

Where Inquests Raise A Question of Human Rights

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Introduction

1. In his celebrated article, “*The ECHR: Time to Incorporate*”, Lord Bingham identified the key aims of incorporation and how he considered it might affect our legal system:

“it would be naïve to suppose that incorporation of the Convention would usher in a new Jerusalem. As on the morrow of a general election, however glamorous the promises of the campaign, the world will not at once feel very different. But the change would over time stifle the insidious and damaging belief that it is necessary to go abroad to obtain justice. It would restore our country to its former place as an international standard-bearer of liberty and justice. It would help to reinvigorate the faith, which our 18th and 19th century forebears would not for an instance have doubted, that these were the fields in which Britain was the world’s teacher not its pupil. And it would enable the Judges more effectively to honour their ancient and sacred undertaking to do right to all manner of people after the laws of usages of their realm, without fear or favour, affection or ill-will”.

2. Some seventeen years after that lecture, and some ten years on from the coming into force of the Human Rights Act 1998, we are in a position to observe the effects of incorporation on one of the oldest of our judicial systems: the Inquest². In this paper, as we attempt to take measure of the stream of development of the Coroner’s Inquest post-incorporation, we shall occasionally look up from the immediate focus of our attention, to find that it is Lord Bingham more than any other Judge, who has his hand on the tiller.
3. The key Article of the European Convention on Human Rights “the Convention” in relation to Inquests, and that which is the subject matter of this paper is Article 2. It has had a very significant impact on the development of the law concerning coroner’s inquests in England and Wales. Most visibly, it has led to a system where there are

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² Jervis on Coroners 12th Edtn. (2002), traces the existence of the ancient office of coroner back to at least 1194.

now two types of inquest, identified by most practitioners as a *Jamieson* and a *Middleton* Inquest.³ A *Middleton* inquest is required when the state is obliged under Article 2 to investigate a potential breach of its positive Convention duty to protect life. When this obligation is not engaged, a coroner will undertake a *Jamieson* inquest.

4. The *Jamieson* inquest is often viewed as something of a poor relation to the *Middleton* inquest, and one to which Article 2 is irrelevant. Such a view is corroborated by the unfortunate use of terminology in this field, and in particular by references to *Middleton* inquests as “Article 2 inquests”.⁴ It is argued in this paper that this categorisation is unhelpful, and that *Jamieson* inquests are affected by Article 2 in different but significant ways, and that the distinction between the two types of inquest is not as great as it is sometimes portrayed. In large part this is a consequence of the emphasis placed by the Strasbourg and domestic courts on the need for coroners to be given a wide discretion as to how to investigate the facts of the individual case in front of them⁵.
5. This paper examines the following areas: the provisions of the domestic legislation governing coroner’s inquiries; the explicit and implied obligations deriving from Article 2(1) of the Convention; the Strasbourg and domestic jurisprudence on the purposes and requirements of an enhanced investigation into a substantive breach of Article 2; the manner in which those purposes and requirements have been addressed through *Middleton* inquests in England and Wales; the role and scope of *Jamieson* inquests; and finally, the distinction between *Middleton* inquests and *Jamieson* inquests. The paper concludes with a brief postscript on the Coroners and Justice Act 2009.

³ *R (Middleton) v West Somerset Coroner* [2004] UKHL 10; *R v Coroner for North Humberside and Scunthorpe, Ex p Jamieson* [1995] QB 1. Lord Bingham as Master of the Rolls gave the judgement of the Court in *Jamieson*, and the leading speech in *Middleton*.

⁴ See, for example, *Secretary of State for Defence v The Queen on the application of Mrs Catherine Smith* [2009] EWCA Civ 441, per Sir Anthony Clarke, MR at §64.

⁵ s.5(2) of the Coroners and Justice Act 2009 (Royal Assent November 2009), puts *Middleton* on a statutory footing by providing that that: “where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998 (c.42)), the purpose mentioned in section 1(b) [how, when and where the deceased came by his death] is to be read as including the purpose of ascertaining in what circumstances the deceased came by his death”.

The Coroners Act 1988 and the Coroners Rules 1984

6. Coroners' inquests in England and Wales are currently governed by the Coroners Act 1988 ("the 1988 Act") and the Coroners Rules 1984 (SI 1984/552) ("the 1984 Rules"). The main provisions of the Act and the Rules were summarised by Lord Bingham in *R (Middleton) v HM Coroner for the Western District of Somerset*:⁶

23. By section 8(1) of the Act an inquest must be held where there is reasonable cause to suspect that a deceased person:
- (a) has died a violent or an unnatural death
 - (b) has died a sudden death of which the cause is unknown; or
 - (c) has died in prison or in such a place or in such circumstances as to require an inquest under any other Act.

If there is reason to suspect that the death occurred in prison or in police custody or resulted from an injury caused by a police officer in the purported execution of his duty, the inquest must be held with a jury (section 8(3)), and the independence of jurors dealing with prison deaths is specifically protected (section 8(6)). The requirement to summon a jury in such cases recognises the substantive and procedural obligations of the state which are now derived from article 2 as well as from domestic law. If a coroner fails to hold an inquest when he should, he may be ordered to do so, and if a coroner misconducts an inquest, another inquest may be ordered (section 13).

24. The task of the jury is to "inquire as jurors into the death of the deceased" (section 8(2)(a)) and they are sworn "diligently to inquire into the death of the deceased and to give a true verdict according to the evidence" (section 8(2)(b)). The coroner is to "examine on oath concerning the death all persons who tender evidence as to the facts of the death and all persons having knowledge of those facts whom he considers it expedient to examine" (section 11(2)). Thus the character of the proceedings is quite different from that of an ordinary trial, civil or criminal. The jury, where there is one, must hear the evidence and give their verdict (section 11(3)(a)). Section 11(5) requires that the inquisition, to be signed by the jury or a majority of them, must set out in writing, so far as such particulars have been proved, and in such form as the Lord Chancellor may by rule prescribe,
- (i) who the deceased was; and
 - (ii) how, when and where the deceased came by his death.

25. The 1988 Act recognises that a death which is the subject of an inquest may also be the subject of criminal proceedings, and also recognises the general undesirability of investigating publicly at an inquest evidence pertinent to a

⁶ [2004] UKHL 10, [23]-[26]

forthcoming criminal trial. In a departure from previous practice, section 11(6) of the Act provides:

"At a coroner's inquest into the death of a person who came by his death by murder, manslaughter or infanticide, the purpose of the proceedings shall not include the finding of any person guilty of the murder, manslaughter or infanticide; and accordingly a coroner's inquisition shall in no case charge a person with any of those offences."

Thus the inquest jury may no longer perform its former role as a grand jury. Section 16 of the Act (and rules 27 and 28 of the Rules) make provision for the adjourning of an inquest when criminal proceedings are or may be pending on certain specified charges or in certain specified circumstances (but not solely because any criminal proceedings arising out of the death of the deceased have been instituted: rule 32 of the Rules). After the conclusion of criminal proceedings the coroner may resume the adjourned inquest "if in his opinion there is sufficient cause to do so" (section 16(3)). Section 17A makes provision for the adjourning of an inquest when a public inquiry into a death is to be conducted or chaired by a judge. A coroner may only resume an inquest so adjourned "if in his opinion there is exceptional reason for doing so", and then subject to conditions (section 17A (4)).

26. The Coroners Rules 1984 have effect as if made under section 32 of the 1988 Act, which gives the Lord Chancellor, with the concurrence of the Secretary of State, a wide power to make rules for regulating the practice and procedure at inquests and to prescribe forms for use in connection with inquests. The 1984 Rules prescribe a hybrid procedure, not purely inquisitorial or purely adversarial. On the one hand, notice of the inquest must be given to the next-of-kin of the deceased and a widely defined group of other interested parties (rule 19), who are entitled to examine witnesses either in person or by an authorised advocate (rule 20); witnesses are privileged against self-incrimination; notice must be given to, and attendance facilitated of, persons whose conduct is likely to be called into question (rules 24 and 25). On the other hand, the coroner calls and first examines all witnesses, the representative of a witness questioning him last (rule 21); no person is allowed to address the coroner or the jury as to the facts (rule 40); and there is no particularised charge or complaint as in criminal or civil proceedings. In addition to examining the witnesses the coroner (rule 41) sums up the evidence to the jury and directs them as to the law, drawing their attention to rules 36(2) and 42. Rule 43 provides:

"A coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held may announce at the inquest that he is reporting the matter in writing to the person or authority who may have power to take such action and he may report the matter accordingly."

Attention should be drawn to two important rules. The first of these, rule 36, provides:

"(1) The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters, namely – (a) who the deceased was; (b) how, when and where the deceased came by his death; (c) the particulars for the time being required by the Registration Acts to be registered concerning the death."

(2) Neither the coroner nor the jury shall express any opinion on any other matters."

The second, rule 42, provides:

"No verdict shall be framed in such a way as to appear to determine any question of - (a) criminal liability on the part of a named person, or (b) civil liability."

Article 2

7. Article 2(1) of the Conventions provides:

"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 this penalty is provided by law."

8. The terms of Article 2(1) impose two specific obligations. The first is a negative obligation prohibiting a state from depriving life (except under the circumstances provided). The second is a positive obligation to provide a legal system to protect life.

