

Life, Liberty and Security: Article 2 ECHR and Inquests

Article 2 ECHR has had a profound impact upon coronial law, no more so than in relation to deaths in custody/detention and mental health deaths.

This talk will cover the following topics: mental health inquests; terrorism inquests (and inquiries); and detention inquests. Through these lenses, we will examine a number of developments in coronial law over the past 18 months and draw out relevant themes.

This paper will expand upon the cases discussed in relation to mental health and detention inquests.

In 2016-17, the following trends can be seen from the case law and Chief Coroner's Guidance:

1. The prevailing of common sense (*DoLS Guidance, Tyrrell*);
2. The law of unintended consequences (*Tainton*);
3. The impact of resource constraints on the coronial system and prison system (DOLS inquests, *Scarff*).

Each topic will be covered in turn below.

(1) Mental health

A: Background

(i) Definition of a "mental health" inquest

1. A "mental health" inquest will be one either (a) where the Deceased's mental health may have had some connection with the death; largely these cases will be those where the Deceased took his or her own life; or (b) where the Deceased's mental health meant that he or she was either detained under the Mental Health Act 1983 or at the time of their death was deprived of their liberty under the Mental Capacity Act 2005.

(ii) Application of the Human Rights Act in the medical/mental health context

2. Traditionally inquests involving the death of patients in the care of healthcare services - including mental health services - have been slightly different from those involving deaths in custody and prisons in that Article 2 does not necessarily apply. Two questions arise: (1) is an inquest required at all? (2) Does that inquest need to be a *Middleton*-type inquest? And if so, what difference will that make to proceedings? Article 2 has had an enormous impact on inquest practice in relation to the second of these two questions, and very much so in the field of mental health, but in this talk I am going to focus on the topic which is the theme for this event, which is liberty; and a topic which has much taxed the coronial system for the last few years: deprivation of liberty. In this context the more relevant Article is Article 5(1)(e): Everyone has the right to liberty and security of person. **No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: ...**(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, **of persons of unsound mind**, alcoholics or drug addicts or vagrants...

B: Deprivations of liberty

(i) DoLS and the requirement to hold an inquest

3. Where there is a question as to whether the acts or omissions of a healthcare provider may have contributed to the death, that is enough to constitute the coroner's reason to suspect that the deceased died an "unnatural" death under section 1(2)(a) of the CJA 2009 and so an inquest will have to be held. This does not necessarily have anything to do with Article 2 ECHR: whilst the state's positive obligations under Article 2 "require an effective independent judicial system to be set up so that the cause of death of patients in the care of the medical profession, whether in the public or the private sector, can be determined and those responsible made accountable", the civil justice system is enough: an inquest does not need to be held to fulfill the state's duty under Article 2.¹
4. Under s 1(2)(c) of the Coroners and Justice Act 2009, a coroner must hold an inquest if the deceased was in "state detention". State detention is defined at s48(2): a person is in state detention if he or she is "compulsorily detained by a public authority"; a public authority is one which is a public authority "within the meaning of section 6 of the Human Rights Act 1998".
5. There is no question that where someone dies whilst compulsorily (or "formally") detained under the Mental Health Act 1983 that will count as state detention for the purposes of section 1 to the CJA 2009; an inquest will be held. Just as with other forms of detention, Article 2 may be engaged where a death is suspicious or there is an arguable breach of the state's general/systemic duties or operational duties.

(ii) DoLs and the PCA 2017

6. However, that was not the case where someone was subject to the Deprivation of Liberty Safeguards under the Mental Capacity Act 2005, until *Cheshire West*². Following that decision there was some considerable concern amongst care and healthcare providers (and their advisors) that when someone died whilst subject to DoLS that person should automatically be treated as being in 'state detention' within the meaning of section 1(2)(c) and section of the Coroners and Justice Act 2009 and that the coroner is therefore be obliged to hold an inquest into the death, and possibly with a jury under section 7(2)(a).
7. In December 2014 the Chief Coroner issued the first *Guidance No. 16 on the Deprivation of Liberty Safeguards (DoLS) which summarised the DoLS regime and indicated his position that persons subject to DoL are in state detention and that an inquest must therefore be held. The Chief Coroner also observed that the Article 2 procedural duty (i.e. to hold a Middleton-type inquest) 'may ... arguably arise where the death is not from natural causes [eg any death where someone was subject to DOLS and where acts or omissions by any public authority or healthcare provider may have caused or contributed to the death] and/or the fact of detention under [DoL safeguards] may be a relevant factor in the cause of death'*.³
8. Following the significant increase in the number of DOLS applications between 2013 and 2015, there was a corresponding increase in the number of coroner's investigations and inquests following deaths of those subject to DoLS – for example, the deaths of elderly people in a care

¹ (*Calvelli v Italy* 32967/96 [2002] ECHR 3).

