NEUTRAL CITATION NUMBER: [2019] EWHC 3227 (Admin)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT IN LEEDS
BEFORE: HIS HONOUR JUDGE MARK RAESIDE QC (Sitting as a Judge of the High Court)

Case No: CO/2414/2017

Thursday, 12th September 2019

B E T W E E N:

THE QUEEN ON THE APPLICATION OF RHODA MARIE LEE

Claimant

and

HM ASSISTANT CORONER FOR THE CITY OF SUNDERLAND

Defendant

and

(1) CITY HOSPITALS SUNDERLAND FOUNDATION TRUST
(2) NORTHUMBERLAND TYNE & WEAR NHS FOUNDATION TRUST
(3) SUNDERLAND CITY COUNCIL

Interested Parties

PAUL KINGSLEY CLARK of Counsel appeared on behalf of the Claimant
JONATHAN HOUGH QC of Counsel appeared on behalf of the Defendant
CLAIRE WATSON of Counsel appeared on behalf of the Second Interested Party
The First and Third Interested Parties did not appear or attend

APPROVED JUDGMENT

HHJudge MARK RAESIDE QC:

This is an *ex tempore* oral judgment which has been briefly corrected on receipt of very poor a transcript without the aid of all the documents.

Introduction

1. This case concerns the claimant Rhoda Marie Lee ("Mrs Lee"), who brings this judicial review claim as an interested person, concerned about the death of her daughter Melissa Dominique Marie Lee ("Melissa") against the defendant Her Majesty's Assistant Coroner for Sunderland ("the Coroner") as a result of a decision on 22 February 2017 ("the Decision"), in which she declined to engage Article 2 of the European Convention on Human Rights in an inquest into the death of Melissa, on either operational or systemic grounds. However, the real essence of this case concerns Mrs Lee's wish to extend the operational duties under Article 2 to the particular factual circumstances of Melissa who was an outpatient under the care of one of the interested parties; Northumberland Tyne and Wear NHS Foundation Trust ("the Trust"). There is a secondary concern of Mrs Lee about the systematic duties under Article 2 in regard to Melissa's care plan, in particular, having regard to more recent authority. The balance of the case is peripheral. The other interested parties; City Hospital Sunderland NHS Foundation Trust and Sunderland City Council, have not attended and have taken no part in this case.

Factual background surrounding the death of Melissa

2. Melissa suffered from significant mental health problems as a teenager and overdosed on drugs and engaged in other dangerous behaviour. In July 2012, she was admitted as an informal patient to a psychiatric ward, and thereafter from December 2012, was under a community care regime, and subject to a series of care plans. Since then, and until the time of her death, Melissa persisted in regular overdosing of prescribed medicines and other drugs and was admitted to hospital, both on a voluntary and, in some cases, compulsory basis under the Mental Health Act 1983.
3. Melissa's primary diagnosis was emotionally unstable personality disorder ("EUPD"), which was the subject of her care plan in the community and was overseen and implemented by a multi-disciplinary team of health and social care services provided by the Trust and from March 2015 a crisis management plan which was in place, and which recorded the frequency of self-harm and overdosing that often required hospital treatment, but was not considered to require admission for a mental health assessment. Between September and December 2015, Melissa took a number of overdoses and also suffered physical harm, which resulted in treatment in A&E.
4. On 15 February 2016, Melissa had an outpatient appointment with a psychiatrist who confirmed the diagnosis of EUPD and arranged medication. On 8 March 2016, Melissa contacted her care co-worker and the crisis service carried out a full assessment on 9 March 2016 at Melissa's home. A few days later, on 13 March 2016, Melissa again attended A&E as a result of an overdose but discharged herself. In consequence from 14 March 2016, the crisis team carried out a further assessment of Melissa and considered her to have a moderate risk of self-harm which did not justify readmission to hospital which was her wish. This decision was affirmed by a consultant psychiatrist who reviewed the documentation.
5. In the early hours of 17 March 2016, Melissa was again treated at A&E as a result of an

overdose but requested and was allowed to discharge herself that evening. Later that evening Melissa sent text messages to her family and friends in the early hours of 18 March 2018, and her father visited her at her home but felt assured and so left her.

