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Agenda

1. Sunyana Sharma: Article 2
2. Susan Jones: Article 2 Effects
3. Elisabeth Bussey-Jones: Practical considerations for Article 2 inquests

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Article 2

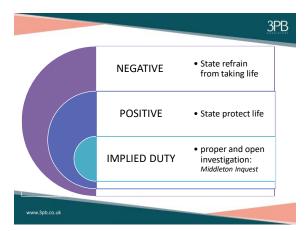
- Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which the penalty is provided by law.
- Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:
 - a. in defence of any person from unlawful violence b. in order to effect a lawful arrest or to prevent the
 - in order to effect a lawful arrest or to prevent the escape of a person lawfully detained, and
 - c. in action lawfully taken for the purpose of quelling a riot or insurrection.



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R (Maguire) v HM Senior Coroner for

Blackpool Fylde [2020] EWCA Civ 738



- Professionals did not appreciate Jackie's life threatening condition
- Failures in communication

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 No advance plan in place to get Jackie to a hospital in the event that she refused to co-operate and admission was urgent.

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The Divisional Court



was not wrong to decide that the procedural duty did not arise on the evidence deployed at the inquest.

"We have reached the conclusion that the touchstone for state responsibility has remained constant: it is whether the circumstances of the case are such as to ${\it call\ a\ state\ to\ account...} In\ the\ absence\ of\ either$ systemic dysfunction arising from a regulatory failure or a relevant assumption of responsibility in a particular case, the state will not be held accountable under article 2."



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The Court of Appeal

Ground 1:

Erred in concluding that procedural obligation under article 2 did not apply. It was not a medical case such as Parkinson

Ground 2:

If Parkinson applied, wrong to conclude that the failure to have in place a system for admitting JM to hospital on 21/02/17 did not amount to a systemic failure.

Ground 3:

Erred in failure to take account of the wider context of premature deaths of people with learning disabilities, which was relevant to the application of article 2 in these circumstances.

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Decision

- 1. There was no basis for believing that JM's death was the result of a breach of the operational duty of the state to protect life...therefore the procedural obligations on the State did not arise.
- 2. An operational duty is not automatically owed to those who are in a vulnerable position in a care home.
- 3. JM's case could be distinguished from a voluntarily a psychiatric patient who was a suicide risk (Rabone). JM was accommodated at the care home to be looked after by carers. She was not there for medical treatment.
- 4. State might be in breach of operation duty in 'two' exceptional circumstances: a. where the state knowingly put an individual's life in danger by denying access to life-saving emergency treatment.
 - b. where a systemic dysfunction resulted in a patient being denied access to life-saving treatment in circumstances where the authorities knew or ought to have known of the risk but failed to take preventative measures.

Lopes de Sousa Fernandez v.

Portugal (2018) 66 EHRR 28, paras 195 to 197

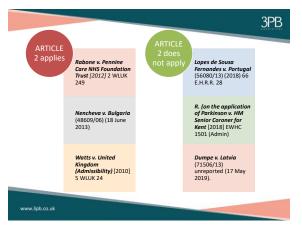
"... the dysfunction at issue must be objectively and genuinely identifiable as systemic or structural in order to be attributable to the state authorities, and must not merely comprise individual instances where something may have been dysfunctional in the sense of going wrong or functioning badly...The dysfunction at issue must have resulted from the failure of the state to meet its obligations to provide a regulatory framework

- The Grand Chamber

in the broader sense indicated above."

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R (on the application of
Teresa <u>Tainton</u>) v HM Senior
Coroner for Preston and
West Lancashire &
Lancashire Care NHS Trust
[2016] EWHC 1396 (Admin)

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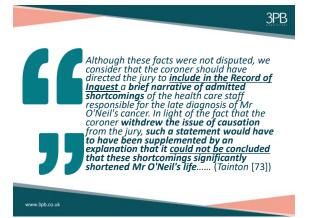
Judicial Review

Whether the Coroner should have directed the Jury to include non-causative

admissions on the record of inquest?

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The Reasons and the Record

The Smith Inquest was conducted by a $\underline{\textbf{Coroner sitting alone}}$.

The Coroner delivered her decision in **TWO PARTS**:

- A carefully structured and reasoned narrative and consideration of the issues delivered orally and made available in writing.
- 2. Completed Record of Inquest.

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The ROI stated:

In Box 3:

"On 28/4/17 the deceased was found hanging by the neck from a bannister at her home address. She was taken to hospital where she was placed on life support. Tests revealed no brain activity was evident and she sadly passed away on 2/5/17. The deceased had a short history of mental health issues with an attempted overdose a week prior to her death. She was receiving antipsychotic medication and was under the care of Mental Health Services at the time of her death".

In Box 4:

"The deceased hung herself with a ligature on 28/4/17. This act caused her death. At the time she took this action it is likely that she was suffering from an episode of psychosis of unknown origin".

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Smith [2020]

Application for Judicial Review

Was the Decision and Record of Inquest compliant with an investigation under Article 2?

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"Both the Reasons and the Record were delivered in public."
Both, therefore, were part of the public record. The argument that more of what appears in the Reasons should have been repeated in the Record has the appearance of an argument of form over substance and we would reject it on that ground alone" (Smith [77]).

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convenient for the points in the second paragraph of the Draft to be added to the Record. In our judgment, it would have been wrong to put them there. They would have compromised the essential brevity and simplicity required of a Conclusion answering the question 'How, when and where, and [this being an Article 2 case] in what circumstances the deceased came by his or her death'. It was correct for the points in the Draft to be placed in the Reasons where the Coroner placed them, and not in the Conclusion'' (Smith [81]).

"It was **neither necessary nor**

3PB Where do these 2 cases leave us? 25 3PB Speaker Susan Jones, Barrister e: susan.jones@3pb.co.uk t: 0330 332 2633 26

Practical considerations for Article 2 inquests

By Elisabeth Bussey-Jones



Questions welcome