9. In addition to these explicit obligations, the Strasbourg and domestic courts have implied a number of further obligations under Article 2(1) in order to ensure that the Convention's provisions "*operate effectively in practice*",⁷ and are accessible to all within its jurisdiction.⁸ These can be divided into two main categories:

- (i) a substantive duty, in certain well-defined circumstances, to take steps in advance in respect of individuals who are at risk of death from non-state agents. Examples include protecting specific individuals from a real and immediate threat to their life from a third-party,⁹ and

⁷ *Dodov v Bulgaria* (2008) 47 EHRR 41, [83], among others

⁸ Article 1 ECHR; *Z v UK* (2002) 34 EHRR 3, [73], among others.

⁹ *Osman v UK* (1998) 29 EHRR 245

protecting vulnerable individuals, including prisoners and mental health patients in non-voluntary detention, from self-harm.¹⁰

- (ii) a procedural duty to carry out an effective investigation into credible claims that an individual's rights under Article 2 – including the implied substantive rights – have been violated.¹¹

10. In respect of coroner's inquests within England and Wales, the explicit and implicit obligations imposed by Article 2(1) are relevant in two main ways:

- (i) The general obligation: The explicit, positive obligation to provide a legal system to protect life requires a state to facilitate an effective independent judicial system to determine the cause of *any* death and, if necessary, to hold accountable those responsible for it.¹² This duty does not require the state to *initiate* an investigation; its obligations are met by ensuring that there is a suitable system in place.¹³ However, in England and Wales, the traditional style of inquest, as considered in the case of *R v HM coroner for North Humberside and Scunthorpe, Ex p Jamieson*,¹⁴ is a significant means by which the state meets this obligation.
- (ii) The enhanced obligation: The implied, procedural obligation to carry out an effective investigation into credible cases in which Article 2 may have been breached requires a state to *initiate* the necessary proceedings. In addition to the criminal law (and in some cases public inquiries), the primary means of meeting this obligation in England and Wales is the enhanced type of inquest considered in the case of *Middleton*.¹⁵

11. Inquests dealing with cases in the second of these categories are regularly referred to as "*Article 2 inquests*". This is unhelpful and misleading as it is important to

¹⁰ *Keenan v UK* (2001) 33 EHRR 913; *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74

¹¹ See discussion and cases below

¹² *Dodov v Bulgaria*, [80]; *Vo v France* (2005) 40 EHRR 12, [90-91]; Application No. 32967/97 *Calvelli and Ciglio v Italy*, 17 January 2002 [49]; *Powell v UK* (2000) 30 EHRR CD362, [49]

¹³ *R (Smith) v Secretary of State for Defence* [2009] EWCA Civ 441, [83]

¹⁴ [1995] QB 1, CA

¹⁵ *Middleton* [20]; *R (Khan) v Secretary of State for Health* [2003] EWCA Civ 1129, [69]; *R (Takoushis) v HM Coroner for Inner North London and others* [2005] EWCA Civ 1440, [38]

remember that all inquests, including *Jamieson* inquests, are affected by Article 2 considerations.¹⁶ The classic example, considered in further detail below, is where a patient in an NHS hospital dies as a result of “mere” negligence. Although the patient’s substantive Article 2 rights have not been violated the state still has an obligation under Article 2(1) to provide an independent judicial system to establish the cause of death and any liability.

12. It is also important to remember that, in general, neither *Jamieson* nor *Middleton* inquests represent the sole means by which the state seeks to meet its general or enhanced investigative obligations under Article 2(1) in England and Wales. The wider civil and criminal law, disciplinary proceedings and public and internal inquiries may all play a part in discharging the relevant duty. The interaction between coroner’s inquests and other investigations is considered in greater detail below.

The Enhanced Investigative Obligation Under Article 2

Underlying principles

13. The Strasbourg and domestic courts have emphasised that what is required of an enhanced investigation will vary from case to case:¹⁷

“The duty to investigate imposed by Article 2 covers a very wide spectrum. Different circumstances will trigger the need for different types of investigation with different characteristics. The Strasbourg court has emphasised the need for flexibility and the fact that it is for the individual state to decide how to give effect to the positive obligations imposed by Article 2.”

14. However, the courts have sought to establish the fundamental purpose of enhanced investigations. In *Edwards v UK*, a case in which a prisoner killed his cell-mate, the Strasbourg Court stated that:¹⁸

¹⁶ *Takoushis*, [38]

¹⁷ *R (JL) v Secretary of State for Justice* [31], per Lord Phillips

¹⁸ (2002) 35 EHRR 487, [69]; see also *Jordan v UK* (2001) 37 EHRR 52, [105] among others.

“The essential purpose of such investigation is to secure the effective implementation of domestic laws which protect the right to life and, in those cases involving state agents or bodies, to ensure their accountability for deaths occurring under their responsibility.”

15. Lord Bingham expanded on these principles in the similar case of *R (Amin) v Secretary of State for the Home Department*,¹⁹ in a passage that has regularly been cited as a starting point in cases considering the enhanced duty:²⁰

“The purposes of such an investigation are clear: 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.”

What is required?

16. The Strasbourg Court has developed a series of essential requirements that must be met in order to discharge the enhanced investigative duty.²¹ These initially arose in cases of deliberate killings by state agents, but the principles have been extended to other cases in which the duty is engaged.²² The requirements have been applied by the domestic courts, most notably by Lord Bingham in *Amin*.²³ They are:

- (i) The investigation must be initiated by the state itself.
- (ii) The investigation must be effective. In *Jordan v UK*, it was stated that the investigation had to be, “*capable of leading to a determination of whether the force used in such cases was or was not justified in the circumstances...and to the identification and punishment of those responsible.*”²⁴ This case, and many others,²⁵ have emphasised that this is “*not an obligation of result, but of means*”, so that it is the process and not the outcome that is relevant to the Article 2 obligation:

¹⁹ [2004] 1 AC, HL [31]

²⁰ See, among others, *JL*, [27]; *The Minister for Legal Aid v R (Main)* [2007] EWCA Civ 1147, [19]

²¹ See, among others: *McCann v UK* (1995) 21 EHRR 97, *Yasa v Turkey* (1998) 28 EHRR 408; *Jordan v UK*; *Salman v Turkey* (2000) 34 EHRR 425, *Edwards v UK* *Nadrosov v Russia*, (2007), 31 July 2007

²² *Salman v Turkey*, *Edwards v UK*

²³ *Amin*, [20], [23]. See also, *JL* [35] among others.

²⁴ *Jordan v UK*, [106]

²⁵ *Nadrosov v Russia*, [38]; *Edwards v UK*, [71]

“[the investigation] should in principle be capable of leading to the establishment of the facts of the case and, if the allegations prove to be true, to the identification and punishment of those responsible”.²⁶ The Strasbourg Court has also stressed the need for the state to take the reasonable steps available to secure relevant evidence.²⁷

- (iii) It must be carried out by a person who is independent of those implicated by the events being investigated. This independence requires, “not only a lack of hierarchical or institutional connection but also a practical independence”.²⁸
- (iv) There must be sufficient public scrutiny of the investigation or its results to secure accountability in practice as well as in theory.
- (v) The next-of-kin must be involved in the procedure to the extent necessary to safeguard his or her legitimate interests.
- (vi) The investigation must be prompt and carried out with reasonable expedition.

17. A further requirement has developed in relation to cases involving possible systemic failings that give rise to Article 2 claims:²⁹

“the competent authorities must... initiate investigations capable of, first, ascertaining the circumstances in which the incident took place and any shortcomings in the operation of the regulatory system”

When it is required

18. As is noted above, the Strasbourg Court initially developed these principles in cases involving deliberate killings by state agents.³⁰ However, both Strasbourg and the domestic courts have extended the circumstances where the state’s obligation to undertake an enhanced investigation is triggered. The rationale for this expansion was given by Lords Bingham in *Amin*:

²⁶ *Nadrosov v Russia*, [38]

²⁷ *Edwards v UK*, [71] among others

²⁸ *Jordan v UK* [106]

²⁹ *Öneryildiz v Turkey* (2005) 41 EHRR 20, [94]; see also *Trubnikov v Russia* App. No. 4979/99, 4 July 2005 [85], [88]

³⁰ See, for example, *McCann v UK*, *Jordan v UK*

“while any deliberate killing by state agents is bound to arise very grave disquiet, such an event is likely to be rare and the state’s main task is to establish the facts and prosecute the culprits; a systemic failure to protect the lives of persons detained may well call for even more anxious consideration and raise even more intractable problems.”³¹

19. Examples of circumstances in which it has been held or stated that there is a need for an enhanced investigation include:

- (i) The death of a prisoner at the hands of his cell-mate;³²
- (ii) Prison suicides;³³
- (iii) The suicide of a patient detained under the Mental Health Act 1983;³⁴
- (iv) The death of a prisoner due to inadequate medical attention;³⁵
- (v) The death, by hyperthermia, of a (non-conscripted) soldier while on active service in Iraq;³⁶
- (vi) The death of a patient where there was a potential failure to act upon information that was expressly brought to the authorities’ attention to the effect that a GP had been administering opiates to terminally ill patients in lethal doses;³⁷
- (vii) Circumstances where a death has been or may have been caused by the failure of the state to protect the deceased from environmental hazards.³⁸

20. A number of cases in the Strasbourg and the domestic courts have explored the boundary between instances where the enhanced investigative duty is triggered and those where it is not. This is a developing and fluid area of law, in which settled principles can be elusive.