6. On the morning of 18 March 2016, Melissa was found unresponsive at her home, and the paramedics who attended to confirm that she was dead. A post-mortem examination revealed drug levels which, individually and in combination, caused respiratory depression and the death of Melissa.

7. This are my summary of the factual background which I do not purport gives a full picture of Melissa but is sufficient simply for the purposes of this judicial review. I fully appreciate that the facts themselves are far more detailed, and in due course will have to be considered by the Coroner accordingly.

Procedural background and Grounds

8. On 22 May 2017, Mrs Lee issued a judicial review claim form against the Coroner, the Trust and to other interested parties, seeking to challenge the Decision of the Coroner that Article 2 was not engaged in the inquest into the death of Melissa and therefore should be quashed or such other further or other relief as the court thinks fit. The attached statement of facts and grounds for judicial review dated 19 May 2017 and relied upon 9 Grounds.

9. The acknowledgement of service dated 7 June 2017, attached submissions of the Coroner, dated 2 June 2017, and opposed all 9 Grounds, and asserted that the Decision should only be quashed if the court considered that the Coroner was wrong to conclude no arguable breach of Article 2 substantive obligations were established on material before the Coroner; but even if the court were to identify some error it would not be appropriate to quash the Decision.

10. The acknowledgment of service dated 8 June 2017 for the Trust considered the submissions of the Coroner on all 9 Grounds and supported that position and this has been their position throughout this case.

11. On 4 July 2017, Soule J refused permission for the reasons given by the Coroner.

12. The grounds of renewal dated 7 September 2017 again relied upon all 9 Grounds.

13. On 13 September 2017 I gave a short *ex tempore* oral judgment and order in which permission for Grounds 1 and 3 were refused, but in respect of the important issue in this case, permission on Ground 2 was granted but adjourned to a substantive hearing. Grounds 4 to 9 were also adjourned all in the hope that the parties could be able to achieve some compromise of this case.

14. On 7 October 2018 Floyd LJ refused permission to appeal, on the basis that Ground 2 gave Mrs Lee an adequate basis for challenging the Decision.

15. On 6 February 2019, I made an order for a rolled-up hearing, which was vacated and re-fixed by order dated 15 February 2019 by His Honour Judge Klein for a hearing before me.

16. In summary, and as described in the statement of facts and grounds for Mrs Lee the 9 Grounds are as follows; (1) Ground 1 – failure to comply with the '*Osman* Test' (*Osman v United Kingdom* [1998] ECRR 101); (2) Ground 2 – irrationally finding as to vulnerability, level of risk and/or assumption of responsibility; (3) Ground 3 – error in the interpretation of *Powell v United Kingdom* [2000] ECHR 703 ; (4) Ground 4 – error in the evidential threshold to determine whether there was a breach of Article 2; (5) Ground 5 – error as to the nature of operational duty; (6) Ground 6 – error as to Article 2 causation tests; (7) Ground 7 – failure to consider adequacy of the applicable system (as opposed to

the existence of the system); (8) Ground 8 – error in the interpretation of *Powell v United Kingdom*; and (9) Ground 9 – failure to consider (adequacy of) the system applicable to Melissa.

17. Of those remaining grounds in this case they can be conveniently (so arguably not entirely correctly) divided into; (1) those grounds which concern the operational duties of the Trust which Ground 2 has permission and Grounds 4 to 6 by adjournment are now part of this rolled-up hearing; and (2) those grounds which concern the systemic duties of the Trust of which Grounds 7 to 9 have been adjourned into this rolled-up hearing of which Ground 8 is the important one. Grounds 1 and 3 are no longer available for argument by Mrs Lee.
18. The original skeleton argument of Mrs Lee, dated 7 September 2017, understandably dealt with all 9 Grounds, but subsequently, and maybe surprisingly, the skeleton argument dated 20 August 2019, for this case before me, only dealt with Ground 4 to 9 and on my invitation was supplemented by a further skeleton argument, dated 10 September 2019, for the substantive hearing of Ground 2.
19. Likewise the original argument for the Coroner, dated 7 September 2017, also dealt with all 9 Grounds, and the skeleton argument dated 27 August 2019, only deals with a substantive hearing for Ground 2 and a rolled-up hearing for Grounds 4 to 9.
20. The Trust took no part in the original hearing, the subject of my judgment, but subsequently have provided a skeleton argument dated 27 August 2019, with a substantive hearing on Ground 2 and the rolled-up hearing for Grounds 4 to 9.
21. There has been two days of oral submissions from Mrs Lee, the Coroner and more shortly, the Trust, before I gave an overview of my decision on all 9 Grounds, followed by this *ex tempore* oral judgment the next day as supplemented the following day.
22. This case proceeds upon the remaining grounds as provided in the documents which, having set out the Decision, I propose to consider the following in this ex tempore judgment; (1) the substantive hearing of Ground 2 concerning the Operational duties of the Trust; (2) Ground 8, which is the core of the case on the Systematic duties of the Trust; (3) more shortly, the rolled-up hearing for Grounds 4 to 6, concerning essentially peripheral Operational duties of the Trust; and (4) the rolled-up hearing for Grounds7 to 9, concerning peripheral Systemic duties of the Trust.

