it had been given, nor as a result of any action by the state. Simply discharging a public function by accommodating Grace, and being paid for doing so, was not enough to make a private body become a functional authority subject to the HRA/ECHR[6].

The difference between Art 2 and non-Art 2 inquests

The Claimant's third ground of challenge was that the Coroner was wrong to hold that the only material effect of this inquest not being an 'Art 2 inquest' was on the conclusions that may be returned, rather than upon the scope of the inquest. Given that the Claimant had not actually challenged the Coroner's ruling on the scope of this particular inquest in her claim form this seems to have been a rather academic point being taken about whether it was legal correct to say that an 'Art 2 inquest' and a 'non-article 2 inquest' can be the same in their investigative character. The judge however decided to entertain this question – if only to dismiss it.

The judge noted that the natural reading of the statute would tend to suggest that an Art 2 inquest by including '*in what circumstances*' the deceased came by his or her death, was inevitably wider investigative scope than a 'non-article 2 inquest' as set out in section 5 (1). The inference being that

the wider circumstances would not otherwise be included in a 'non-article 2 inquest'.

However, the stance the Coroner took in this case had been to say that this particular non-article 2 inquest would be very broad in scope and so would effectively look at the same issues. His allowed the Coroner to keep an open mind on the Art 2 issue so that the matter of engagement of Art 2 could be reconsidered at the conclusion of the inquest. Furthermore, the Coroner had recognised that she was still likely to need to consider issues regarding procedures and systems when considering her duty under reg. 28 to make a prevention of future deaths report.

The Claimant argued this was not good enough. She submitted it was legally incorrect to say there was no difference in scope between the two types of inquest. She argued that by embarking on a non-article 2 '*Jamieson* inquest', the Coroner had exercised a discretion to narrow down the scope of the inquest, in effect making it difficult or impossible to convert it to an Art 2 inquest at a later stage. She submitted that a Coroner's decision on scope would inform issues of disclosure, the relevance of questions, as well as the findings made at the inquest.

The judge was again not persuaded that the scope of Art 2 and non-Art 2 inquests was *necessarily* different. The Claimant accepted it would be open to a coroner to embark on a *Middleton* type Art 2 inquest and then decide that was unnecessary. Furthermore, it was plain from analysis of the authorities that, notwithstanding that the natural reading ofsections 5(1) and 5(2) might suggest there is a difference in scope of the two types of inquest, in practice that was not the situation. Recent decisions in the Court of Appeal make that point abundantly clear.[7] Accordingly the Claimant's claim for judicial review must be dismissed on all grounds.

Commentary

The coroner's discretion on the scope of an inquest is wide. Even in a 'non-Art 2' inquest a Coroner can exercise discretion to look at those matters an Art 2 inquest must cover – that is the circumstances that arguably have some relevance to the cause of the death. Indeed, Jonathan Hough's lovely funnel analogy (that had its first outing in *Lewis*[8]) has much to recommend it.

The practical solution (that this Coroner had adopted), is for an inquest to address the broad circumstances of a death, especially where there is a possibility that Art 2 may become relevant in the future. In those case the enquiry should be broad enough to cover the ground for the coroner or jury to make the necessary conclusions depending on the final decision regarding Art 2.

Whilst it is of course preferable to come to a view at the very outset of an investigation as to whether Art 2 obligations were owed to the deceased and were arguably breached, this can be a premature decision to make until the inquest evidence has all been heard and tested. In this present case the Coroner had expressly recognised the possibility that arguable breaches of Art 2 might be uncovered and that would inevitably feed into her decisions as to scope generally, whether in relation to the scope of questions, disclosure or her conclusions. The wise coroner will always have the Houghian funnel in mind as they conduct their investigation. Of course the question might still remain of quite how wide the top of that funnel should be? But that of course will depend on the facts of each particular case.

Footnotes

[1] *R (Morahan) v HM Asst Coroner for West London* [2021] EWHC 1603; [2021] 3 WLR 919. Although under appeal (to be heard in June 2022) this case remains good law and provides a very clear exposition of when and why Art 2 obligations might automatically arise.

[2] Sitting as a judge of the High Court

[3] 2014] UKSC 19; [2014] AC 896

[4] *R (Ferreira) v Inner South London Senior Coroner* [2017] EWCA Civ 31; [2018] QB 487

[5] *Savage v South Essex Partnership HNS Foundation Trust* [2008] UKHL 74, and also see *Van Colle v Chief Constable of Hertfordshire* [2008] UKHL 50; [2009] 1 AC 225 at §138

[6] See *YL v Birmingham City Council* [2007] UKHL 27; [2009] 1 AC 681

[7] See: *R (Sreedharan) v Manchester City Coroner* [2013] EWCA Civ 181, at §18(vii); *R (Maguire) v HM Senior Coroner for Blackpool and Fylde* [2020] EWCA Civ 738; [2021] QB 409 at §77

[8] See *R (Lewis) v HM Coroner for the Mid and North Division of the County of Shropshire* [2009] EWCA Civ 1403 at §26 '*Mr Hough's answer is that the inquest process can be visualised as a funnel, wide at its opening, but narrowing as the evidence passes down it so as to exclude non-causative factors from the eventual verdict.*'