² *P v Cheshire West and Chester Council* [2014] UKSC 19

³ *Guidance No 16* (December 2014 version), paragraph 63.

home with dementia who died of natural causes, and whose deaths would never formerly attract an inquest, would now be subject to the coronial process. Despite a fairly efficient process being developed which ensured that such cases were dealt with on the papers swiftly, this clearly overburdened the system. In the Chief Coroner's Report 2015/2016 it was noted that the workload of all coroners had increased "for no good reason".⁴ The Report also noted elsewhere that "many coroner's areas have been neglected for years if not decades in the provision of resources".⁵ It was recommended that DoLS cases be removed from the category of "in state detention".⁶

9. Accordingly the Policing and Crime Act 2017 inserted a new s48(2A) into the CJA 2009: with effect from 3 April 2017, it now states expressly "But a person is not in state detention at any time when he or she is deprived of liberty under section 4A(3) or (5) or 4B of the Mental Capacity Act 2005". Accordingly there is no requirement to hold an inquest into the death of anyone who dies subject to DoLS, if that death is not caught by the other provisions of section 1 CJA 2009. It should be noted that this applies only to deaths after April 2017; there will still be a tail of cases from before that time. Accordingly Guidance Note 16 is still extant and available; the new version to be applied for deaths after 3 April 2017 is known as Guidance Note 16A.

(iii) Ferreira

10. As Guidance Note 16A indicates, a person who dies while subject to restrictions amounting to "state detention" in a hospital or care home, but without there having been a deprivation of liberty authorised under the MCA 2005, will still have to be the subject of an investigation and inquest on "state detention" grounds. This is a revision of the previous version of the guidance which stated at paragraph 66 that a person was not subject to state detention until the DoL was authorised; that guidance was held to be wrong in ***R (on the application of Ferreira) and HM Senior Coroner for Inner London South***:⁷

"It would be highly anomalous if, in order for there to be "state detention", there had to be authorisation for removing a person's liberty. Parliament cannot have intended such an absurd result."⁸

11. As well as stating this, the Court of Appeal addresses the question of when someone can be classed as being in state detention where they do not have capacity, but where there has been no DoLS in place.
12. In *Ferreira* the deceased, Maria, had Down's syndrome. She lived at home with her family and there were no formal arrangements for her care – including, of course, no DoLS. In November 2013 she suffered breathing difficulties and was taken to hospital; whilst there her condition deteriorated and she was admitted to ICU, intubated and sedated. A mitt was placed on her hand to stop her dislodging her breathing tube, but she managed to do so anyway and died of a cardiac

⁴ Chief Coroner's Report 2015-6, para 146.

⁵ Ibid para 155

⁶ Ibid paras 149 and 173

⁷ *R (on the application of Ferreira) and HM Senior Coroner for Inner London South, King's College Hospital NHS Foundation Trust, the Intensive Care Society and the Faculty of Intensive Care Medicine and Secretary of State for Health and Secretary of State for Justice* [2017] EWCA Civ 31, para 104

⁸ Ibid, per Arden LJ at para 104

arrest. The coroner decided that there should be an inquest but also decided that the inquest did not need to be held with a jury. Maria's family judicially reviewed that decision.

13. The Court of Appeal determined that Maria was not deprived of her liberty because she was being treated for a physical illness; her coincidental mental impairment had nothing to do with the physical restrictions on her movements. The "root cause" of any loss of liberty was her physical condition, not any restrictions imposed by the hospital:

Arden LJ:

80. A deprivation of liberty in general requires more than mere restrictions on movement... This is illustrated by *Austin v UK*⁹ not every interference with a person's liberty of movement involves a potential violation of Article 5.

