Misadventure in police custody does not automatically engage Article 2

written by Bridget Dolan QC | 7 April 2025

R (Robinson) v. HM Assistant Coroner Blackpool & Fylde [2025] EWHC 781 (Admin), 3 April 2025 (judgment here)

The ever the developing jurisprudence of Article 2 means that the categories of cases that can engage Art.2 obligations is not closed. However, in this recent decision Kerr J has firmly slammed the door in the face of Claimant who was proposing an extension of Art.2 into cases of misadventure occurring in police officers' presence, saying that he "*did not see any good reason to extend the existing categories of case in which article 2 applies automatically.*"

The automatic Art.2 categories are considered automatic because the state will *always* need to explain how a death in specific circumstances came about: a paradigm example being where a suicide occurs in custody. But as the judge here recognised, it is not the mere fact of being in state custody that triggers the obligation. Cases of misadventure, even if occurring in police custody, are not apt to attract the automatic application of Art.2, because the misadventure may be unpredictable; the state agents may bear no blame for it; and it may require urgent medical attention beyond their expertise.

The Facts

In March 2021 Mr. Robinson was stopped by the police on suspicion of driving a stolen car. He got out of his car and whilst being subdued by the officers placed an object in his mouth. It appeared to the officers that he was trying to swallow something, which they suspected to be drugs.

The officers placed Mr Robinson in handcuffs and on the ground and tried to get him to spit out the object. When he stopped resisting and became lethargic, they suspected that the drugs he had swallowed had taken effect and that he had therefore overdosed. They tried to rouse him. There were no signs of gagging and the officers did not suspect that his airway was obstructed. They called an ambulance, placed him in the recovery position and removed his handcuffs. They tried to give him care, administering CPR and oxygen and attempting to use a rebreathing mask and an oropharyngeal airway.

Mr. Robinson went into cardiac arrest. The ambulance arrived. The ambulance crew thought a check on Mr Robinson's airway had been done by the police as they had inserted an airway. When in the ambulance another paramedic noted a blockage to Mr Robinson's airway and used a laryngoscope and forceps to remove the package from his throat. CPR and advanced life support was continued, without success and Mr. Robinson was pronounced dead on his arrival at the hospital.

The Inquest

The Coroner treated this jury inquest as one where Art 2 ECHR was engaged with a view to reviewing this at the conclusion of the evidence.

There was no dispute in the inquest that Mr Robinson's airway had been obstructed by the package he tried to swallow. Medical evidence raised the possibility that there had been a missed opportunity to administer blows to the back at the roadside, whilst recognising that the officers faced a very

challenging situation.

A report which considered the use of force, concluded that the officers had deployed a level of force to Mr. Robinson which was a proportionate, reasonable and the minimum amount necessary. It was noted that Mr Robinson had made the conscious decision to place the item within his mouth with the intention of avoiding being found in possession of controlled drugs. The officers were armed with firearms that were within Mr Robinson's reach and could not have used their tasers as Mr Robinson was too close to them for that to be a realistic option.

The family invited the Coroner to leave gross negligence manslaughter and/or neglect to the jury. They argued that Mr Robinson's death was in the self-evidently "suspicious" category automatically triggering the article 2 enhanced procedural obligation and that the officers knew or ought to have known that there was a real and immediate risk to his life. It was argued that the officers had a duty to keep Mr. Robinson safe and take reasonable steps to prevent him from having swallowed the package, such as by securing his hands before he had time to put the package in his mouth and seeking medical assistance urgently. The family also contended the unnecessary and excessive force had been used.

For the police, it was argued that there was no arguable case of gross negligence manslaughter here; Mr Robinson had acted voluntarily when he placed the package in his own mouth. Furthermore the case did not fall within any category that automatically engaged article 2. It was for the coroner to make an evidential assessment and decide whether there has been an arguable breach of article 2.

The Coroner's rulings and the jury's conclusion

The Coroner determined that there was no case of gross negligence or neglect to go to the jury and that Art 2 was not engaged. There was not sufficient evidence that the use of force was either unreasonable or disproportionate, that there was a breach of a duty of care or that the risk of death was a reasonably foreseeable consequence of any misconduct. Mr Robinson was not in a custodial setting when he put the package in his mouth. The airway obstruction could not be cleared without the assistance of the medical equipment carried by the paramedics. The actions of the officers could not be said to have caused the death.

