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How to engage A2 ECHR in Healthcare Inquests

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This article provides practitioners with an overview of the law relating to inquests which engage Article 2 ECHR in the context of deaths arising from shortcomings in healthcare. It is intended to provide a pithy summary on the legal complexities in domestic and European case law and it offers some general advice on how best to engage Article 2 arguments.

In particular, we consider how Article 2 was successfully engaged by the family in relation to both the mental health out-patient treatment and the emergency services' response to a 999 call in the recent inquest of LM, heard at Northampton earlier this month. Tim Green KC was instructed by Gary Rubin and Jo Kaucher of Blackfords Solicitors, on behalf of the family.

FACTUAL CONTEXT

1. At the inquest in June arising from LM's death, the family of the deceased successfully established that Article 2 ECHR ("**A2**") was engaged by virtue of the systemic failings both of the NHS out-patient mental health care teams and ambulance services.

2. LM died as a result of suicide. He had attempted to take his own life less than two years previously, a fact which was well-known to his medical practitioners. The Coroner heard evidence that there were numerous

missed opportunities to escalate concerns regarding LM's increase in suicidal ideation and psychotic episodes.

A2: BROAD ARCHITECTURE

3. A2 provides the right to life. It involves a negative obligation on the state not to take life without justification. It also includes a positive obligation. Those substantive positive duties are two-fold:

    - an obligation to create and implement appropriate systems, laws and procedures to protect life generally (the "**systems duty**"); and

    - an obligation to take steps to protect a person when it is known that there is a "real and immediate risk to life where the state knows, or ought to know, of that risk" (the "**operational duty**"): *Osman v UK* (1988) 29 EHRR 245.

4. A further facet of the state's positive systemic obligation is its enhanced procedural duty to investigate deaths for which the state may bear responsibility. In such cases the inquest must ascertain not only "by what means" a deceased came to their death, but also "in what circumstances", by means of an effective and independent investigation: *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182. This is typically known as a "Middleton" or an "Article 2" inquest.

5. A2 inquests encompass wider investigative scope and may lead to the Coroner giving an expanded narrative conclusion for the purposes of section 5(2) Coroners and Justice Act 2009 (a provision which gave *Middleton* statutory force) (see Chief Coroner's Guidance Note 17). This narrative conclusion can include factual findings on matters which are possible but not probable causes of death. This means that judgmental language such as "unsatisfactory", "failure" and "inadequate" can be used. As Lord Carnwath

noted (at [102]) in *R (on the application of Maughan) v Her Majesty's Senior Coroner for Oxfordshire* [2020] UKSC 46, quoting Lord Bingham in *R (Amin) v Secretary of State for the Home Department* [2003] UKHL 51 (at [31]), the fact-finding purposes of an A2 inquiry is:

> *"… to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others."*

6. This emphasis on accountability of state bodies and the additional consequences which are brought about as a result is further reinforced by Lord Sales' observation in *R (Maguire) v HM Senior Coroner for Blackpool & Flyde* [2023] UKSC 20 ("*Maguire*") at [30]:

> *"Where a public authority such as an NHS trust breaches the substantive positive obligations inherent in article 2 it may be sued for compensation for breach of its duty under the HRA to act compatibly with that Convention right: Savage, para 72 (Lord Rodger)."*

7. A2 will always be engaged, and this will be reflected in the form of the inquest, where the death occurs in certain circumstances (e.g. suicides in prison and deliberate killings by state agents). A2 may also be engaged where it appears that there has been an "arguable breach" of the substantive duties that are placed on the state or its agents: *R (Humberstone) v Legal Services Commission* [2010] EWCA Civ 1479. The threshold for "arguable" is "anything more than fanciful": per Hickinbottom J in *R (AP) v HM Coroner for Worcestershire* [2011] EWHC 1453 (Admin) at [60]. Accordingly, the A2 inquest should examine not just probable causes of death, but measures which could have had a real prospect of altering the outcome or mitigating

the harm: *R (Medihani) v HM Coroner for Inner South London* [2012] EWHC 1104.

8. Further to establishing systemic or operational failings, in order to conclude that A2 is engaged the Coroner will need to be satisfied that those failings were causative, at least to some degree, of death: see *Lopes de Sousa Fernandes v Portugal* (2018) 66 EHRR 28 ("Fernandes"), at [188]. There must be some link between the deficiency complained of and the harm which the deceased sustained.