The Decision

23. The written submissions from Mrs Lee, dated 17 February 2017, set out the case under Article 2 in respect of; (1) operational duty; and (2) systemic duty. Insofar as the former was concerned, reliance was placed on *Rabone v Pennine Care NHS Trust* [2012] 2 AC 72 (which I dealt with previously in my previous ex tempore judgment) by reference to threefold factors of assumed responsibility, vulnerability and risk. Insofar as the second was concerned, the case relied upon failures or inadequacies in care planning and discharge planning, that could entail a breach of the systemic duty and set out in some detail the concerns of Mrs Lee.
24. The transcript of the pre-inquest review, carried out by the Coroner, which gave rise to this *ex tempore* oral judgment, so far as material to Article 2, comprises some 69 pages; 66 pages of submissions and 2 pages for the Decision of which there are 24 pages of submissions in respect of the operational duty, and only 6 pages on the systemic failings, which broadly represents the importance of how the case was brought before the Coroner.
25. It is clear from the approach taken by the Coroner to the operational duties and *Rabone v Pennine Care NHS Trust* (Supra) that the Coroner focussed almost exclusively on the question of responsibility, which she equated to "control" despite the fact that when she

was shown paragraph 34 of *Rabone v Pennine Care NHS Trust* (and the threefold test) and which she appeared to accept as a matter of law, she nonetheless reverted back to her sole concern on the question of assumption of responsibility, as is apparent from the Decision.

26. The approach taken by the Coroner on the systematic duty did not appear to get off to an auspicious start as she maintained; 'I do not see with regard to your arguments on the systemic failure, effectively it is clear that there was a system in place; whether or not there were flaws within the system remains to be considered in the inquest, but effectively there was a system in place, so I cannot see that there is any systemic failure'.

27. It would appear from the transcript that consideration was not specifically given to the written submissions of Mrs Lee, in respect of that systemic duty or failure, in particular in respect to care planning of Melissa though, the Coroner did accept that she could, 'revisit the decision". I will set out these submissions below solely for the purpose of considering what effective if any this could have on the most recent law applicable.

28. The Decision itself is short, and so far as material to this case, deals separately with the operation and systemic duties in that order as follows:

(1) Operational duties;

'Case law has examined Article 2 and, in particular, the operational duties engaged in difficult circumstances. The case of *Rabone v Pennine Care NHS Trust* considered mental health patients and extended the operational duty to mental health patients who are not sectioned under the Mental Health Act, and the court did extend the operational duties to include such patients, and it considered extreme vulnerability and exceptional nature of the risks, and also the degree of responsibility and control assumed over that case, which was a young lady…Considering all the other cases referred to by Mr Clarke, on behalf of Melissa's family, despite his contention to the contrary, I believe I am being urged to extent *Rabone v Pennine Care NHS Trust* to mental health patients in the community; I do not find that the operational duty arises in those circumstances; the Trust has not assumed control or responsibility in that regard of the word, and therefore there can be no breach';

(2) Systemic duties;

'I have also considered the contention there has been a breach of systemic nature, however, I find there is no evidence before me which would suggest the breach of care professionals have not made adequate provisions for securing high professional standards among health professionals and the protection of lives of patients, and I remind myself it is not accepted that errors of judgement on the part of health professional or negligence cooperation among health professionals and the treatment of particular patients are sufficient in themselves to give rise for contracting state to account from the standpoint of applications under Article 2 of the convention to protect life, and that is in Powell v United Kingdom…'.