81. The weaknesses in the appellant's analysis, in my judgment, are in (1) the assumption that, because Maria was of unsound mind for Convention purposes, any interference with her liberty had to be justified by complying with Article 5(1)(e); and (2) the contention that no regard could be had to the fact that the interference was considered to be in Maria's best interests. As I see it, a person whose liberty of movement has been restricted may be found not to have been deprived of her liberty even though none of the exceptions in Article 5(1) apply and regard may be had to the purpose of the interference.

88. ... Whether circumstances amount to a deprivation of liberty involves a question of assessing all the circumstances. The Strasbourg Court in *Austin* has specifically excepted from Article 5(1) the category of interference described as "commonly occurring restrictions on movement". In my judgment, any deprivation of liberty resulting from the administration of life-saving treatment to a person falls within this category. It is as I see it "commonly occurring" because it is a well-known consequence of a person's condition, when such treatment is required, that decisions may have to be made which interfere with or even remove the liberty she would have been able to exercise for herself before the condition emerged...

89. On this basis, any deprivation of liberty resulting from the administration of life-saving treatment to a person falls outside Article 5(1) (as it was said in *Austin*) "so long as [it is] rendered unavoidable as a result of circumstances beyond the control of the authorities and is necessary to avert a real risk of serious injury or damage, and [is] kept to the minimum required for that purpose". In my judgment, what these qualifications mean is in essence that the acute condition of the patient must not have been the result of action which the state wrongly chose to inflict on him and that the administration of the treatment cannot in general include treatment that could not properly be given to a person of sound mind in her condition according to the medical evidence...

⁹ *Austin v UK* (2012) 55 EHRR 359, in which the police had kettled some protestors. The UK has not signed up to Article 2(3) of Protocol 4 to the Convention, which limits "restrictions" on liberty of movement; in *Austin* the ECtHR made it clear that this goes beyond the "deprivation" of liberty which is covered by Article 5. The difference between deprivation of and restriction upon liberty is one of degree or intensity, and not of nature or substance (*Austin* at para 57).

95. In addition, in my judgment, Article 5(1)(e) is directed to the treatment of persons of unsound mind because of their mental impairment. The purpose of Article 5(1)(e) is to protect persons of unsound mind. This does not apply where a person of unsound mind is receiving materially the same medical treatment as a person of sound mind. Article 5(1)(e) is thus not concerned with the treatment of the physical illness of a person of unsound mind. That is a matter for Article 8. Where life-saving treatment is given to a person of sound mind, the correct analysis in my judgment is that the person must have given consent or the treating doctors must be able to show that their actions were justified by necessity or under section 5 of the MCA. If this cannot be shown, then there has to be some method of substituted decision-making, such as obtaining an order from the Court of Protection.”

14. . So far, so much commonsense.

15. Arden LJ’s approach becomes slightly less clear under the second two limbs on which it found against the Claimant: Firstly, under the “acid test” developed in *Cheshire West*, whilst Maria was under continuous supervision and control, it was not clear that she was not “free to leave”:

98. Moreover, as I read it, the two-part acid test formulated by Lady Hale in *Cheshire West* in my judgment was designed to apply only where the second element – lack of freedom to leave – was the consequence of state action, particularly state action consisting of the continuous supervision and control constituting the first element of the test.

99. In the case of a patient in intensive care, the true cause of their not being free to leave is their underlying illness, which was the reason why they were taken into intensive care. The person may have been rendered unresponsive by reason of treatment they have received, such as sedation, but, while that treatment is an immediate cause, it is not the real cause. The real cause is their illness, a matter for which (in the absent of special circumstances) the state is not responsible. It is quite different in the case of living arrangements for a person of unsound mind. If she is prevented from leaving her placement it is because of steps taken to prevent her because of her mental disorder. *Cheshire West* is a long way from this case on its facts and that, in my judgment, indicates that it is distinguishable from the situation of a patient in intensive care (Whether this argument survives scrutiny is another matter: Firstly, there will be cases where someone is sedated to prevent them from disrupting the treatment being given to them due to the underlying disturbance of their mind, and in their perceived best interests. Secondly, if she had attempted to leave, or her family had tried to remove her, it is inconceivable that there would not have been immediate court action by the hospital to prevent her from doing so.¹⁰)

¹⁰ How this is different from the case of *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2, where Lord Dyson found that the deceased was under the control of the trust and that although she was not a detained patient, it is clear that, if she had insisted on leaving the hospital, the authorities could and should have exercised their powers under the MHA to prevent her from doing so (judgment of Lord Dyson at para 34), is not clear.