CASE LAW AND KEY PRINCIPLES

9. As *Rabone and another v Pennine Care NHS Trust (Inquest and others intervening)* [2012] UKSC 2 highlighted, the ambit of A2 is in theory neither rigid nor fixed. There, a voluntary psychiatric patient who was known to be suicidal was permitted by the authorities to leave for a two-day home visit, during which she killed herself. She had been admitted following a suicide attempt and had been assessed by the hospital as being at high risk of a further suicide attempt. Her parents claimed damages for breach of A2. They succeeded on the basis that, although she was a voluntary patient and not sectioned under the Mental Health Act 1983, the NHS Trust had breached the operational duty which it found applied to her under A2. As Lady Hale observed at [104]:

> *"The state does have a positive obligation to protect children and vulnerable adults from the real and immediate risk of serious abuse or threats to their lives which the authorities are or ought to be aware and which it is within their power to prevent. Whether they are in breach of this obligation will depend upon the nature and degree of risk and what, in the light of the many relevant considerations, the authorities might reasonably have been expected to do to prevent it. This is not only a question of not expecting too much of hard-pressed authorities with many other demands upon their resources. It is also*

a question of proportionality and respecting the rights of others, including the rights of those who require to be protected."

10. Importantly, the general systems duty may extend beyond written procedures and protocols, encompassing the planning and control of operations, as well as supervision, enforcement and the training of staff: *Kakoulli v Turkey* (2007) 45 EHRR 12 at [106]. Some illustrative examples are outlined below:

- In *R (Takoushis) v Inner London Coroner and Another* [2005] EWCA Civ 1440 a schizophrenic patient was taken to an accident and emergency department by a member of the public having been found apparently about to jump from a bridge. The hospital operated an emergency mental health triage system under which he should have been seen by a doctor within 10 minutes. A doctor did not arrive for some 40 minutes, by which time the patient had left. After leaving the hospital the patient took his own life by jumping from the bridge. The coroner found that there was no systemic failure at the hospital. The Court of Appeal, in quashing the verdict, held that there was no evidential basis on which he could have made such a finding and that the possibility of a systemic failing should have been fully investigated in order to comply with the investigative A2 duty in any event.

- In *Asiye Genç v Turkey* (24109/07) (27 January 2015), the applicant's new-born baby died in an ambulance after being refused admission to a number of public hospitals owing to a lack of space or adequate equipment. It was determined by the Strasbourg Court that this was a case where the baby "had not died because there had been negligence or an error of judgment in his medical care, but because no treatment whatsoever had been offered" (Fernandes at [179]).

- In *The Queen on the application of Carole Smith v HM Assistant Coroner for North West Wales v Betsi Cadwaladr University Health Board* [2020] EWHC 781 (Admin) the facts of a suicide concerning a 27-year-old psychiatric

patient were considered to engage A2. There were failings in the hospital trust's care and service delivery caused by inadequate levels of staffing for dealing with patients receiving treatment at home. There, the coroner decided that a duty to investigate was engaged by A2 and she formulated a list of nine issues to be included in the inquest, which included "Availability of / Access to a Consultant Psychiatrist", "Diagnosis", "Medication/Dosage" and "Staffing, in particular adequate provision of consultant psychiatrists".

Maguire

11. Practitioners will be well-aware of the recent Supreme Court judgment in *Maguire*. In that case, the central issue was whether A2 required an enhanced inquest into the death of a vulnerable woman who had become unwell during her time in a private residential care home and who had died in hospital. In its unanimous judgement, the Supreme Court held that it did not: there were clearly systems in place at the care home despite the existence of individual lapses in putting those systems into effect. Put simply, such individual failings "were not to be confused with a deficiency in the system itself" [146].

12. In summarising the relevant case law, it was found that:

- Deaths which have involved allegations of negligence by care home staff or medical practitioners will not generally engage the A2 procedural obligation, by virtue of the fact that such failings will be attributable on an individual level and not on a systemic level.
- There is a high bar for successfully pleading that it is arguable there has been any breach of the A2 operational duty, as it will be dependent on the specific risks which authorities have particular responsibility to protect against by taking reasonable steps.

13. The approach of *Maguire* draws on a lineage of case law that has applied A2 restrictively. In particular, it has been determined that the availability of a civil claim in negligence has generally been regarded as sufficient in satisfying the state's procedural obligation under A2: *(R v Goodson) v Bedfordshire and Luton Coroner* [2006] 1 WLR 432. Citing *Fernandes*, Lord Sales noted in Maguire at [42] that in cases concerning medical negligence "the court has rarely found deficiencies in the regulatory framework of member states as such" and it was only in "very exceptional circumstances" that the substantive responsibility of the state under A2 would be engaged in respect of the acts and omissions of healthcare providers [145]. In *Fernandes*, those exceptional circumstances touched upon included where "an individual patient's life is knowingly put in danger by denial of access to life-saving emergency treatment" or "where a systemic or structural dysfunction results in a patient being deprived of access to life-saving treatment and the authorities knew about or ought to have known about that risk and failed to undertake the necessary measures to prevent that risk from materialising" [191]-[192].

The case law applied to the facts of LM's death

Ground 1: Systemic failings in mental health out-patient care

14. Despite LM's care in the hands of out-patient mental health care services in the months and weeks leading up to his death, copious shortcomings were identified by the Coroner in his findings of fact, including: (i) the failure to implement a withdrawal plan while LM was taken off all medication; (ii) the failure amongst medical professionals to effectively communicate the quantity (and indeed existence) of LM's prescriptions, meaning that the management of his medication was far from clear; (iii) the failure to get LM

access to a psychiatrist due to a general lack of resources available to vulnerable out-patients; and (iv) a persistent failure to communicate with LM's family.