29. What appears clear from the Decision, in respect of both duties, is that whilst the Coroner apparently sets out correctly the legal propositions for both the operational and systemic duties, she does not appear that in the first of these two duties only to have given effect to the argument put by Mrs Lee as shown in the transcript.

30. On (1) Operational duties, the Coroner appears to have appreciated that *Rabone v Pennine Care NHS Trust* referred to three factors which is what the written submissions and oral submissions of Mrs Lee made asserted, however, she seemed satisfied and, indeed, from the outset approached the pre-inquest review as if it only concerned a single factor of an assumption of responsibility which she equated to 'control' during the submissions made prior to the Decision. As she appeared to have appreciated during the

submissions, she had been asked to extend *Rabone v Pennine Care NHS Trust* to the facts of Melissa who was in the community and not under hospital, voluntary or otherwise. Having appreciated that *Rabone v Pennine Care NHS Trust* extended the previous duty to a voluntary patient in hospital, as opposed to an in-patient, and it was done by reference to all those three factors, one would have expected that the Coroner would do likewise, and review the case on the basis of risk and vulnerability of Melissa, as set out in written submissions and not just focus, essentially, on a narrow concept of control which she found synonymous with an assumption of responsibility. On (2) Systemic duties, the Coroner was dismissive of the case as a result of a total lack of evidence which was referable on the systems in place by the Trust. There was not any doubt as to the law in that regard, and the case rightly proceeded on *Powell v United Kingdom*, but since then, this now is subject to the decision of *Fernandes v Portugal* [2017] 163 BMLB 182 which I shall refer to below.

31. However, and importantly, this is what was said in the written submissions on the systemic duties; 'The family has particular concerns on the contents and adequacy of the care plan applicable at the time of Melissa's death… this appears primarily on the care plan dated from March 2015, as updated on 22 February 2016. Addressing this issue would include seeking clarification of the services offered to Melissa, and the adequacy of the overall plan among questions that arise in this category, are whether specialist resident services… where they considered to be made available to Melissa, and the attendant of care is at her home address. The family have particular concerns in areas, both in terms of the facts that those specialist residential service was offered, and also in terms of the mixed messages that Melissa had received as to the role of Dr Mitchell. In particularly in relation to the availability of specialist residential services for Melissa, it is an issue in relation to which the family has substantial concerns. The key issue is whether it is appropriate for Melissa to reside alone, and the adequacy of the plan to manage the risks that arise for this. In this relation the family knows that although accepting the care plan – carers were due to visit Melissa at home following her last discharge from hospital, scheduled visits which did not take place'. It is right to record; the document goes on further to consider Melissa's discharge plan and her admittance to hospital also.

32. When the Coroner specifically asked about the arguable evidence of the failure of the system itself, none was provided by Mrs Lee and, indeed, it was agreed that, 'There was no such information', in regard the system itself. The Decision of the Coroner thus proceeded on that basis as set out above.

33. In the context of the Decision it is also right and fair to record the subsequent position of the Coroner in the pre-action response letter of 9 May 2017 ("the Response"), where there was an elaboration of reasons for the Decision in respect of the operational duty in this way; (1) the starting point (under the Powell line of authority) is that the operational duty will not apply to a person receiving ordinary clinical care; see *Rabone v Pennine Care NHS Trust* at paragraphs 19 to 20. Although such persons may exhibit a real immediate risk of death, and the clinicians have and failed to take reasonable steps to prevent it, they would ordinarily there is no breach of Article 2 duties in a case simply of negligence; (2) there is no authority cited or known to the Coroner which establishes that the operationary duty arises on the facts, such as those in this case where a person took an overdose in her own home; (3) this case does not involve the type of assumption of responsibility by the state considered in *Rabone v Pennine Care NHS Trust* at paragraph 22. Each of the scenarios considered there involved a degree of constant supervision and control by the state. By contrast, Melissa's case was in the community in her own home; her structured programme of care was intended to enable her to live without contact supervision; (4) neither does the case involve the type of acute vulnerability considered in *Rabone v Pennine Care NHS Trust* at