³¹ per Lord Bingham, [21]

³² *Edwards v UK*

³³ *Keenan v UK* (2001) 33 EHRR 913; *Trubnikov v Russia*

³⁴ *Savage v UK*. Lord Rodger expressly stated in *Savage* that he was not considering the procedural obligations under Article 2 [17]. However, he found that the principles developed by the Strasbourg Court in respect of prisoners also applied to patients detained under the Mental Health Act [49]. It follows, as the Court of Appeal states in *Smith*, [103], that the circumstances in which an enhanced investigative obligation is triggered in respect of prisoners would also trigger that obligation in respect of detained mental health patients.

³⁵ *R (Wright) v Secretary of State for Home Affairs* [2001] UKHRR 1399; approved by Lord Bingham in *Edwards v UK*, [25]; *Tariyeva v Russia* (2009) 48 EHRR 26

³⁶ *Smith*

³⁷ *R (Moss) v HM Coroner for the North and South Districts of Durham and Darlington* [2008] EWHC 2940

³⁸ *Öneryıldız v Turkey*

21. At the most fundamental level, the House of Lords have held that the enhanced investigative obligation under Article 2 is “*parasitic upon the existence of a substantive right*”.³⁹ Thus a claimant needs to make an arguable case that a substantive Article 2 right has been breached before the obligation is triggered. In *R (Gentle and another) v The Prime Minister and others*, a case in which the relatives of two servicemen killed in Iraq sought an enhanced investigation into the legality of the war, it was held that no such substantive right was engaged and hence the application failed.
22. In medical negligence cases, it has been held that “mere” negligence does not breach Article 2 and hence does not trigger an enhanced investigation. The Strasbourg Court found in *Powell v United Kingdom* that:⁴⁰

“The Court accepts that it cannot be excluded that the acts and omissions of the authorities in the field of health care policy may in certain circumstances engage their responsibility under the positive limb of Article 2. However, where a Contracting State has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, it cannot accept that matters such as errors of judgment on the part of a health professional or negligent co-ordination among health professionals in the treatment of a particular patient are sufficient of themselves to call a Contracting State to account from the standpoint of its positive obligations under Article 2 of the Convention to protect life.”

In short, in order to trigger the enhanced investigative obligation, a claimant must establish the treatment in question went beyond “mere” negligence by an individual or individuals and represented a failure by the state to meet its Article 2 obligations to make adequate provisions for healthcare standards and the lives of patients.⁴¹

23. Although this distinction between “mere” or “operational” negligence and “systemic” negligence such as to breach a substantive Article 2 right is tolerably clear in theory, the practical utility of this approach has been doubted. In *JL*, Lord Walker stated that:⁴²

³⁹ *R (Gentle and another) v The Prime Minister and others* [2008] UKHL 20, [6]. See also the Court of Appeal judgment in *R (Amin) v The Secretary of State for the Home Department* [2002] EWCA Civ 390, [32], which was overruled by the House of Lords on other points.

⁴⁰ *Powell v UK* (2000) 30 EHRR CD362, pp17-18; cited in *Takoushis*, [87]

⁴¹ See also *Takoushis*, [105]-[107]; *Savage*, [68]-[71]; *Richard Rabone v Gillian Rabone and Pennine Care NHS Trust* [2009] EWHC 1827 (QB), [77]-[82]

⁴² *JL*, [88]

“at a lower level there is often no clear dividing line between systemic and operational failure, and the distinction is one of degree only. Moreover an excessively elaborate and prescriptive system may carry the seeds of its own failure, in that it may be predictable that overworked and under-motivated staff in the lower levels of the system will be unable or unwilling to comply fully with it. In the Prison Service, as in branches of the social services dealing with vulnerable old people and children, there is almost inevitably a gulf between policy-makers’ visions of informed, collective, multi-disciplinary decision-taking and the incidents of missing files, missed appointment, misunderstandings and muddling through which regrettably occur among those on the ground.”

24. In respect of deaths in custody, the courts have in effect taken the view that any death by force (including self-inflicted force) potentially involves a substantive breach of the state’s Article 2 obligations and hence should be subjected to an enhanced investigation. In *R (Sacker) v HM Coroner for West Yorkshire*, a prison suicide case, the House of Lords explained why:⁴³

“It is hard to fault the attention that has been given to this problem by senior management in the Prison Service and by the Prison Inspectorate. There is a high level of awareness, and much effort has been devoted to improving the system for the prevention of suicides. But every time one occurs in a prison the effectiveness of the system is called into question. So all the facts surrounding every suicide must be thoroughly, impartially and carefully investigated. The purpose of the investigation is to open up the circumstances of the death to public scrutiny. This ensures that those who were at fault will be made accountable for their actions. But it also has a vital part to play in the correction of mistakes and the search for improvements. There must be a rigorous examination in public of the operation at every level of the systems and procedures which are designed to prevent self-harm and to save lives.”

25. Although much of the logic in the two previous quotations applies to non-prisoner cases, the courts have continued to hold that there is a firm distinction between deaths in custody and other negligently caused deaths. In *Takoushis*, a case in which a voluntary mental health patient killed himself after leaving a hospital where there had been a delay in assessing him, the Court of Appeal held that:⁴⁴

“We do not accept Mr Fitzgerald’s submission that the principles in the custody cases.... apply here because Mr Takoushis would have been detained [under the Mental Health Act 1983] if the hospital had been aware that he was

⁴³ [2004] UKHL 11, [11]

⁴⁴ *Takoushis*, [108]; see also, in a different but related context, *Rabone*, [55]

about to leave the hospital. In our opinion there is an important difference between those who are detained by the state and those who are not. Mr Takoushis was not.”

26. Thus on one view of negligence cases (excepting gross negligence, on which see below), an enhanced investigation will only be required where an applicant can make an arguable case that a death was the result of systemic failures that were serious enough to breach the state’s Article 2 obligations to provide systems and laws to protect the deceased’s life. In custody cases the threshold is so low that it is crossed whenever a death by force occurs, but the courts have emphasised that these cases involve a different approach than that which is taken elsewhere. However, it is possible to argue from Lord Walker’s comments in *JL*, that the courts should take a flexible approach to the question of when the enhanced investigative obligation is triggered; in particular, the courts should be sympathetic to an argument of systemic failures in social services cases involving vulnerable people.

27. In respect of *gross* negligence, the case of *R (Khan) v Secretary of State for Health*, has been cited as authority for the proposition that the possibility of gross medical negligence triggers the enhanced investigative obligation.⁴⁵ There are some problems with this proposition. First, *Khan* was decided with reference to the Court of Appeal’s judgment in *Amin*, which was subsequently overturned in the House of Lords.⁴⁶ Second, while the Court of Appeal in *Takoushis* raised the possibility that gross negligence “*may*” trigger the enhanced investigative duty, it did not decide the point.⁴⁷ Third, Blake J in *R (Moss) v HM Coroner for the North and South Districts of Durham and Darlington* doubted that the degree of negligence should determine whether or not Article 2 was breached: “*if ordinary carelessness by an individual doctor is not to be treated as a breach of that obligation, I do not see why particularly bad carelessness should do so.*”⁴⁸ Finally, such a distinction will in practice require the investigating body to undertake the extremely difficult task of deciding, at the outset of its work, whether the allegation involves “gross” or “mere” negligence. It should be noted in this regard that Simon J in *Richard Rabone v Gillian Rabone and*

⁴⁵ [2003] EWCA Civ 1129

⁴⁶ See, for example, *Khan*, [64] and [67], cited at *Takoushis*, [96]

⁴⁷ *Takoushis*, [96]

⁴⁸ [2008] EWHC 2940, [24]

Pennine Care NHS Trust rejected the suggestion that a test of “*serious negligence*” should be used in order to establish whether Article 2 had been breached.⁴⁹

28. It is submitted that Blake J was right to question the utility of a distinction between “gross” and “mere” negligence in this area. This does not, however mean that the enhanced investigative duty will not be triggered in cases of gross negligence. As in the case of all deaths that are potentially the result of criminal actions, the state’s explicit duty to provide a system of laws to protect lives will require it to investigate the death with a view to bringing criminal charges. If the facts of the case reveal problems in procedures, regulations or systems that potentially constitute a further breach of Article 2, these too will have to be investigated. As is discussed below, if these issues are not sufficiently examined in the criminal examination, a further investigation will have to be initiated by the state. This will usually be in the form of a *Middleton* inquest, or (rarely) a public Inquiry.

***Middleton* Inquests in England and Wales**

The decision in *Middleton*

29. The leading case concerning the application the Article 2 principles to coroner’s inquests in England and Wales is *Middleton*, in which Lord Bingham addressed the following three questions:⁵⁰

“(1) What, if anything, does the Convention require (by way of verdict, judgment, findings or recommendations) of a properly conducted official investigation into a death involving, or possibly involving, a violation of Article 2?”

