

# Coroners are not a one stop Human Rights Court

written by Imogen Hildred | 24 March 2022

## ***Lee v Assistant Coroner for County Durham and Chief Constable of Durham [2022] High Court QBD (CO/4066/2021)***

The tragic death of Dylan Lee is a distressing case. Dylan was only 19 years old when he took his own life by hanging himself at his family home. Before his death Dylan's family were said to have been the victims of abuse and harassment by private individuals (primarily neighbours) as a result of their Romani Gypsy heritage. Sixteen crimes against his family had been, reported to police in the period before Dylan's death.

Dylan's mother felt strongly that the police had failed to treat the family's reports with the seriousness that they deserved, failed to recognise the treatment as discriminatory, and failed to carry out adequate investigations. However, at Dylan's inquest the Coroner ruled that the scope of the inquest would not include investigation of the alleged discriminatory treatment to which Dylan and his family were subjected, nor the alleged failure of the police to respond appropriately thereto.

Dylan's mother sought permission to bring judicial review proceedings challenging the conduct of this non-Article 2 inquest. Although not a binding authority, the comments of the Judge when refusing permission to bring the claim are illuminating.

The application was brought on the basis of both Article 2 and Article 8 ECHR. The Article 2 aspect was easily dispensed with: there was nothing in the evidence to suggest police (or indeed anyone) ought to have known Dylan was at risk of taking his own life, nor was there any evidence of any link between the alleged harassment and Dylan's death. As for the Article 8 claim, the judge noted that even if the state does have an investigative duty under Article 8, it does not follow that that investigative duty falls upon a Coroner. It is no part of the function of an inquest to investigate an alleged breach of a person's right to respect for private and family life.

### **Background**

Dylan's family reported being the subjects of wholly unwarranted abuse from their neighbours, motivated or influenced by discrimination. A petition had been started to 'rid the village of gypsies' after they moved in; broken glass was repeatedly thrown into the family's chicken coop; complaints were made to the Council, the Environment Agency, the Police, and Social Services, which the Claimant considered to be malicious (and none of which had been upheld).

Police had attended the property on a number of occasions although the police had only two direct interactions with Dylan himself in the year before he died. One occasion was just a few weeks before his death when Dylan was asked about how an incident with a neighbour made him feel. He was recorded as responding that he was worried about the safety of his chickens but, otherwise, "everything [was] ok". The Coroner (and later the judge) found that there was nothing in those interactions which ought to have put the police on notice that Dylan's life might be at risk.

Evidence, in the form of a report from a pilot research project into the psychological effects of hate crime on Gypsy Roma and Traveller communities had been provided to the Coroner by the Claimant. [1] The authors had concluded that such discriminatory behaviour increases risk of death

by self-inflicted means. However, there had been nothing said at the time to evidence a link between the harassment and Dylan's death. Indeed, his mother had reported that "*Dylan's death came as a complete shock to [her]*", that she "*had no idea that he was thinking of taking his own life*" and that "*there were no warning signs*".

Against that background the Coroner declined to investigate the alleged harassment of the family saying:

*"this is not an Article 2 inquest, so we are simply looking at the facts around the death, and not going into the wider circumstances. [The Chief Coroner] said[2], 'Even when Article 2 is engaged, the role of the inquest is not to provide an answer to any sort of why question' ...I am simply looking at how he died and not ... anything to do with why he did what he did."*

Consequently, the Claimant's Counsel was not allowed to question police witness in any detail about interactions with Dylan. The Coroner did not allow inquiry into Durham Police's training or policies around hate crimes and their link to suicide in the Gypsy Roma and Traveller community.

### **The Judicial Review**

The Judicial Review claim was brought on a number of grounds: the principal issue being whether the Defendant Coroner was in error in not considering this an 'Art 2 inquest' and investigating the circumstances in which Dylan died. The judge held that it was not sufficiently arguable, that the police had a substantive operational duty to Dylan. Such a duty would only have arisen if police knew, or ought to have known, of a real (that is, a not remote or fanciful) and immediate (that is, present and continuing) risk to Dylan's life from the conduct of the neighbours.[3]

As to the Art 8 claim, the judge was clear: even if the state has an investigative duty under Art.8, it does not follow that that investigative duty falls on a coroner. The function of an inquest is not to investigate a breach of a person's right to respect for private and family life. Rather, its function is to investigate who has died, and how, when and where (and, where appropriate, in what circumstances) a person came to die. There was an established procedure for dealing with complaints against the police and this lay outside the coronial system.

The Coroner had been entitled to exclude these aspects from the inquest and the claim was not sufficiently arguable and so would be dismissed.

Briony Ballard of Serjeants' Inn Chambers advised the Assistant Coroner in respect of this claim.

### **Footnotes**

[1] *Hate: 'As Regular as Rain'* Greenfields and Rogers, Dec 2020 (funded by the Ministry of Housing, Communities & Local Government) here

[2] See here

[3] See *R (Skelton) v. Senior Coroner for West Sussex* [2021] QB 525 at [45]-[63]