The Coroner summed up the evidence and gave his legal directions. He left the jury two conclusions to consider: misadventure; or a short factual narrative of how the death came about. The jury's conclusion was misadventure.

At the conclusion of the inquest the Coroner declined to issue a regulation 28 prevention of future deaths report ('PFD' report). Instead, he proposed to send a non-statutory letter of concern in relation to professional training at a national level and how it might be adapted or expanded in light of the facts of this case.

The JR challenge

The family's judicial review claim relied upon 3 grounds, namely that: (1) Art.2 ECHR was engaged; (2) the Coroner's summing up was inadequate; and, (3) the Coroner was required to have issued a PFD Report. The family did not challenge the decision to rule out unlawful killing and neglect.

The Claimant referred to Popplewell LJ's judgment in the Divisional Court in *Morahan****[1]*** in which (at [122(5)]) he identified categories in which the state's procedural Art.2 obligation arises automatically as including killings by state agents, suicides or attempted suicides and unlawful

killings in custody, suicides of conscripts and suicides of involuntary mental health detainees. Popplewell LJ had added that the jurisprudence was developing and "these categories cannot be considered as closed". The Claimant argued that these categories should be extended, and suggested that these should include unnatural deaths occurring while in the involuntary custody or control of the state, or after the use of any physical control or force by police officers.

The Claimant's second ground was that the jury had been wrongly directed that they should 'choose' between a simple verdict of misadventure or a narrative verdict and that the jury may have misunderstood or appreciated that it was open to them to return both. For the third ground, the Claimant argued that the Coroner had evaded his statutory duty to make a PFDR and that his decision not to do so was wrong in principle.

The Coroner took a neutral stance. However the Chief Constable also participated and submitted that the inquest had been conducted in a manner that was akin to an Art.2 inquest, receiving evidence sufficiently wide in scope to satisfy the enhanced procedural obligation, if it should arise. The Coroner had deliberately and lawfully left the issue of whether Art.2 was engaged until after the evidence. He was right to do so, and his ruling that Art.2 was not engaged was correct. There was no proper basis nor a need to extend the categories in which Art.2 automatically arose, as "it is the level of responsibility by the state towards the individual in their dealings with the individual that dictates whether the automatic nature of an article 2 inquest arises.".

It was argued that Mr Robinson was not yet fully under the control of the officers when he placed the package in his mouth. They had secured one of his hands but he used his still free other hand to do so. He was not in a custodial setting when he put the package in his mouth. Placing of the package in his mouth was a voluntary act. It would have been no more than speculation to suppose that any delay contributed materially to the death.

As to the second ground, the Chief Constable referred the Court to Guidance No. 17 and submitted that a narrative conclusion is not mandatory in either an article 2 or non-article 2 inquest. On the third ground, it was submitted that it was for the Coroner to decide whether the criteria for a PFDR were met and that the approach taken by the Coroner may be appropriate in exceptional circumstances.

DECISION

Ground 1

Principally, on the first ground the Court held:

> "I do not see any good reason to extend the existing categories of case in which article 2 applies automatically. The circumstances of the death must be such that "they fall into a category which necessarily gives rise, in every case falling within the category, to a legitimate ground to suspect state responsibility by way of breach of a substantive article 2 obligation" (Popplewell LJ in Morahan at [122(7)])."

Kerr J noted Popplewell LJ's ninth proposition in *Morahan*, that the type of death is important (quoting Popplewell LJ at [122(9)]):

> "[d]eaths from natural causes are not to be treated in the same way as suicides or unlawful killings".

Here, the death was as a result of misadventure, i.e. doing an intended act with unintended fatal consequences for the doer. Kerr J held that the further categories proposed by the Claimant were

too wide and:

> "…would capture cases where, for example, police officers encounter and arrest a drug addict on the street who is in the throes of dying from an overdose taken before the arrival of the police officers."