(2) Does the regime for holding inquests established by the Coroner’s Act 1988 and the Coroners Rules 1984 (SI 1984/552) as hitherto understood and followed in England and Wales, meet the requirements of the Convention?

(3) If not, can the current regime governing the conduct of inquests in England and Wales be revised so as to do so, and if so, how?”

⁴⁹ *Rabone*, [86]-[87]

⁵⁰ *Middleton*, [4]

30. In answer to the first question, Lord Bingham held:⁵¹

“To meet the procedural requirement of Article 2 an inquest ought ordinarily to culminate in an expression, however brief, of the jury’s conclusion on the disputed factual issues at the heart of the case.”

31. In response to the second and third questions, he found that the existing system was not compliant with the Convention, but that:⁵²

“Only one change is in our opinion needed: to interpret “how” in section 11(5)(b)(ii) of the Act and rule 36(1)(b) of the Rules in the broader sense previously rejected, namely as meaning not simply ‘by what means’ but ‘by what means and in what circumstances’.”

The narrower interpretation of s.11 and rule 36 is considered below in relation to *Jamieson* inquests.

32. Although the alteration to the existing system prescribed by Lord Bingham was modest, the decision in *Middleton* and the wider issues raised by Article 2 have led to numerous considerations and reconsiderations of the practical requirements for coroner’s inquests in cases where the enhanced investigative obligation is triggered. This is the consequence of the emphasis placed by the Strasbourg Court on the need to tailor the investigation to the facts of the specific case. Thus any given *Middleton* inquest affords a wide opportunity for the interested parties to make requests and representations on the methods to be adopted. While this assists in the individual case, it comes at the cost of some uncertainty to the wider system. Some of the most significant developments in this continually developing area are considered in turn below.

Representation of the family

33. Following the Strasbourg case law, there is a clear requirement for the deceased’s next-of-kin to participate in a *Middleton* inquest to the extent necessary to safeguard his or her legitimate interests. In some cases this may require the provision of legal

⁵¹ *Middleton*, [20]

⁵² *Middleton*, [35]

aid. For example, in *Khan* the family of the deceased were so traumatised by the death that they were in “*no fit state*” to play an effective part in an inquest by themselves, and hence it was held that the state had to make provision, through legal aid or some other means, for their representation.⁵³ In *R (Smith) v Assistant Deputy Coroner for Oxfordshire*, Collins J held that he had “*no doubt*” that, subject to financial eligibility, a failure to provide legal aid to the families in that case would be likely to breach their rights.⁵⁴

34. It is not, however, possible to state as a broad principle that Article 2 requires that legal aid should be available to all or even most of those involved in *Middleton* inquests who meet the financial eligibility requirements. This is the result of two principles that have been repeatedly referred to by the Strasbourg court: first, is the general requirement that each case be assessed on its individual facts; second is the proposition that the next-of-kin’s right to participation extends only to those areas in which he or she has a legitimate interest.

35. When applying these principles to inquests, the domestic courts have emphasised the role of the coroner and the inquisitorial process in safeguarding the families’ interests without the need for additional representation. In *Khan*, the Court of Appeal held:⁵⁵

“the function of an inquest is inquisitorial, and, in the overwhelming majority of cases the coroner can conduct an effective judicial investigation himself, without there being any need for the family of the deceased to be represented.”

The Court of Appeal went on to find that *Khan* itself was an exceptional case, given the complexity of the evidence involved and the inability of the family to represent themselves.⁵⁶

36. Although *Khan* was decided before *Middleton* and was, therefore, referring to inquests in general, similar points were made in *Minister for Legal Aid v The Queen on the application of Tobias Main* [2007] EWCA Civ 1147. The case involved the refusal of a request for legal aid for a *Middleton* inquest by a relative of two victims

⁵³ *Khan*, [74], [87]-[101]

⁵⁴ [2008] EWHC 694 (Admin), [33]

⁵⁵ *Khan*, [74]

⁵⁶ *Khan*, [74]-[75]

of a rail crash. The Court of Appeal rejected the argument that the decision was irrational and/or incompatible with Article 2, holding that:⁵⁷

“[49]...To conclude that Article 2 required [legally aided] representation in this case would go beyond all European or domestic precedent.

“[50] The question is whether the coroner could reasonably be expected to carry out a proper investigation into the deaths of the deceased, including wider safety aspects which have been identified, without full legal representation of the family. In our judgment the answer to that question is yes.”

37. As ever, the facts of the case are critical. In support of the claimant’s position, the case raised complex issues that required expert evidence (e.g. on relevant safety measures), there was evidence that the claimant had been severely traumatised and would not be willing or able to play an active part in the hearing, and the coroner supported the claimant’s application.⁵⁸ However, the Court held that these factors were outweighed by the following considerations: (i) the Appellant had been granted Legal Help, although not representation; (ii) the accident had already been the subject of investigation by a rail safety authority and the police; (iii) the facts of the accident were unlikely to be in dispute and did not reveal serious wrong-doing by agents of the state; (iv) there was no reason to suspect that the experts in the case were likely to be evasive or to participate in a cover-up.⁵⁹

38. In *Bubbins v UK* (2005) 41 EHRR 458 the Strasbourg Court held that the enhanced investigative duty was not breached in a case where the family of the deceased were represented at an inquest despite the non-availability of legal aid.⁶⁰

39. The principle that the next-of-kin participation need only be sufficient to safeguard their legitimate interests might lead to cases in which the family of the deceased are given only partial representation or assistance, such that they are able to contribute more to some parts of the inquest than to others. In *R (Scholes) v Secretary of State for the Home Department*, a case concerning the suicide in custody of a sixteen year

⁵⁷ *Main*, [49]-[50]

⁵⁸ *Main*, [5], [28]

⁵⁹ *Main*, [3], [14], [50]

⁶⁰ (2005) 41 EHRR 24, [163]

old, Pill LJ held that:⁶¹ “Participation in issues of sentencing policy and the allocation of resources are in a different category from the investigation of the particular facts of the case.”

The functions of the coroner and the jury

40. In *Middleton*, Lord Bingham addressed the issue of how an inquest jury could give the conclusions on the central issues of fact that were necessary for compliance with the enhanced investigative obligation under Article 2. He stated that this was a matter for individual coroners, but suggested various methods that might be adopted such as traditional short form verdicts, expanded verdicts, narrative verdicts and questionnaires inviting answers to factual questions put by the coroner. In respect of the last category, Lord Bingham suggested that it might be helpful to direct the jury with reference to some, but importantly not all, of the matters to which a sheriff will have regard under s.6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976:⁶²

“where and when the death took place; the cause or causes of such death; the defects in the system which contributed to the death; and any other factors which are relevant to the circumstances of the death.”

41. Lord Bingham emphasised that the prohibitions in the domestic legislation against the jury expressing opinions beyond those required of them, and against making findings of criminal or civil liability remained. He gave the following example of a suitable verdict:⁶³

“A verdict such as that suggested in paragraph 45 below (“The deceased took his own life, in part because the risk of his doing so was not recognised and appropriate precautions were not taken to prevent him doing so”) embodies a judgmental conclusion of a factual nature, directly relating to the circumstances of the death. It does not identify any individual nor does it address any issue of criminal or civil liability. It does not therefore infringe either rule 36(2) or rule 42 [of the 1984 Rules].”⁶⁴

⁶¹ [2006] EWCA Civ 1343, [74]-[75]

⁶² *Middleton*, [36]

⁶³ *Middleton*, [37]

⁶⁴ It is sometimes the case that coroners direct juries that permissible language may include words such as “inadequate”, “inappropriate”, “inefficient”, “insufficient”, “lacking”, “unacceptable”, “unsuitable”; whilst, impermissible language includes: “breach of duty”, “careless”, “foolish”, “guilty”, “negligent”, “reckless”, “reprehensible”.

42. The relatively limited role of the jury in making its verdict is to be contrasted with the power of the coroner under rule 43 of the 1984 Rules, set out at paragraph 4 (26) above, to report to the relevant authorities on actions that he believes should be taken to prevent the recurrence of fatalities similar to that which he is investigating. In respect of rule 43, Lord Bingham said the following in *Middleton*:⁶⁵

“Under the 1984 Rules, the power is reserved to the coroner to make an appropriate report where he believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held. Compliance with the Convention does not require that this power be exercisable by the jury, although a coroner's exercise of it may well be influenced by the factual conclusions of the jury. In England and Wales, as in Scotland, the making of recommendations is entrusted to an experienced professional, not a jury. In the ordinary way, the procedural obligation under article 2 will be most effectively discharged if the coroner announces publicly not only his intention to report any matter but also the substance of the report, neutrally expressed, which he intends to make.”