paragraph 23 (there a child was known to be at risk of abuse) likewise it is analogist of the type of heightened risk situation considered in paragraph 24 of *Rabone v Pennine Care NHS Trust* (the risk of dangerous military operations). Melissa appropriately was living in the community but posed no long-term chronic risk to self-harm, which entailed the possibility of an inverted seriously harm; (5) in summary, the Coroner does not consider that Article 2 imposes an operational duty on health care professionals to intervene and prevent the suicide of a person in Melissa's position, with EUDP living in her own home.

Ground 2 – Operational duties

34. The statement of facts and grounds for judicial review on Ground two, provides under the heading – Irrational findings as to vulnerability, level of risk and/or assumption of responsibility, the following; 'The Coroner made no reference to the extent of [Melissa's] vulnerability or nature or extent of risk, in her decision… the Coroner approached these matters by seeking analogy (with *Rabone v Pennine Care NHS Trust*) at the expense of principle. No attempt was made to consider the combined effect of the extent of assumption of responsibility, the nature and extent of vulnerability, and risk… and to consider whether in the light of the combination of those factors the Trust knew, or ought to have known, of a real risk and immediate risk and whether, again, in the light of those factors taken together, response to the state agents was unreasonable'.
35. The submissions to the Coroner asserted that this case does not involve the type of assumptious responsibility by the state considered in *Rabone v Pennine Care NHS Trust*, neither does the case involve the kind of acute vulnerability considered in *Rabone v Pennine Care NHS Trust*. Likewise, it is not analogist to a type of heightened risk case, also in *Rabone v Pennine Care NHS Trust*.
36. As set out above, I did consider Ground 2 to be arguable, because of no consideration having been given to the two other factors in *Rabone v Pennine Care NHS Trust*; namely vulnerability and risk, which was at the heart of the case put by Mrs Lee; as apparent from the submissions made by Mrs Lee before the Coroner.
37. The claimant's further skeleton argument deals, briefly with both the Decision and the Response, and argues that three factors in *Rabone v Pennine Care NHS Trust*, namely; (1) that the Coroner in the consideration of 'extent' of responsibility required, but as a matter of law, there was no requirement for 'constant supervision', before the Trust should be aware of the real and imminent risk to Melissa and (2) and (3), as to these factors, the extent of Melissa's vulnerability and/or the nature and extent of risk to her was not considered in the decision, and the response considered an analogous with the *Rabone v Pennine Care NHS Trust* in principle. Further, no attempt was made to consider the combination of the assumptive responsibility and the nature and extent of vulnerability and risk.
38. The Corners skeleton argument before me on the last occasion again proceeded on the basis that the operational duty did not apply to an ordinary case of clinical care and there was no authority for the Article 2 operational duty to a person in Melissa's position i.e. a person living at home with a care plan took an overdose and then reference was made to the three 'indicia' in *Rabone* and rightly noted that the Corner took the view that the type of assumption of responsibility in paragraph 22 *Rabone* did not exist, but went on to assert that this case did not involve the form of acute vulnerability in paragraph 23 of *Rabone* and the type of heightened risk in paragraph 24 of *Rabone* neither of which in fact had been considered or found by the Coroner. It was not the Coroner's case that the correct test in law

is simply to be equated to “control” without more as the Coroner had effectively found. In the oral submissions on that occasion it was pointed out that these ‘indicia’ at paragraph 25 of *Rabone* “may be” appropriate.