The Court gave an example in relation to one of the Claimant's suggested categories (the fifth), where article 2 would be triggered in circumstances where there had been no breach of an article 2 obligation, but a suspect escaped from police custody and then died either having jumped into a river or into the path of a vehicle.

He held that:

> "…Misadventure cases are not apt to attract the automatic application of article 2 because the misadventure may be unpredictable; the state agents may bear no blame for it; and it may require urgent medical attention beyond their expertise, where the state's obligation would be, at most, to call for it and do their best with first aid meanwhile."

Kerr J found that there was no fault with the Coroner's legal directions, that his reasoning was sound and his conclusion was correct.

Ground 2

As to the second ground, the Court accepted that a summing up need not rehearse the evidence in forensic detail and that the issues here were not very complicated. Clearly, the jury did not accept that the officers were to blame. That does not mean the coroner failed to elicit the findings the public interest required. It means only that those findings were not the ones the family members hoped for.

The Court noted that the summing up did not make it clear whether or not the jury had to choose between a short form (misadventure) or a short narrative conclusion and that it would have been better if they had been told that "they could return a "hybrid verdict". However, he also noted that parts of the summing up were capable of meaning that the jury did have the option of returning both conclusions. It could not be deduced from the fact that the jury preferred a short form conclusion, that they had been misdirected. Kerr J observed that he was:

> "…aware of no authority that a jury can be compelled to return a narrative conclusion, whether in addition to or instead of a short form conclusion, and whether in an article 2 or non-article 2 inquest."

Ground 3

Finally, ground 3 turned on whether the decision not to issue a PFDR was irrational. Although the Coroner had not said so explicitly, the Court accepted that his view had fallen short of deciding that "action should be taken":

> "Rather, he sought to sound out those with the power to take such action on what their view was on whether action should be taken. That seems to me a properly considered and rational view to take and is not out of line with what is said on the subject in Revised Guidance No. 5."

Conclusion

The Court dismissed all three grounds of challenge. Of importance, the Court observed that:

> "… The scope of the inquest was wide and the evidence plentiful and thorough. The cause of death was undisputed. Aside from the bar on judgmental language in a narrative verdict, the conduct of the inquest was akin to an article 2 inquest."

As a consequence, had any of (or all) of the grounds of challenge succeeded, it is unlikely the Court would have directed a fresh inquest. The Court continued to note that a jury could not be compelled to return a narrative conclusion, even in an Article 2 case, and that lengthy narrative accounts of the circumstances of death were to be discouraged.

The short form conclusion of misadventure clearly pointed to the jury's view that the officers were not significantly to blame for Mr Robinson's death. This was consistent with the evidence. Had the officers realised earlier that Mr Robinson's airway was completely blocked, they would have called for medical assistance sooner but would not have been able to remove the blockage themselves.

Comment

This judgment will be of particular interest to those dealing with cases where the Police had dealt with a deceased immediately before their death, but where the direct cause of death was brought about by the deceased's own actions. The mere involvement of police in events surrounding a death will not trigger Art.2 obligations without more.

As an aside: Kerr J chose to use the now defunct term 'verdict' in place of 'conclusion' throughout this judgment. This was no mere oversight, as the judge positively explained (at §80) that: "the word 'conclusion' is now commonly used to describe what used to be and sometimes still is, as in this judgment, called the verdict of the coroner or jury at the inquest". It is remarkable that despite the statutory reforms of Coronial Law since 2013 introducing of the term 'conclusion' in the statutory 'Form 2' Record of Inquest, the use of the term verdict still persists, although no verdict has been retuned in any English or Welsh Coroners Court for well over a decade now.

Footnotes

[1] The Court cited both the Divisional Court and Court of Appeal judgments in *Morahan*, but did not always make clear which was being cited, save by reference to the judge (i.e. Popplewell LJ or Lord Burnett CJ). For ease, the citations are *R. (Morahan) v. West London Assistant Coroner* [2021] EWHC 1603 (Admin), [2021] QB 1205, DC and *R. (Morahan) v. West London Assistant Coroner* [2022] EWCA Civ 1410, [2023] KB 81