43. The respective roles of jury and coroner were examined by the Court of Appeal in *R (Lewis) v HM Coroner for the Mid and North Division of Shropshire and another*.⁶⁶ The deceased, Karl Lewis who was then 18, hung himself while in a Young Offenders' Institution. As he was hanging, he was seen by a prison officer who had received no suicide prevention or first-aid training, who was not equipped with the standard tool for cutting suicides down, and who reported the incident incorrectly over his radio. As a result of these failings, help took longer than it should have done to arrive. However, it was not possible to establish that it was more likely than not that appropriate and swifter intervention would have saved Karl's life, and the action that was taken after Karl was found hanging in his cell was not left to the jury's consideration at the inquest.⁶⁷

44. It was argued on behalf of Karl's father that although the circumstances outlined above could not, on the balance of probability, have been shown to have caused or contributed to the death, they *should* nonetheless have been left to the jury. The Court of Appeal dismissed the appeal on the basis that the coroner did not have a *duty*,

⁶⁵ *Middleton*, [38]

⁶⁶ [2009] EWCA Civ 1403

⁶⁷ *Lewis*, [4]-[5]

under domestic or Strasbourg authority, to leave possibly causative factors to the jury. In particular, it was noted that while the House of Lords in *Middleton* had included several of the questions referred to in s.6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 as relevant matters for a jury to consider, it had apparently deliberately excluded s.6(1)(c): “*the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been excluded*” [emphasis added].⁶⁸ Etherton LJ held that the jury’s role as set out in the 1988 Act:⁶⁹

“is more naturally confined to the actual, that is to say, probable causes of death rather than all possible causes, even if less than probable, That also fits naturally into a scheme in which limited issues are left to the jury, but a much wider power is given to the coroner, a professional adjudicator, to report on systemic failures. As I have said, Strasbourg jurisprudence does not require a different conclusion.”

45. Etherton LJ’s ruling is in line with that of Pill LJ in *Scholes*, where he was critical of a coroner putting questions to the jury on potential criticisms of resource allocation and policy:⁷⁰

“As a fact finding tribunal, the jury is well established and valued... Questions [put by the coroner] on factual issues will sometimes be helpful. However, the value of a jury’s views as a tool for assessing and improving procedures is in my view limited in circumstances where further investigation of policies and administrative procedures, as distinct from facts, is required.”

46. However, *Lewis* raises two further points that qualify the final decision in that case in important ways. The first is that although Sedley LJ held that there was no duty for the coroner to leave possible (as opposed to probable) contributing factors to the jury, he did allow that there was a discretion to do so, especially if this enabled the coroner to obtain a finding of fact that was of relevance to a rule 43 report:⁷¹

“For my part I see no reason to doubt the propriety of the ruling we have been shown of the City of London coroner in the case of *Heather Claire Watts* (3 July 2006) that

‘the jury may, in addition to finding the direct or indirect causes or contributions to death, also find facts relevant to the exercise of the coroner’s power under rule 43.’

⁶⁸ *Lewis*, [21]-[22], [41]

⁶⁹ *Lewis*, [40]

⁷⁰ *Scholes*, [70]; see also the examples given by Pill LJ at [69]

⁷¹ *Lewis*, [27]

This is likely to be more useful – as the House of Lords suggested in *Middleton* [20]⁷² – where facts are disputed or uncertain. Indeed it may be in such cases that a finding by verdict is a desirable or even a necessary foundation of any rule 43 report.”

And later:⁷³

“it can intelligibly be said that, in a jurisdiction which is not concerned with the allocation of blame, potentially causative circumstances can be just as relevant as actually causative ones.”

47. The second additional point is that although the issue was not pursued in the appeal, Sedley LJ found that the coroner had breached rule 43 by failing to report on the systemic failings revealed by the actions of the prison officer who found Karl:⁷⁴

“The want of equipment, training and effective procedure which the undisputed evidence revealed was so eloquent of action that needed to be taken to prevent similar fatalities that the coroner cannot have believed otherwise... In such a situation the permissive power [in rule 43] – ‘may report’ – could only be properly exercised in one way if the purposes of article 2 were to be respected, and that was by making a report on the issue.”

48. It follows from *Middleton* and *Lewis* that while the role of the jury is generally relatively limited, the range of issues on which it may pronounce may be expanded at the discretion of the coroner. Its findings of fact may be a helpful, or indeed an essential base from which the coroner can exercise his wider powers to report under rule 43. Finally, circumstances may mean that although the coroner’s power under this rule is expressed in permissive language, a failure to report an egregious systemic failure can amount to an unlawful breach of duty.

The scope of the investigation

49. In order to fulfil its role as an effective investigation into a purported breach of Article 2, a *Middleton* inquest will have to address the circumstances in the case that are said to have caused the breach. It was for this reason that Lord Bingham used section 3 of

⁷² It is submitted that the correct reference is to paragraph 38 of *Middleton*, quoted at paragraph 40 of this paper.

⁷³ *Lewis*, [28]

⁷⁴ *Lewis*, [16]; see also [38] per Etherton LJ

the Human Rights Act 1998 (“HRA 1998”) to interpret s.11(5)(b)(ii) of the 1988 Act and rule 36(1)(b) of the 1984 Rules in *Middleton* in the way that he did.

50. The higher courts have stressed that the scope of investigation at an inquest is a matter for the coroner.⁷⁵ However, they have also given indications in particular cases about the matters that they consider should be examined. In *Smith*, where the deceased soldier died of hyperthermia while on active service in Iraq, the Court of Appeal stated:⁷⁶

“The precise limits of the inquest will of course be a matter for the coroner but we would expect the coroner to consider the questions whether there were any systemic failure in the army which led to Private Smith’s death and, indeed, whether there was a real and immediate risk of his dying from heatstroke and, if so, whether all reasonable steps were taken to prevent it.”

51. The Court of Appeal’s decision in *Lewis*, considered above, raises interesting issues about the scope of the investigation in that case, as well as the respective roles of the coroner and the jury. Sedley LJ’s finding that the coroner had breached rule 43 by not reporting the deficiencies in the actions of the prison officer who saw Karl hanging in his cell indicates that the failures were so grave that this was a matter that the coroner *had* to investigate, even though it was only a possible (and not probable) causative factor in the death.⁷⁷

52. The approach in *Smith* and *Lewis* is in line with the principles set out by the House of Lords in *Sacker* (quoted at paragraph 22 above), on the purpose of the enhanced investigation in ensuring public scrutiny of closed systems, identifying responsibility for errors, and assisting in correcting mistakes and seeking improvements.

53. However, in *Middleton* itself Lord Bingham stated that it would not always be necessary to take advantage of the broadening of the verdict (and by implication, the investigation) that his decision allowed. The facts of some cases were such that all Article 2 obligations could be met by relatively straightforward factual examinations

⁷⁵ See, among others, *Hurst*, [7], [51] *Smith* [106], quoted in the following paragraph.

⁷⁶ *Smith*, [106]

⁷⁷ See also *R (Pounder) v HM Coroner for the North and South Districts of Durham and Darlington* [2009] EWHC 76 (Admin), [73] where Blake J held that an inquest into the death in detention of 14 year old Adam Ricketts was defective because, among other reasons, it had failed to consider the lawfulness of the use of force by staff at the Secure Training Centre.

and the traditional short-form (*Jamieson*) verdicts.⁷⁸ Lord Bingham gave the example of the *McCann v UK*, in which the deceased, a suspected terrorist, had been shot by British soldiers in Gibraltar in the “Death on the Rock” killings.⁷⁹ The Strasbourg Court made some criticisms of the pre-*Middleton* inquest in that case, but concluded that these had not substantially hampered the carrying out of a thorough, impartial and careful examination of the circumstances of the killing.⁸⁰

54. It had been thought, based on the decision in *Powell v UK*, that a further limitation on the scope of an inquest was that it need only examine the events leading up to a death, and not allegations of a cover-up afterwards.⁸¹ However, *Powell v UK* was distinguished in *Khan*, where the Brooke LJ held that the failure to investigate concerns about a “*medically orchestrated cover-up*” was one of the reasons why the state was in breach of its Article 2 obligations:⁸²

“this case is a long way from the case of *Powell* where the alleged falsification of records was discrete and separate from the negligent omissions with which the doctors were charged. Here the alleged cover-up was close to the centre of the events into which the coroner will be inquiring, and the evidence as to what really happened could cast light on the credibility of the Trust’s witnesses in this respect.”

55. As these decisions show, the emphasis on flexibility and the need to respond to the facts of the individual case means that it can be difficult to assess where the investigative boundaries of an inquest lie. This is particularly the case where issues of policy and resource allocation are raised.

