Precedent and Article 2: Just because a different coroner wasn't challenged doesn't mean they were right

written by Bridget Dolan QC | 21 September 2021

***Dove v Assistant Coroner for Teesside* [2021] EWHC 2511(Admin)**

This latest Divisional Court lesson on Article 2 ECHR not only provides a helpful summary excursion through the principles to apply when establishing whether the state's obligations to protect life are engaged (or not) but it also takes the reader back to basics on the doctrine of precedent.

That another coroner elsewhere had determined that Art 2 rights were engaged in very similar circumstances to the present case was not helpful to the Divisional Court when considering whether Art 2 applied to the death now under consideration. The Claimant's reference to an interim direction of the previous Chief Coroner in the Fishmongers Hall Inquests was also of no avail, given that decisions of earlier coroners are not binding on, or even persuasive, in the High Court.

In *Dove* the Claimant drew the High Court's attention to an earlier decision by a different Assistant Coroner in a different part of the country to bolster the submission that the Assistant Coroner for Teesside had fallen into error. The Divisional Court was having none of it. Mrs Justice Farbey made short shrift of such an approach, pointing out that it did not advance the Claimant's submission one jot to put a series of conclusions reached by other coroners in a number of different inquests before the Court.

The principle of *stare decisis* requires that all lower courts should make decisions consistent with previous decisions of higher courts – certainly not the other way round. The decisions of other coroners cannot be deployed to persuade the High Court (or even a fellow coroner in a different inquest) to tread a new path, rather than to follow established and binding case law on Article 2. When considering whether the state's duty to protect life is engaged towards people who are not under state control (which was a key issue here) then application of the judgment of Supreme Court in *Rabone* [1] will be a far more fruitful place to focus attention.

The background

When Jodey Whiting died as the result of an overdose of prescription medication there was no question that her death was a result of suicide. Notes left by Ms Whiting suggested that she had intended to kill herself and the Assistant Coroner duly returned a suicide conclusion. *How* Ms Whiting died had been properly established and recorded. What the Assistant Coroner did not do was explore in detail or formally record *why* Ms Whiting had taken her own life.

It was the family's position that Ms Whiting had been suffering from severe stress in the period leading to her death. A decision taken by officials within the Department for Work and Pensions ('DWP') just two weeks before her death to stop paying Ms Whiting's Employment and Support Allowance ('ESA') was said to have contributed to that stress.

The evidence was that Ms Whiting had a long history of physical and mental health difficulties which included previous suicidal intent, plans and acts. She was entitled to ESA which was withdrawn after

she had failed to attended a 'work capability assessment'. In breach of their own guidelines the DWP staff had failed to contact her by telephone and consider a 'safeguard visit'. Although the DWP was aware of her mental health difficulties, it seems that staff had not considered whether her medical condition had affected her cognition and attendance before stopping Ms Whiting's ESA (which also led to her housing and council tax benefits stopping). Very shortly after lodging a request for a reconsideration of that decision via the Citizen's Advice Bureau Ms Whiting was found dead at home from a self-administered overdose.

The coroner had noted as part of her findings that "*Jodey had her ESA claim turned down in the weeks before her death, and her mother believes, as does her sister, that this was causing her extra stress…Jodey's mum believes the extra stress Jodey was under in relation to her ESA claim was a contributing factor in her death*." However, the coroner made no formal inquest determination about this aspect of the case: she had concluded that Art 2 procedural obligations were not engaged and that it was not her function to question any decisions made by the DWP which she considered to be outside the scope of her investigation.

The application

Ms Whiting's mother was dissatisfied with the inquest conclusion and, in an application under Coroners Act 1988, argued that there ought to be a fresh inquest to look at the failings of the DWP staff and their contribution to her daughter's mental state.

Mrs Dove's case was that the evidence had now become available which made it likely that a different conclusion would be returned at a fresh inquest, namely a conclusion that identified the Department's role in the circumstances of the death. The fresh evidence that had emerged was: (i) the report of the Independent Case Examiner ('ICE') which followed an investigation into the DWP's handling of the case and which criticised the DWP's actions in a number of respects[2]; and (ii) a report from a consultant psychiatrist, whose conclusions were said to provide fresh evidence of a link between the decision to stop Ms Whiting's ESA and her suicidal state of mind.

The Divisional Court's decision[3]

As the Divisional Court has now said many times in respect of applications "*The single question is whether the interests of justice make a further coronial investigation necessary or desirable*".[4]

The Court recognised that the scope of an inquest's investigation and conclusion will depend upon whether or not Art.2 ECHR is engaged. If Art.2 it is not engaged the inquest need only address four limited factual questions: the identity of the deceased, the place and time of death, and how the deceased came by their death. The "how" question is directed only to the means by which the deceased died and does not encompass the wider circumstances of death.