16. Thirdly, the court was not required to consider the jurisprudence of the ECHR on deprivation of liberty in order to define “state detention” for the purposes of the CJA 2009.¹¹ This last approach by the Court of Appeal of course throws into question whether it had been unnecessary for coroners to deal with deaths under DoLS all along, and the legislative amendment to section 48 CJA 2009 was unnecessary. Nevertheless, Guidance Note 16A (which takes into account **Ferreira**) makes it clear that it applies only to deaths after 3 April 2017, the coming into force of the amendment. The old Guidance Note 16 still applies to deaths before that time. Moreover, Guidance Note 16A ends on a note of uncertainty: the new Chief Coroner says “There will always be a public interest in the careful scrutiny of any death in circumstances akin to state detention. As in all cases there must be sufficiency of coroner inquiry.”¹²
17. In June 2017 the Supreme Court refused the Claimant in **Ferreira** permission to appeal.

(2) **Detention inquests**

1. Under section 1(2)(c) of the Coroners and Justice Act 2009, all deaths in custody or otherwise in state detention must be investigated by a coroner. Further, all deaths in custody/state detention must be held with a jury if the coroner has reason to suspect that the death was violent, unnatural or the cause of death is unknown (CJA 2009, s.7(2)(a)).
2. As to whether Article 2 is engaged, such that a *Middleton* inquest is required, this will depend on the circumstances of the death. If the death arose from violence or self-harm, Article 2 is automatically engaged. However, Article 2 may be engaged where a death is suspicious or there is an arguable breach of the state’s general/systemic duties or operational duties.
3. Over the past 18 months the courts have both narrowed and extended the applicability of Article 2. While the narrowing of Article 2 was a pragmatic decision, the extension has proved to be more controversial.

(a) **Natural causes: a pragmatic approach**

4. One of the issues that needed resolving following the introduction of CJA 2009 was whether a prisoner who dies naturally requires a fully-compliant *Middleton* inquest. In **Tyrell v HM Senior Coroner County Durham and Darlington [2016] EWHC 1892 (Admin)** common sense prevailed as the Court held that the procedural obligation under Article 2 does not apply where a death is from natural causes and there is no arguable breach of the state’s duty to protect life. The procedural obligation only arises where there is a suspicious death in custody.
5. In this case the prisoner died of pneumonia secondary to cancer. All the investigations carried out by the coroner and the Prisons and Probation Ombudsman pointed death by natural causes and there was no evidence of a breach of the state’s obligations. The coroner therefore concluded that the procedural obligation under Article 2 was not

¹¹ *Ferreira* para 107: If Parliament had intended to legislate for inquests to be held with juries whenever there was any indication in the Strasbourg case law that there was a deprivation of liberty for Convention purposes, it would in my judgment have said so.

¹² Guidance 16A, para 52

engaged. The claimant, the prisoner's sister, judicially reviewed the coroner, arguing that he should have held an Article 2-compliant inquest. However, she could not point to any practical difference between the inquest held by the coroner and an Article 2 compliant inquest.

6. Having considered the Strasbourg cases, the Divisional Court noted that the ECtHR, in essence, had a two stage test when a person dies in custody: First, an explanation of the cause of death must be given. Second, a suspicious death in custody inevitably gives rise to a question of a potential breach of article 2 by the authorities. It is only where a death is suspicious that the procedural obligation arises [para 24].
7. Lord Justice Burnett, giving judgment for the Court, stated:

29. ...in my judgment the reasoning of the Strasbourg Court demonstrates that the *positive* obligations under article 2 encompass a duty to account for the cause of any death which occurs in custody. The procedural obligation arises only in circumstances where the responsibility of the state is engaged in a sense that there is reason to believe that the substantive obligations (identified by Lord Bingham in the *Middleton* case) has been breached by the state. In the case of deaths in custody the procedural obligations will be triggered in the case of all suspicious deaths, including apparent suicides...." [emphasis in the judgment].
8. The Court therefore concluded that the coroner was correct to hold that the procedural obligation under Article 2 was not engaged. The evidence all showed that the deceased died from natural causes and that he had received appropriate treatment.
9. Reference was also made to the Chief Coroner's advice to coroners regarding deaths in prison and the need for post mortem examinations. The advice indicated that where a death is patently natural, there may be no need for a forensic examination, which would be both unnecessary in the public interest and expensive to the taxpayer.