39. In the Corners skeleton argument for this case the Coroner noted that Mrs Lee's case appeared to proceed on irrationality when in fact it is probably a case concerned with the law however referring to R(Parkinson) v HM Senior Coroner for Kent [2018] UKHC 1501 and on R (Muriel Maguire) v HM Senior Cornoner for Blackpool and Fylde [2019]ECHC 1232 it was asserted that there was no error of law and therefore Mrs Lee had to establish that the Decision was irrational and relied upon Maguire which was treated as a healthcare case and not one of hospitalisation as in *Rabone*. Dealing with the three factors in *Rabone* it was said (1) the Coroner had to consider whether Melissa's case was truly comparable or analogous to the situations where duty has been found to exist and a “critical” distinguishing factor in those cases involving a regime of control and constant supervision were as opposed to living at home, (2) on vulnerability it was said that in the Decision and Response this factor had been addressed and the courts had always reasoned to an extent by analogy” as in Savage Mitchell and *Rabone*, (3) in respect of the real and imminent risk to Melissa's life it was said that that would only be relevant if the Coroner concluded that Osman duty applied. I have to say that I have found nothing in the Decision in respect of vulnerability and also there was no finding of a real and imminent risk in the Decision. Both these two factors simply were not considered as a matter of substance as opposed to quotations of law in the Decision or considered during the argument.

40. I should record that the Response on these two factors not considered by the Coroner was somewhat thin and shortly asserted neither does this case involve acute vulnerability considered in *Rabone* paragraph 23(there are child known to be at risk of abuse). Likewise it is not analogous to a case of heightened risk situation considered in *Rabone* at paragraph 24(their risk to dangerous military operation) but Melissa was appropriate living in the community but posed a long-term chronic risk of self-harming which untold tale the possibility of inadvertent serious harm.’

41. The Coroner’s skeleton argument in this case proceeds to rely upon the Response on the basis that even if the duty applied a breach could not be established and sets out in some detail five factual points that are relied upon specific to Melissa. I have set out above my summary of the facts for the background of this case and the particular facts relied upon in the Response was slightly different and some instances more detailed and focused.

42. In the oral submissions for the Coroner a more detailed and comprehensive review of the facts was presented and relied upon in a similar way and which went beyond the Response. It became clear to me that if I was to engage at this substantive hearing in making primary findings of fact surrounding the death of Melissa to resolve on Ground 2 for the purposes of this judicial review the case would go well beyond how I had initially understood the arguments and this would be the first time that such primary facts been considered in a case which in essence involves deciding whether *Rabone* should be developed further in a case such as Melissa's.

43. As there had been no engagement in this part of the Coroner's case on behalf Mrs Lee it seems fair an proper to return to the case which was before the Coroner in the written submissions for Mrs Lee to see what was said about vulnerability and risk and had not been considered in either the discussion before the Coroner or the Decision because the case had proceeded solely and essentially on the question of control of Melissa without more. What is clear to me is that the case was set out in some factual detail on vulnerability and risk to Melissa and those facts did not entirely accord with either my summary of the background facts for the purposes of this judgement but more importantly with the facts relied upon by

the Coroner in the Response or indeed and significantly in the detailed oral submissions made by the Coroner in this case.

44. The case for the Coroner on the relevant law was detailed and impressive and supported by the Trust who invited an earlier start the authorities by reference to Osman prior to Savage. I should point out that such a review did not take place before the Coroner in the case largely turned almost exclusively on *Rabone*. The review therefore proceeded as follows; in Osman at paragraph 115 it was said; "it is thus accepted by those appearing before the court that article 2 of the convention may also imply in certain well-defined circumstances a positive obligation on the authorities to take preventative operational measures to protect an individual whose life is at risk from the criminal effects of another individual the scope of this obligation is a matter of dispute between the parties," and at 116 said "for the court and bearing in mind the difficulties involved in placing modern societies the unpredictability of human conduct and the operational choices that must be made in terms of priorities and resources such an obligation must be interpreted in a way that does not impose an impossible or disproportionate burden on the authorities. Accordingly not every claimed risk to life can entail for the authorities a convention requirement to take operational measures to prevent that risk materialising." Lord Rogers in Savage relying upon the first of these two quotes in Osman paragraph 49 "plainly parties who have been detained because of the health or safety demands that they should receive treatment in hospital are vulnerable they are vulnerable not only by reason of their illness which may affect their ability to look after themselves but also because they are under the control of the hospital authorities like anyone else in detention they are vulnerable to exploitation abuse bullying and all the other potential dangers of a closed institution… The hospital authorities are accordingly responsible for the health and well-being of their detained patients their obligations under article to include an obligation to protect those pensions from self-harm and suicide," and as pointed out for Mrs Lee he also said "neither Powell's case… Provides any basis whatever for the proposition that is a matter of principle medical staff in a medical hospital can never be subject to an operational duty under article 2 to take steps to prevent a (detained) patient from committing suicide- even if they know or ought to know that there is a real and immediate risk of doing so the obvious response to that proposition is; why ever not? What else would they be supposed to do? Article 2 imposes on the hospital authorities and the staff an obligation to adopt a framework of general measures to protect detained patients from the risk of suicide why should they not be under the usual complimentary operational obligation to try to prevent a particular suicide in an appropriate circumstance?" In Mitchell Lord Roger again having cited from Osman set out above said at paragraph 66"where estate has assumed responsibility for an individual with a by taking him into custody by imprisoning him detaining him under mental health legislation or conscripting him into the Armed Forces the state assumes responsibility for that individual safety soon these circumstances please authorities prison authorities health authorities and the Armed Forces are all subject to positive obligations to protect the lives of those in their care… If however an authority fails to fulfil one of these obligations and someone in their care dies as a result there will be a violation of his or her article 2 Convention rights authorities which are under the general obligation to persons in care may also come under distinct additional" operational" obligations to take special preventive measures to protect a particular individual in their care that obligation arises only where the authorities knows or ought to know of a real and imminent risk to the life of the particular individual" and then proceeded to consider that factor paragraph 67 to 71 as follows "the peer pursues of the local authority new or ought to have known that there was a real and imminent risk to Mr Mitchell's life in the day he was killed… The position of the local authority is quite different Mr Mitchell