The Claimant's first ground of challenge, that the inquest should have had a broader scope and should not have focused solely on the immediate cause of death, was based on common law principles. That argument did not prevail. As the court stated, the primary purpose of an inquest is to determine by what means someone has died. There is an ancillary power – now contained in para 7 of Schedule 5 CJA 2009 – to make a report to prevent future deaths ('PFD'). However, that power does not dictate the scope of an inquest.[5]

Having an ancillary power to make a PFD report does not imply that a coroner becomes the guardian of the public interest in matters relating to social security. The coroner was not required by the public interest to undertake a broader inquiry, whether for the purpose of calling the DWP to account or for the purpose of enabling questions of the DWP's conduct to be publicly ventilated.

Importantly, other forms of scrutiny existed including the DWP's three-tier complaints procedure and the ICE process. Any legal defect in the ICE's approach or any legal error falling outside the ICE's powers would be amenable to judicial review in the High Court. It was the constitutional function of that court, not the coroner, to hold the executive to account.

> ***"It was the constitutional function of the High Court, not the coroner, to hold the executive to account."***

The Claimant drew the court's attention to the conclusions of a number of other inquests and a long ruling by a different assistant coroner who had come to a different view. That tactic was shot down for not being persuasive in any way. Furthermore, said Farbey J, "*although the ruling itself is lengthy, I would regard the legal analysis of the critical points (which is what is important) as less than comprehensive*".[6] Even an attempt to rely upon a case management ruling and directions by the previous Chief Coroner did not assist: his was not a final decision and anyway could not bind the High Court.

Art 2 was not engaged

The Claimant alternatively argued that the new evidence arguably revealed a breach of Art 2 substantive obligations. Again the Divisional Court did not agree. When determining whether such an obligation is owed to an individual the *Rabone* indicia will be the key. [7]

There was no authority to support the proposition that when allocating public funds by way of welfare benefits the DWP had assumed responsibility for preventing the suicide of those who receive those funds. It was a huge leap to say that conducting a badly flawed work capability assessment might engage Art 2 rights. Ms Whiting was not under the control of the state and there can be no general obligation on the state to prevent suicide in the absence of the assumption of responsibility for the person's welfare.

Furthermore, an operational duty would not be established merely because an individual was vulnerable by reason of physical or mental ill-health. Any risk to Ms Whiting created by stopping her ESA was not an exceptional one in the *Rabone* sense. Sadly, the risk of suicide posed by Ms Whiting's mental state had been a constant in her life for many years.

As for any more general systems duty, on the evidence before the court there were adequate systems in place, the DWP's errors were shocking, but they amounted to individual failings of staff attributable to mistakes or bad judgment. They were not systemic or structural in nature. Further, the new psychiatric report did not go as far as saying the DWP's decision to stop Ms Whiting's ESA caused her to take her own life. It was likely to remain a matter of speculation as to whether or not the cessation of ESA caused Ms Whiting's suicide.

Conclusion

What this coroner did was, on the evidence she had, sufficient to satisfy the requirements of a coronial investigation of the *Jamieson* variety. The inquest was short but fair. It covered the legal ground and dealt with the evidence before the coroner including the views of Ms Whiting's family. The inquest complied with the requirements of *Jamieson*. It was not bound to do anything else and the interests of justice did not call for anything else.

As the court noted, when addressing the "how" question in such a case a coroner may, as a matter of

discretion, go beyond a bare determination of the mechanism of death. But the exercise of that discretion is wholly a matter for the coroner. That a different coroner may have explored much wider matters in a similar case does not mean that every coroner must do so. Where Art 2 procedural obligations are not engaged all that is required of a coroner is that they establish an answer to the statutory questions under s.5(1) CJA 2009.

Footnotes

[1] *Rabone v Pennine Care NHS Trust* [2012] UKSC 2

[2] As Mrs Justice Farbey felt it appropriate to observe, the DWP's failures in MS Whiting's case, as set out in the ICE report, were shocking. The withdrawal of ESA should not have happened.

[3] The Secretary of State for Work and Pensions made an application to be joined as an interested party to the application. See the decision at [2021] EWHC 1738 where the court criticised the Secretary of State's delay in seeking to take part in these proceedings and restricted her to written submissions only. Although it was subsequently agreed that she should be permitted to make oral submissions.

[4] *Attorney-General v HMC South Yorkshire (West)* [2012] EWHC 3783 (Admin)

[5] *R (Butler) v HM Coroner for the Black Country District* [2010] EWHC 43 (Admin), at para 74.

[6] And one might feel sympathy for that particular coroner who ended up having their own Art 2 decision so publicly commented upon when it wasn't even the subject of the claim being brought.

[7] Assumption of responsibility, vulnerability and exceptional risk: see *Rabone v Pennine Care NHS Trust* [2012] UKSC 2

Claire Watson of Serjeants' Inn Chambers acted for the second respondent in the inquest