(b) Causation test: an unintended consequence?

10. The Divisional Court's approach in *Tyrrell* was a pragmatic solution to what was a loose end in the 2009 Act. However, a further issue arose in relation to the causation test regarding Article 2. In ***R (Tainton) v HM Senior Coroner for Preston and West Lancashire [2016] EWHC 1396 (Admin)*** the Divisional Court was asked to consider whether the coroner should have left a medical causation issue to the jury. The facts were as follows:
11. Mr O'Neill, a prisoner, died following a delayed diagnosis of oesophageal cancer. The independent clinical review undertaken by the Prison and Probation Ombudsman (PPO) was highly critical of the failure to provide appropriate and timely medical treatment. Lancashire Care NHS Trust admitted negligence but denied causation. The medical evidence was complex and there were uncertainties as to the possible progression of cancer and the potential impact of a timely diagnosis. Consequently, the coroner refused to leave to the jury the issue of whether the trust's negligence had significantly hastened the prisoner's death because he could not be satisfied that the *Galbraith* or *Galbraith plus* test was met,¹³ and that any conclusion reached would be unsafe.

¹³ Sir Brian Leveson P and Kerr J: "According to that test, when deciding whether or not to leave a particular conclusion or issue to a jury, coroners should answer "yes" to both of the

12. The claimant, the deceased's mother, judicially reviewed the coroner's decision and the jury's consequential short form verdict that the deceased had died of natural causes. She sought a new inquest. The Court held that the coroner had rightly concluded that it would be unsafe to leave the issue of causation to the jury. However, they allowed the claim on the basis that a record of the admitted failings should be attached to the Record of Inquest. Sir Brian Leveson P and Kerr J stated:

73. ...[W]e consider that the coroner should have directed the jury to include in the Record of Inquest a brief narrative of the admitted shortcomings of the healthcare staff responsible for the late diagnosis of Mr O'Neill's cancer. In light of the fact that the coroner withdrew the issue of causation from the jury, such a statement would have to have been supplemented by an explanation that it could not be concluded that these shortcomings significantly shortened Mr O'Neill's life....

74. Putting it another way, in an inquest such as this, where the possibility of a violation of the deceased's right to life cannot be wholly excluded, section 5(1)(b) and (2) of the 2009 Act should require the inclusion in the Record of Inquest of any admitted failings forming part of the circumstances in which the deceased came by his death, which are given in evidence before the coroner, even if, on the balance of probabilities, the jury cannot properly find causative of the death.

13. The Court held that this approach was a matter of fairness to the family, and was also required to discharge the obligations on the state of article 2 ECHR and on the coroner under s.5 of the 2009 Act [para 75].

14. Though not suggesting that any admitted failings had to be included in every case, the omission of a reference to the substandard care in this specific inquest "would render the bland short form "natural causes" verdict inadequate to describe properly the circumstances in which the deceased met his death" [para 80]. The Court held that the brief appended summary of the failings would fairly reflect the issues that were the focus of the inquest.

15. Bridget Dolan QC for the coroner argued that *Middleton* did not require a statement of undisputed facts to form part of the verdict. However, the Court did not accept this: without the admitted failings, the conclusion was "materially incomplete and verged on misleading by omission" [para 78].