was a secured tenant of the local authority and of course if the local authority allowed their housing stock to fall into disrepair so that the tenant was at risk of suffering life-threatening injuries were becoming seriously ill the local authority could have been in breach of article 2 but nothing like that is alleged hear what is said is that the local authority were under a positive duty to protect Mr Mitchell from a criminal attacked by Drummond… Like anyone else Mr Mitchell was free to come and go as he pleased and to act as a responsible adult indeed as already mentioned the whole policy behind the introduction of secure tenancies was a free public sector tenant from some of the controls to which they had previously been subjected and to emphasise their independence as individuals was rights in their own homes… it follows that even if the local authority officials have been aware of a real and imminent threat to Mr Mitchell's life from Drummond they were not been under an art to obligation prevented the other months of a breach of Mr Mitchell's article to conventional rights by the local authority are consequently irrelevant."

45. Reference was again made as at the last occasion to *Rabone* and it was noted that Lord Dyson having considered Osman, Powell, Savage and Mitchell reference was made to those same paragraphs 21 to 25 inclusive as follows; paragraph 21"it is therefore necessary to attempt to discover the essential features of the cases were Strasbourg has so far recognised existence of an operational duty it is clear that the existence of a 'real and imminent risk' to life is a necessary but not sufficient condition for the existence of the duty that is because the cortical said a patient undergoing major surgery may be facing a real and imminent risk of death and yet the Powell case shows that there is no article to operational duty to take reasonable steps to avoid the death of such a patient," paragraph 22"no decision of ECHR has been cited to us with the court clearly articulates the criteria by which it decides whether an article to operational duty exists in any particular circumstances it is therefore necessary to see whether the cases give some clue as to why the operational duty has been found to exist in some cases and not others there is a certain in this year which point the way as Miss Richard and Mr Brown submit the operational duty will be held to exist where there has been an assumption of responsibility by the state for the individual's welfare and safety (including by the exercise of control) the pyridine example of assumption of responsibility is where the state has to take individual weather in prison in a psychiatric hospital in an immigration detention centre otherwise…" Paragraph 23 "when finding that the article to operational duty has been breach ECHR has repeatedly emphasised the vulnerability of the victim as a relevant consideration in circumstances of sufficient vulnerability the ECHR has been prepared to find a breach of operational duty even where there has been no assumption of control by the state such as where a local authority fails to exercise its powers to protect a child who tweets knowledge is at risk of abuse…" Paragraph 24 "a further factor is the nature of the risk. Is it an ordinary' risk of the kind that individuals in the relevant category should reasonably be expected to take or it is an exceptional risk?... The court drew a distinction between risks which a soldier must expect instant of his ordinary military duties and 'dangerous' situations of specific threat to life which arise exceptionally from the risk posed by violent unlawful acts of others or man-made or natural hazards and operational obligation only arises in the latter situation," and paragraph 25 particularly relied upon by the Coroner" all of these factors may be relevant in determining whether the operational duty exists in any given circumstances but they do not necessarily provide a sure guide as to whether an operational duty will be found by the ECHR to exist in circumstances which have not yet been considered by the court…" In my judgement I particularly focused on paragraph 34 which I do not need to quote again because it makes clear that in coming to a decision on the facts of this case and thus extending the law beyond the previous cases cited above Lord Dyson plainly considered all