56. *Taylor v UK (Admissibility)* concerned the investigation into the deliberate killing and injuring of a number of children by a trainee nurse.⁸³ The nurse was convicted of murder and attempted murder following a criminal investigation, and an internal inquiry was established under a senior Queen’s Counsel. The European Commission

⁷⁸ *R (P) v HM Coroner for Avon* [2009] EWHC 820 (Admin)

⁷⁹ (1995) 21 EHRR 97

⁸⁰ *Middleton*, [14], [31]; *McCann v UK* [163]

⁸¹ *Powell v UK*, pp17-18, quoted in *Takoushis*, [87]

⁸² *Khan*, [70]

⁸³ (1994) (23412/94) 18 EHRR CD 215 Eur Comm HR

on Human Rights ruled that a complaint that a public inquiry had not been held was inadmissible on the grounds of being manifestly ill-founded:⁸⁴

“The Commission acknowledges that neither the criminal proceedings nor the Inquiry addressed the wider issues relating to the organisation and funding of the National Health Service as a whole or the pressures which might have led to a ward being run subject to the shortcomings apparent on Ward Four.... The Commission finds no indication that the facts of this case have not been sufficiently investigated and disclosed, or that there has been any failure to provide a mechanism whereby those with criminal or civil responsibility may be held answerable. **The wider questions raised by the case are within the public domain and any doubts which may consequently arise as to policies adopted in the field of public health are, in the Commission's opinion, matters for public and political debate which fall outside the scope of Article 2 and the other provisions of the Convention.**”
[emphasis added]

57. In *Scholes*, a prison suicide case, Pill LJ cast some doubt on this authority.⁸⁵ He held that in that case there *was* an Article 2 duty on the state to consider broad issues, such as sentencing policy and resource allocation, that had been raised by the factual findings of the inquest. However, as is discussed above, he doubted whether it was appropriate for a jury to include such matters in a verdict, and dismissed the appeal on the basis that a public inquiry was neither the sole nor (on the facts of the case) a necessary means of discharging the obligation.⁸⁶

58. However, the decision in *Taylor* was supported by Arden LJ in her judgment in *Scholes*:

82. There is, however, a distinction to be drawn between legal and political questions. In *A v Secretary of State for the Home Department* at paragraph 29, Lord Bingham also held:

"The more purely political (in a broad or narrow sense) the question is, the more appropriate it would be for political resolution and the less likely it is to be for an appropriate matter for judicial decision. The smaller therefore would be the potential role of the court. It is the function of political and not judicial bodies to resolve political questions. Conversely, the greater the legal content of any issue, the greater the potential role of the court because under our constitution

⁸⁴ *Taylor*, CD221

⁸⁵ *Scholes*, [67]

⁸⁶ *Scholes*, [66]-[73]

and subject to the sovereign power of Parliament it is the function of the courts and not of political bodies to resolve legal questions."

83. Likewise, in this case, as it seems to me, Mrs Scholes is in part seeking, by way of individual rights under article 2 of the Convention, to intervene in the political process which determines the allocation of resources to institutions such as secure children's homes. In my judgment, in so far as she seeks to do so or to establish a right for members of the public to be consulted on these matters, she seeks to carry Convention rights further than authority or Convention jurisprudence would require (see, for example, the Taylor case, cited by Pill LJ in para. 60 of his judgment).

59. Lord Bingham addressed this disagreement in *Gentle*, where he stated (obiter) that he did not think that the authorities justified Pill LJ's doubting of *Taylor*, and that he thought Arden LJ's approach was correct.⁸⁷ His comments carry particular weight given his leading judgment in *Middleton*, to which Pill LJ referred in the relevant paragraph of his judgment in *Scholes*.⁸⁸

60. The importance placed by the Strasbourg and domestic courts on a flexible approach to each case and the coroner's discretion in setting the parameters of his inquiry make it difficult to distil the case law in this area to a few pithy principles. However, it can be said that a *Middleton* inquest needs to be broad enough to deal with the Article 2 issues at stake before it, and that this *may* require a consideration of circumstances (such as systemic failings or an alleged cover-up) that are raised by the death even though they cannot be said, on the balance of probabilities, to have contributed to it. However, a coroner should exercise caution about the appropriateness of inquiring into "*more purely political*" questions. Finally, it should be remembered that not all cases in which an enhanced investigative obligation is triggered will be complex and controversial; some may be resolved by a relatively brief and narrow inquiry and a traditional short form verdict that is in effect indistinguishable from a traditional/*Jamieson* inquest.

Relationship with other investigations

61. As has been noted, a *Middleton* inquest may not be the only method by which the state discharges its enhanced investigative obligation in a particular case. Criminal

⁸⁷ *Gentle*, [9]

⁸⁸ *Scholes* [67]; as well as explicitly citing *Middleton*, it is submitted that Pill LJ's reference to how, "*the law has now been interpreted*" also refers, at least in part, to the same case.

proceedings, public inquiries and regulatory or disciplinary hearings may all play a part. Whether or not the state has met the requirements of Article 2 will be judged on the *totality* of these investigations, and not on the inquest alone.⁸⁹

62. It follows that if a criminal investigation into a death deals with all possible breaches of Article 2 then there will be no requirement under the Convention that the state initiate or undertake any further examination. In other cases, the combination of a police investigation with that of the relevant safety/regulatory body may be sufficient. In such cases, a coroner can be flexible and limit or curtail his investigation and/or procedures. For example in *Main*, it was held that there was no requirement for the next-of-kin to be represented at the inquest given the wider investigations that had taken place.⁹⁰

63. However, two important points must be remembered in cases where there is more than one investigation. The first is that if the investigations as a whole fail to consider all matters relevant to Article 2 then the state will be in breach of its obligations. Lord Bingham made this point in *Middleton*:⁹¹

“In some cases the state’s procedural obligation may be discharged by criminal proceedings. This is most likely to be so where a defendant pleads not guilty and the trial involves a full exploration of the facts surrounding the death. It is unlikely to be so if the defendant’s plea of guilty is accepted (as in *Edwards*), or the issue at trial is the mental state of the defendant (as in *Amin*), because in such cases the wider issues will probably not be explored.”

64. Second, the investigations as a whole must also meet the further requirements of the enhanced investigative obligation that are considered above (e.g. sufficient public scrutiny, expedition, appropriate involvement of the next-of-kin etc.). Again, failure to do so will result in a breach of Article 2, as it did for example in *Amin* (lack of family representation).

65. In cases where other investigations have addressed some but not all Article 2 issues, a *Middleton* inquest has an important role to play as a long-stop to ensure that the state meets its Convention obligations. The wide discretion granted to coroners in respect

⁸⁹ See, among others, *Scholes*, [71]-[72]

⁹⁰ See above, paragraph 34

⁹¹ *Middleton*, [30]. See also the decision in *Moss*

of the scope of their investigation enables a flexible approach to be taken to minimise duplication, delay and unnecessary expense.

***Jamieson* Inquests in England and Wales**

66. The *Jamieson* inquest is often seen as the poor relation of the *Middleton* inquest, in part because of the (erroneous) perception that Article 2 is not engaged. It is submitted that this is a mistake. The *Jamieson* inquest can be a wide-ranging and important investigation and the differences between it and a *Middleton* inquest are easily over-stated. Before comparing the two types of inquest, it is necessary to consider what is required of a *Jamieson* inquest, the decision in *Jamieson* itself, and the related but distinct questions of the scope of verdict and the scope of the investigation that is available to the coroner.

What is required of a *Jamieson* inquest?

67. As is discussed above, the explicit terms of Article 2(1) place a positive obligation on a state to provide a legal system to protect life. This requires a state to facilitate an effective independent judicial system to determine the cause of *any* death and, if necessary, to hold accountable those responsible for it.⁹² This *general* investigative obligation is different from, and less onerous than the enhanced investigative obligation that is considered above. However, it is still a duty that derives from Article 2, and a state's failure to meet it represents a breach of the Convention.

68. The most obvious difference between the general and enhanced investigative obligations is that there is no requirement that the state *initiate* the investigation in the former instance. Its obligations are met by ensuring that there is a suitable system in place for inquiring into a death.⁹³ The availability of civil and/or disciplinary proceedings to an interested party (e.g. the estate or the next-of-kin) may be sufficient to meet this requirement.⁹⁴ However, the Strasbourg courts have again stressed that

⁹² *Dodov v Bulgaria*, [80]; *Vo v France* [90-91]; *Calvelli and Ciglio v Italy*, [49]; *Powell v UK* (2000) 30 EHRR CD362, [49]

⁹³ *R (Smith) v Secretary of State for Defence* [2009] EWCA Civ 441, [83]

⁹⁴ See among others, *Vo v France*, [90]; *Powell v UK*, quoted at *Takoushis* [87]

cases must be assessed on their own merits, and thus it will be necessary to show that the system relied upon has provided a actual and not just a theoretical opportunity to investigate the death sufficiently. In *Dodov v Bulgaria*, the Strasbourg Court gave the following statement of its role in examining the provisions for investigating deaths from medical negligence:⁹⁵

“It must examine whether the available legal remedies, taken together, as provided in law and applied in practice, could be said to have secured legal means capable of establishing the facts, holding accountable those at fault and providing appropriate redress to the victim. Article 2 of the Convention will not be satisfied if the protection afforded by domestic law exists only in theory: above all, it must also operate effectively in practice.”

[references removed]

69. A *Jamieson* inquest therefore plays a role in discharging the state’s general investigative obligation under Article 2, but not necessarily the *only* role. If civil proceedings are readily available in a case (e.g. where a valid and funded Fatal Accidents claim has been issued following a death caused by alleged negligence), then it is likely that there will be no requirement under Article 2 for there to be a *Jamieson* inquest at all. However, where there is little or no possibility of such proceedings (e.g. following the negligently caused death of an elderly patient with no dependants and no relatives), the *Jamieson* inquest may well be the sole means by which the general investigative obligation is discharged. As is discussed below, this could have a significant impact on the scope of the coroner’s investigation (although not on his verdict). The difficulty for the coroner lies in assessing at the outset how great a role his inquest is expected to play.