16. The Divisional Court was in essence circumventing the causation test, and as such expanding the reach of Article 2. The causation test¹⁴ requires that the act or omission be proved, on the balance of probabilities, to have contributed to the death. However, the

questions (a) whether there is evidence on which a jury properly directed could properly reach that conclusion; and (b) whether it would be safe for the jury to reach that conclusion on the evidence before it? The latter question is the "plus" part of the test, added to the classic formulation in the criminal law derived from the judgment of Lord Lane CJ in [R v Galbraith \[1981\] 1 WLR 1039](#)." [para 39]

¹⁴ The causation test as derived from the *R (Dawson) v HM Coroner for East Riding and Kingston upon Hull Coroners District* [2001] EWHC Admin 352 is whether, on the balance of probabilities, the conduct in question more than minimally, negligibly or trivially contributed to the death. *R (Dawson) v HM Coroner for East Riding and Kingston upon Hull Coroners District* [2001] EWHC Admin 352.

Court accepted that, without proof of causation, where there is the possibility of state contribution to the death then there ought to be a summary of the admitted failings so as to satisfy the Article 2 obligations. Even if non-causative, the breaches can still be included in the Record of Inquest.

17. This is heartening for families, as otherwise a neutral short-form verdict would be wholly inadequate and would not reflect the significant failings by organisations, medical or otherwise. However, this judgment may also have unintended consequences. Doctors must self-report to the General Medical Council if they are criticised at an inquest.¹⁵ This requirement could lead to conflicts with the duty of candour, in that clinicians are less likely to be frank with families if their admitted failings could be attached to a Record of Inquest, with the potentially career-limiting consequences.
18. *Tainton* is the first case of its kind, and it remains to be seen whether coroners will follow its example.

(c) ACCT policies

19. There has also been consideration given to policies in prisons, in particular the national and local policies on Assessment, Care in Custody and Teamwork ('ACCT'),¹⁶ which aim to prevent and reduce incidents of self-harm and deaths in custody.
20. Their relevance has been emphasised in ***R (Hamilton-Jackson) v Assistant Coroner for Mid Kent and Medway [2016] EWHC 1796 (Admin)***, where the importance of compliance with the policies has been underlined. A prisoner with a history of mental health issues and self-harm committed suicide in HMP Woodhill on 10 January 2013. He had been remanded in custody in August 2012, and had been managed under the ACCT care plan until 30 December 2012 when it was closed. Two days before his death, on 8 January 2013, he self-harmed and reported it to a prison nurse. She did not reopen his ACCT plan. On 9 January 2013 he changed his plea to guilty and was remanded for sentence, so that his status within the prison changed. However, this change did not trigger a reopening of the ACCT plan.
21. The main issue at the inquest was whether the deceased ought to have been recognised as a risk of harming himself in the days leading up to his death, and whether the response from the prison healthcare staff was appropriate. The jury's conclusion was one of accidental death.
22. The Claimant, the deceased's mother, brought judicial review proceedings against the coroner in relation to the questionnaire put to the jury and sought an order quashing the questionnaire. She alleged that the Assistant Coroner's direction to the jury on the policies was misleading. The Divisional Court, which included the Chief Coroner, held that the nurse should have opened an ACCT on 8 January 2013. They quashed one of the questions and responses in the questionnaire, but refused to order a new inquest. Of most relevance, though, in this context, was the Chief Coroner's comments in relation to national and local ACCT policies. He stated:

¹⁵ http://www.gmc-uk.org/Reporting_criminal_and_regulatory.pdf_58841314.pdf

¹⁶ PSI 64/2011

61. In my judgement both the national and the local ACC T policies were triggered.... It goes without saying that an incident of self-harm indicates a risk of self-harm...

62. The differences between the policies, such as they were, were not significant. **Both are mandatory. Both should be followed.**

63. **These are long-standing policies which are (or should be) well understood. They are in place for a very good reason, to protect the vulnerable who are at risk from themselves. The policy should therefore be followed in the absence of cogent reasons to the contrary:** see *R (Munjaz) v Mersey Care NHS Trust* [2005] UKHL 58. [Emphasis added]

23. This case helpfully emphasises the importance of following policies, be they in a detention, police, mental health or medical context. However, even though the policies are mandatory, repeated failures to follow the policies will not necessary amount to systemic failures, as was made evident in *R (Scarff and Ors) v Governor HMP Woodhill and Secretary of State for Justice* [2017] EWHC 1194 (Admin).

24. The backdrop for this case pertained to the suicide rate at HMP Woodhill. At the time of the hearing, in May 2017, the prison had the highest number and highest rate of self-inflicted deaths of any prison in the entire prison estate - 18 self-inflicted deaths since 2013.