15. Significantly, the evidence given by the deceased's GP made it clear that help from community mental health care teams was "not forthcoming" and such assistance had remained difficult to access for other patients in her care at the time of the inquest. In LM's case, this had meant that he was ultimately left without either psychotherapeutic treatment or drug support while he was to wait for a period of 15 months upwards to start formal treatment. The Coroner concluded these shortcomings in the provision of out-patient mental health care were possibly causative of LM's death.

Ground 2: Systemic failings in EMAS response

16. It was readily admitted by the local ambulance services that their delay was "unacceptable" and fell short of the standards which "every patient has a right to expect". On the evening of LM's death, a call alert was received by them which they categorised as requiring a 120-minute 90th percentile response time. Despite their efforts, however, LM was ultimately attended to 5 hours and 19 minutes after that call was received. The Coroner heard undisputed evidence that, had the ambulance arrived within their time estimate, LM would still have been alive, given the time-stamp of his last WhatsApp message to a family member.

17. Those concerns regarding ambulance delays were conceded as being ongoing, with remedial steps being taken but future shortcomings not guaranteed to be avoided. Significantly, the Coroner found that the ambulance's triage system in relation to handling mental health emergency calls was inadequate, expressing serious concerns that ambulance workers

were not able to access critical mental health data to safeguard life. This included lack of access to information concerning patients' medication and prior suicide attempts.

18. Again, the Coroner in his conclusion found that such systemic breaches in the provision of emergency care were possibly causative of LM's death.

ANALYSIS

Tactics

19. Attempting to engage A2 in healthcare or medical inquests remains challenging for bereaved families. If A2 is engaged, then families can expect the scope of the inquest to be wider. Even more importantly, Chief Coroner's Guidance Note 17 permits a narrative conclusion using judgmental language which is then mirrored in Prevention of Future Deaths Report. LM's case involved a set of facts so egregious that, despite the restrictive case law, the Coroner was prepared to find A2 engaged on two distinct grounds.

20. In reality, although the bar to finding A2 engaged appears that of only an "arguable breach", such inquests are the exception rather than the norm. In our experience, in seeking to meet the legal test practitioners should lay the ground for making an application in respect of A2 as soon as the disclosure provided by the Coroner can reasonably justify such a finding. A chronology demonstrating repeated shortcomings in case is an essential tool for persuasive advocacy at this stage.

21. A successful application at a PIRH can then be a trigger for wider disclosure and change how the Coroner approaches the facts and examination of witnesses. It may also be a gateway for legal aid and vital for any civil damages

claims upon the conclusion of the inquest. On the other hand, an unsuccessful application can always be re-visited at any point during the inquest if fresh evidence and disclosure justify this.

22. A finding that A2 is engaged arising from a death in healthcare will often be a fact sensitive assessment, involving a balancing exercise regarding the burdens imposed on a state's bodies and protecting citizens' A2 rights. It is also not always clear where the dividing line lies between systems and operational duty breaches and, in practice, it is commonplace for operational breaches to be argued in conjunction with systems breaches (see *Maguire* at [180]). In LM's inquest, whilst the Coroner found systemic failings in LN's out-patient care and EMAS's response, he declined to label breaches as a "systems" or "operational" breaches of the A2 duty. This perhaps supports the view that in practice the concepts can regularly overlap in the healthcare sector.

Systemic Breaches

23. In relation to systems duty breaches, staff shortages, lack of resources, delays and waiting times were given considerable weight in LM's case. LM's inability to access a qualified psychiatrist in times of desperate need proved crucial in bolstering the A2 arguments which were made, as he was effectively denied proper or adequate medical support. Critically, too, the Coroner was concerned by the evidence that there were ongoing risks to life: something which was confirmed by both the GP and the local ambulance services' evidence.

Operational Breaches

24. While each situation falls to be considered on its own facts, we think Coroners are persuaded where emphasis can be placed on the particular vulnerability of the patient. There should be evidence before the Coroner of serious and urgent risks which were apparent or should have been apparent to the healthcare provider but which were repeatedly ignored or overlooked. Again, a chronology can be very helpful here.

25. As the High Court in *R (Lee) v HM Assistant Coroner for Sunderland and Others* [2019] EWHC 3227 (Admin) identified, when assessing the breach of an operational duty the "threefold factors of assumed responsibility, vulnerability, and risk" are material to that assessment. It should also be noted that there is a heightened burden or duty on care home providers to medical providers and, as Lord Sales observed in *Maguire* at [57], a "stricter standard of scrutiny" applies for involuntary psychiatric patients.

26. So, whilst the case law is restrictive, LM's inquest shows this can be overcome, leading to a full and searching inquest, robust findings of fact and an assertive Report: all of which can be significant consolation to a grieving family.

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