The decision in *Jamieson*

70. In *Middleton*, Lord Bingham summarised his judgment in *Jamieson*:⁹⁶

“The Court of Appeal interpreted “how” in section 11(5)(b)(ii) of the [The 1988 Act] and rule 36(1)(b) of the [1984 Rules] narrowly as meaning “*by what means*” and not “*in what broad circumstances*” (page 24, conclusion (2)). It was not the function of a coroner or an inquest jury to determine, or appear to determine, any question of criminal or civil liability, to apportion

⁹⁵ *Dodov v Bulgaria*, [83]

⁹⁶ *Middleton*, [28]

guilt or attribute blame (page 24, conclusion (3)). Attention was drawn to the potential unfairness if questions of criminal or civil liability were to be determined in proceedings lacking important procedural protections (page 24, conclusion (4)). A verdict could properly incorporate a brief, neutral, factual statement, but should express no judgment or opinion, and it was not for the jury to prepare detailed factual statements (page 24, conclusion (6)). It was acceptable for a jury to find, on appropriate facts, that self-neglect aggravated or contributed to the primary cause of death, but use of the expression “lack of care” was discouraged and a traditional definition of “neglect” was adopted (pages 24–25, conclusions (7), (8) and (9)). Where it was found that the deceased had taken his own life, that was the appropriate verdict, and only in the most extreme circumstances (going well beyond ordinary negligence) could neglect be properly found to have contributed to that cause of death (pages 25–26, conclusion (11)). Reference to neglect or self-neglect should not be made in a verdict unless there was a clear and direct causal connection between the conduct so described and the cause of death (page 26, conclusion (12)). It was for the coroner alone to make reports with a view to preventing the recurrence of a fatality (page 26, conclusion (13)). Emphasis was laid on the duty of the coroner to conduct a full, fair and fearless investigation, and on his authority as a judicial officer (page 26, conclusion (14)).”

71. Much of what is contained in that passage is common to the subsequent ruling in *Middleton* as to the scope of the jury’s verdict where the enhanced investigative obligation is engaged. However, there are two significant differences between *Jamieson* and *Middleton* inquests. First, whereas in a *Jamieson* inquest the coroner must ask himself of “*by what means*” the deceased met his death, a *Middleton* inquest is directed towards the wider question of “*by what means and in what circumstances*” the death occurred. Second, and related, the verdict in a *Middleton* may be broader than that in a corresponding *Jamieson* inquest, partly as a result of the wider question, and partly because the jury will be required to make a finding on the central issue or issues.⁹⁷

The scope of the verdict and the scope of the investigation

72. On one level, the decision in *Jamieson* can be seen to have limited both the scope of a coroner’s verdict and the scope of his likely investigation. The stated interpretation of rule 11(1) of the 1984 Rules is that the proceedings and evidence at an inquest should be directed solely to ascertaining “*by what means*” the deceased died. This would

⁹⁷ *Middleton*, [35]-[36]; *Hurst*, [51]; *Smith*, [64]

seemingly restrict the ambit of a *Jamieson* inquest significantly, and in contradistinction to a *Middleton* investigation.

73. However, a distinction has been made between the scope of the coroner's verdict and the scope of his investigation in a *Jamieson* inquest. It is submitted that there are compelling reasons in 1988 Act and both domestic and Strasbourg authority for so doing.

74. This issue was addressed in *Hurst*, in particular by Baroness Hale and Lord Mance on one side, and Lord Brown (with whom Lord Bingham stated his agreement) on the other. The case concerned the refusal of a coroner to re-open an inquest into the death of Troy Hurst following the conviction of his killer for manslaughter. It was suggested that the authorities had failed to act on a number of complaints made about the killer's violent behaviour and hostility to the Hurst family prior to the killing. As the death occurred before the HRA 1998 came into force, the case concerned the merits of re-opening a *Jamieson* inquest in which the possible verdict would have been limited to "unlawful killing".⁹⁸

75. Baroness Hale and Lord Mance raised the following arguments in support of the proposition that a re-opened investigation could serve a useful purpose:⁹⁹

- (i) "[T]he nature of a verdict and the scope of the coroner's investigations are different matters"¹⁰⁰
- (ii) The decision in *Jamieson* was not directly concerned with the scope of the investigation (as opposed to the scope of the verdict). However, previous authority did address this issue, notably *R v Inner West London Coroner, Ex p Dallaglio*. In that case it was held that the scope of the investigation was always likely to be wider than the eventual verdict, and to limit the inquiry to the last link in the chain of causation would be to defeat the purpose of holding an inquest at all.¹⁰¹

⁹⁸ *Hurst*, [1], [9], [17]-[18], [48]-[52], [72], [75]

⁹⁹ *Hurst*, [21], [74]-[75]

¹⁰⁰ *Hurst*, [75] per Lord Mance; see also [51] where Lord Brown appears to agree on this point, despite his wider critique of Lord Mance and Baroness Hale's approach.

¹⁰¹ *R v Inner West London Coroner, Ex p Dallaglio* [1994] 4 All ER 139, per Simon Brown LJ, p.155 and Sir Thomas Bingham, p.164; *Hurst* [21] per Baroness Hale.

- (iii) Although the decision in *Jamieson* limited the interpretation of “how” in the ways described above, it did not disapprove previous authoritative statements such as: (a) “the word ‘how’ is wide and it is not possible to foresee every way in which someone may meet his death”;¹⁰² (b) “The function of an inquest is to seek out and record as many of the facts concerning the death as [the] public interest requires.”;¹⁰³ (c) “Although the possible verdicts at an inquest under the 1988 Act are circumscribed and, in particular must not ascribe criminal or civil liability, that does not mean that the facts should not be fully investigated.”¹⁰⁴
- (iv) Rule 43 of the 1984 Rules might lead the coroner to undertake a wider investigation than is required by the verdict alone in order to produce a report with a view to preventing the recurrence of such a fatality.¹⁰⁵
- (v) The final conclusion in *Jamieson* points out that: “It is the duty of the coroner... to ensure that the relevant facts are fully, fairly and fearlessly investigated... He must ensure that the relevant facts are exposed to public scrutiny... He fails in his duty if his investigation is superficial, slipshod or perfunctory. But the responsibility is his. He must set the bounds of the inquiry...”¹⁰⁶

76. In a speech with which Lord Bingham expressed his agreement, Lord Brown criticised the approach of Baroness Hale and Lord Mance to re-opening the inquest into Mr Hurst’s death:¹⁰⁷

“Given... as both Lady Hale and Lord Mance in terms accept, that upon the conclusion of such an inquest, the jury would be debarred from expressing any views whatever upon the conduct which they had been examining... the value of such an inquest may be doubted. It might, indeed be thought to be the worst of all worlds. Lady Hale and Lord Mance expressly acknowledge that it would not satisfy the UK’s international obligations under article 2 of the

¹⁰² *R v Southwark Coroner, Ex p Hicks* [1987] 1 WLR 1624, p.134, per Croom-Johnson LJ, quoted by Baroness Hale at *Hurst*, [21]

¹⁰³ *R v South London Coroner, Ex p Thompson* (1982) 126 SJ 625, per Lord Lane LCJ; see also the Brodrick Committee’s “Report on Death Certification and Coroners” (1971, Cmnd 4810), [16.40], quoted by Baroness Hale at *Hurst*, [21]

¹⁰⁴ *Takoushis*, [41] per Sir Anthony Clarke MR; quoted by Lord Mance at *Hurst*, [70]

¹⁰⁵ *Hurst*, [74] per Lord Mance

¹⁰⁶ *Jamieson*, [14], quoted by Baroness Hale at *Hurst*, [21]

¹⁰⁷ *Hurst*, [34] per Lord Brown

Convention. Nor would it satisfy the respondent's understandable desire for detailed findings to be made upon the circumstances leading to her son's death. At best it could occasion a report from the Coroner to a responsible authority under Rule 43... Small wonder that such an inquest was not one for which Mr Starmer [for Mr Hurst's mother] has ever contended."

77. It is submitted that although Lord Brown's reservations may have been appropriate on the facts of the case, the arguments of Baroness Hale and Lord Mance should be preferred as a broader statement of principle. In addition to the points they raised in *Hurst*, a number of other factors support the proposition that it may be necessary for a *Jamieson* inquest to undertake a broad investigation akin to that which would have been conducted by a *Middleton* investigation.

78. First, there is the issue of the role that a *Jamieson* inquest may have to play in meeting the state's general investigative obligation under Article 2 (as opposed to the enhanced obligation with which a *Middleton* inquest is concerned). Although, as has been noted above, the availability of civil proceedings may mean that in some cases the general obligation does not require an inquest at all, in cases where no such proceedings are available a *Jamieson* inquest becomes the primary means by which the state discharges its duty. This point was made by Sir Anthony Clark MR when giving the judgment of the Court of Appeal in *Takoushis*:¹⁰⁸

"[99] If, as in our opinion is the case, the system [of investigation] must be practical and effective, we are not persuaded that the mere fact that the state has made it possible in law for the family to bring a civil action against those said to be responsible is by itself a sufficient discharge of the state's obligation in every case. For example, it may not be practicable for the family to procure an effective investigation of the facts by the simple expedient of civil proceedings. Their claim may be for a comparatively small sum, as for example where the only claim is that of the estate of the deceased, such that it would not make practical or economic sense for civil proceedings to be begun, especially for a family who is not able to obtain legal aid.

[100] Another possibility is that the facts may be such that liability has been admitted, with the result that, at any rate under the adversarial system in operation in England, there can be no trial and thus no independent investigation of the facts as part of the civil process."