25. There had been numerous critical jury findings and PFD reports. However, although the prison has accepted all the recommendations made by the coroner and the PPO and had taken steps to address the deficiencies, the high death rate had persisted.

26. It was against that background that the judicial review proceedings were brought. The claimants were all relatives of prisoners who had committed suicide at HMP Woodhill. They alleged that the Governor of HMP Woodhill and the Secretary of State for Justice had systematically failed “to comply with their public law, common law and article 2 ECHR duties to protect prisoners at HMP Woodhill from suicide” [para 2]. They sought a declaration that the defendants had breached those duties and an order requiring them to comply with the mandatory provisions of national prison policy. They argued that the errors that led to the suicides were sufficiently similar to amount to systemic failures.

27. The issue for the Court to decide was whether the claimants had established that the suicides at HMP Woodhill were the result of a systemic failure by the prison or individual operational failures, whether by a prison officer or an administrator:

[W]hat matters is not the number of errors, but their character. Where there are identical, or very similar errors, of practice, that may point to a systemic fault in the design or supervision of the system; where there are repeated, but different operational errors, it may be impossible fairly to characterise that as a system fault. [para 54]

28. The Court concluded that the suicides were a result of a series of “distinct but separate operational mistakes in suicide prevention at HMP Woodhill. The frequency does not, of itself demonstrate a failure of the system but instead, that this is a system prone to operational error”. It went on to say “Overall, the evidence does not suggest to us that the same mistake was made time and time again. Instead it demonstrates that different mistakes were made in specific factual circumstances” [paras 58-9].

29. The fact that mistakes are made was not surprising:

Where there are human beings involved on both sides of the arrangement, in situations of some stress and complexity, and where there are inevitably numerous distractions from the performance of what are often important but routine tasks, the scope for mistake is substantial.” [para 58]

30. Claimants therefore failed to establish a systemic failing that would be amenable to the declaration that they sought.

31. In any event, the Court noted that even if they had been persuaded that there was a systemic error, they doubted whether an injunction, mandatory order or a declaration would have been appropriate. Given that the defendants recognised the errors made and had sought to take steps to address the deficiencies, it was not obvious to the Court what else should be done. Mr Justice Garnham concluded “The Claimants’ submissions came close to an argument that “something must be done”, without identifying what it is that could be done.” [para 70]. The solution for these problems lay not with the courts but those who are managing prisons.

32. *Scarff* has clarified, not changed the law on systemic failures. However, following this judgment it is likely that submissions on systemic failings will receive a sharper scrutiny from coroners, prisons and other Interested Persons.

(d) Conclusion: detention inquests

33. However, rather than seeking to ensure policies are followed, there are more fundamental issues that need to be addressed in order to halt the rise of incidents of self-harm/deaths. Austerity has severely affected the HM Prisons and Probation Service (HMPPS),¹⁷ with savings being made by cutting prison budgets. According to the Prison Reform Trust’s latest report from summer 2017, there is currently shortfall of over 900 frontline operational staff in public prisons against target ‘benchmark’ numbers.¹⁸ This has led to a significant loss of experienced prison staff between 2010 and 2015. They are replaced by cheaper, but less experienced, staff, who are working in overcrowded prisons.¹⁹ The rise of self-harm incidents is a symptom of the reduction in staff levels and of knowledgeable staff.

¹⁷ Formerly the National Offender Management Service (NOMS). HMPPS had reduced its budget by nearly a quarter since 2010–11. Prison Reform Trust, *Prison: the facts Bromley Briefings Summer 2017*, page 5.

<http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefings/Summer%202017%20factfile.pdf>

¹⁸ *ibid.*

¹⁹ “The prison system as a whole has been overcrowded in every year since 1994.” Prison Reform Trust, *Prison: the facts Bromley Briefings Summer 2017*, page 3; John Attard, “Gove’s prison reform cannot undo the harm already inflicted by the cuts”, *The Guardian*, 19 May 2016, <https://www.theguardian.com/public-leaders-network/2016/may/19/gove-prison-reform-cuts-budgets-deaths-custody>.

34. Reforms to the prison system is an executive decision, not a legal one, but until those reforms are implemented the coronial system will continue to deal with a significant number of prison deaths.