¹⁰⁸ *Takoushis*, [99]-[100]

In support of the Court of Appeal's position, the Strasbourg Court's ruling in *Dodov v Bulgaria*, quoted above at paragraph 66, bears repetition. The state must ensure that the system for investigating death by medical negligence is:¹⁰⁹

“capable of establishing the facts, holding accountable those at fault and providing appropriate redress to the victim. Article 2 of the Convention will not be satisfied if the protection afforded by domestic law exists only in theory: above all, it must also operate effectively in practice.”

79. Second, and related, is the practical consideration that the coroner is generally forced to decide on the type and scope of his inquest as a preliminary matter, when it is not clear what issues may arise and/or what other legal proceedings may be open to the deceased's estate or relatives. In these circumstances, it is submitted that the coroner at a *Jamieson* inquest should keep an open mind as to the breadth of his investigation and the role that it may be required to play in satisfying Article 2. In *Amin*, a case concerning the necessity of holding a further inquiry following criminal and internal investigations, Lord Steyn said the following:¹¹⁰

“The Court of Appeal posed the question: What would be the benefit of a further inquiry?... it is vital that procedure and the merits should be kept strictly apart otherwise the merits may be judged unfairly: *Wade & Forsyth, Administrative Law*, 8th ed (2000), pp.501-503. In *John v Rees* [1970] Ch 345, 402, Megarry K observed about the argument that ‘it will make no difference’:

“As everybody who has anything to do with the law well knows, the path of the law is strewn with examples of open and shut cases which, somehow, were not; of unanswerable charges which, in the event, were completely answered; of inexplicable conduct which was fully explained; of fixed and unalterable determinations that, by discussion, suffered a change.”

This observation is apposite to the assumption that, although there had not been an adequate inquiry, it may be refused because nothing useful is likely to turn up. That judgment cannot fairly be made until there has been an inquiry.”

It is submitted that these observations would apply with still greater force to a coroner charged with undertaking the initial public investigation into a death.

¹⁰⁹ *Dodov v Bulgaria*, [83]

¹¹⁰ *Amin*, [52]. Although *Amin* was a case in which the enhanced investigative obligation was triggered, it is submitted that Lord Steyn's remarks are applicable to *Jamieson* inquests as well.

80. Finally, recent case law has reinforced the position of Baroness Hale and Lord Mance. As is discussed above, the decision in *Lewis* emphasised the importance of rule 43 and the need in some cases for a coroner to investigate potentially and not just actually causative factors in order to discharge his duties. Although *Lewis* was a *Middleton* case it is submitted that the principles are readily applicable to a *Jamieson* inquest.¹¹¹ Further, the debate in *Hurst* was referred to in *Smith* where, it is submitted, Sir Anthony Clarke MR, giving the judgment of the court, indicated a preference for the position of Baroness Hale and Lord Mance.¹¹²

81. If this analysis is correct, then the distinction between the scope of the verdict and the scope of the investigation at a *Jamieson* inquest is a particularly significant one. However, the difference between the approach of Lord Brown and that of Baroness Hale and Lord Mance is a difference of degree and emphasis rather than firm principle. In practice, the coroner at a *Jamieson* inquest has a broad discretion to set the boundaries of his own investigation, and it is to this discretion rather than the decisions of the higher courts and Strasbourg, that the representatives of the interested parties must principally address themselves.

Conclusion: *Middleton v Jamieson* Inquests

82. What then are the principal differences between a *Middleton* and a *Jamieson* inquest? First, it is relevant to note that the House of Lords and the Court of Appeal have stated unambiguously that there *is* a difference, and that there are two types of inquests in England and Wales. A *Middleton* inquest will be required when the state's enhanced investigative obligation under Article 2 is or may be engaged; where it is not but an inquest is still deemed necessary under domestic law and/or the Article 2 general investigative duty, a *Jamieson* inquest can be held.¹¹³

¹¹¹ For example, the coroner might still have been in breach of rule 43 if he did not report on the failure of a hospital to provide equipment and training to a nurse who discovered a suicide and acted in the same way as the prison officer in *Lewis*, in circumstances where it could be established that the patient was dead before the nurse arrived.

¹¹² *Smith*, [64], [76]-[78]

¹¹³ *Hurst*, [1], [9], [48]-[52], [72]; *Smith*, [64]

83. Second, there is also agreement that the scope of available verdicts, and the role of the jury in providing them, is wider in a *Middleton* inquest than in a *Jamieson* inquest.¹¹⁴ It should, however, be remembered that not all *Middleton* inquests will require a verdict beyond that which is available in a *Jamieson* inquest.

84. Beyond these two areas, however, the distinction between *Middleton* and *Jamieson* inquests is far less tangible. It is relevant to consider again the list of requirements of an enhanced investigation under Article 2 which are identified at paragraph 14 above. It is submitted that these do not reveal a stark distinction between a *Middleton* and a *Jamieson* inquest:

(i) The investigation must be initiated by the state

This will be so in both a *Middleton* and a *Jamieson* inquest.

(ii) The investigation must be effective

This requirement led to the changes in *Middleton* identified above, and is relevant to the debate about the scope of inquests that is considered below. However, as a broad principle, it cannot be denied that a *Jamieson* inquest should also be “effective” in the ways described in the Strasbourg case law.

(iii) It must be carried out by a genuinely independent investigator

In the overwhelming majority of cases this will not be an issue in either *Middleton* or *Jamieson* inquests; if it were in latter, common law principles of natural justice would provide a remedy.

(iv) There must be sufficient public scrutiny

The general principle that inquests should be held in public is, for now at least, the same for *Middleton* and *Jamieson* inquests.

(v) The next-of-kin must be involved to the extent necessary to safeguard his or her interest

There may be greater scope to argue at a *Middleton* inquest that the relatives of the deceased should be entitled to legally-funded representation; however, as is discussed above, it cannot be stated as a general principle that this will be so in all cases.

¹¹⁴ *Middleton*, [35]-[36]; *Hurst*, [51]; *Smith*, [64]

85. As to the scope of the coroner's investigation, which will play a role in determining the "effectiveness" of the inquest in Article 2 terms, there is some debate as to the extent of the difference between a *Middleton* and a *Jamieson* approach. It is submitted, for the reasons given above, that Baroness Hale and Lord Mance are right to suggest that the scope of a *Jamieson* inquest should not be unduly restricted as a result of the difference in statutory interpretation of section 11(5)(b)(ii) of the 1988 Act and rule 36 (1)(b) of the 1984 Rules. It follows that the distinction between the two types of inquest is narrow in this regard as well.

86. To give an example: an elderly man with no estate and no close relatives dies as the direct result of a an individual doctor's medical negligence. However, in the background to his death is the possibility that the standards of care given to the elderly at the hospital that treated him were sub-standard. It cannot, however, be established that this was a probable cause of the man's death. What kind of inquest will ensue? If it is apparent that the failings at the hospital were so serious that they represented an arguable breach of the state's Article 2 obligations to secure high medical standards among healthcare professionals, then a *Middleton* inquest would be required and it would be necessary to investigate the purported systemic failings. However, in the likely event that the death seemed on the face of it to be a straightforward case of individual medical negligence, then a *Jamieson* inquest would be instigated. If the coroner restricted his or her investigation into the immediate cause of the death then a verdict of accidental death would be recorded and no further steps taken. But if he or she undertook a wider investigation, mindful that other civil proceedings were extremely unlikely in this case, then the failings in the hospital could be examined, and if necessary made the subject of a rule 43 report or a further inquiry. It is submitted that in some circumstances only the latter investigation, which would be akin to the *Middleton* inquest, would be compatible with the coroner's duties under the domestic law and the Convention.¹¹⁵

87. In both *Middleton* and *Jamieson* inquests, the coroner is given a wide discretion as to the nature and scope of the investigation (as opposed to the available verdicts). This allows the flexibility to ensure that whatever Article 2 obligations have arisen or

¹¹⁵ See for example the case of *Lewis*, considered above.

remain can, in theory, be met. In practice, it will be for the representatives of the interested parties to make their case as to the questions that should be asked and the procedures that should be adopted. If the enhanced investigative duty is triggered, this will give an advocate a greater range of arguments, authorities and obligations to deploy. Ultimately, this may well be the most important difference between a *Middleton* and a *Jamieson* inquest for those who are actually involved.

Postscript: The Coroners and Justice Act 2009

88. It is not intended to address the provisions of The Coroners and Justice Act 2009 in this paper. However, it is relevant to note the observations of Sedley LJ in *Lewis*:¹¹⁶

“The second development which needs to be noted is the prospective amendment of rule 43, along with much else, by the Coroners and Justice Act 2009. Section 5 adopts the ruling in *Middleton* about the proper scope of an inquest. It goes on to limit the expression of opinion by coroners and juries to the prescribed issues, but by paragraph 7 of Schedule 5 it makes a coroner's report, and an official response to it, mandatory where in the coroner's opinion action should be taken to prevent the occurrence or continuation of circumstances creating a risk of other deaths. We are told that the prospective commencement date of the material provisions of this Act is April 2012. It follows that our judgment in this appeal is likely to affect a substantial number of inquests in the interim.”

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15 January 2010

¹¹⁶ *Lewis*, [19]