three factors in the order cannot be ignored i.e. he started with the real and immediate wristed to suicide then vulnerability and lastly assumption of responsibility and then referred to control.

46. Since *Rabone* and the decision of the Coroner two further cases were relied upon as referred to above Parkinson and Maguire. Singh LJ in Parkinson having reviewed the law by reference to Humberside (which has not featured in this case) but also the cases cited above the then review *Rabone* was 55 to 61 inclusive by reference to parts of paragraph 19, 21, 22, 33 and then 34 viz" her position was far closer to that of such a hypothetical patient than to that of a patient undergoing treatment in a public hospital for a physical illness." And then said at paragraph 94 "a case like Savage concerned compulsory detention of the patient under the Mental Health Act. *Rabone* was very similar to such a case because although there was not compulsory detention and the patient was strictly speaking 'voluntarily' patient she was in an analogous situation for reasons that Lord Dyson explained furthermore both of those cases concerned a suicide risk the present case is nothing like that sort of case on its facts this is a case about emergency diagnosis and treatment in an A&E department frequently there will be patients who come into A&E who have mental capacity issues either because they are very elderly or has some other reason in our view normal principles which we have set out only apply." Again all cases turn on their particular facts and in Melissa's case suicide is a relevant factor. In Maguire Irvin LJ dealt with the particular facts in that case in paragraph 44 referred to *Rabone* in this way" that the case has extended the positive duty beyond the criminal justice context in Osman is not in doubt the reach of the duty beyond what Lord Dyson called the 'paradigm's example'of detention is less easy to define we have reached the conclusion however that the touchstone for state responsibility has remained constant it is whether the circumstances the case are such as to call a state account *Rabone* para 19 citing Powell" and doubt further with the case in paragraphs 47 to 49 as follows" as the responsibility which the state assumed here Jackie was a vulnerable person for whom the state cared… In our judgement each case turns on its own facts… Where the state has assumed some degree of responsibility for the welfare of an individual.. Will sometimes be a fine one. However it was the function of the coroner to draw it the court will not interfere save on grounds of irrationality or other area of law. The coroner's approach reveals no such error on the evidence before the coroner was open for him to conclude that this was a medical case that a jury could not safely find that Jackie died result of any actions or omissions which the state would be responsible the coroner considered the relevant issues and reached the conclusion that was open to him." I have found this authoritative less assistance however it does indicate that it is for the coroner to make appropriate findings of fact and if as in this case those facts would also consider vulnerability and risk that applied to Melissa in this case gives me some confidence that it should be the Coroner who should carry out this exercise and not this court.

47. I am satisfied as indeed was the Coroner that the case of Melissa arguably invites an important extension of the law beyond *Rabone* and therefore it would be unfortunate to limit the case to simply a question of control as the Coroner apparently did but also place this in the context of the vulnerability and the risks surrounding Melissa. That is how the case was presented to her by Mrs Lee in the written submissions but unfortunately was not considered that all.

48. I have not read the authorities set out above is absolutely and categorically as a matter of law limiting a tribunal's consideration of the facts to only a question of control by the state over an individual for the purposes of Article 2 which is what I consider is all that the Coroner in fact did. If this is right and probably in any event when fine distinctions may arise and the Coroner in their oral submissions maintains as they did in the Response that

either the particular facts on vulnerability and risk in this case are not sufficient to give rise to an Article 2 claim but in the alternative if the facts are gone into in detail and in any event there was no breach of Article 2 obligations I am quite satisfied that the appropriate course to take in this case is to remit the case back to the Coroner to consider certainly the written submissions provided by Mrs Lee and probably in view of how this case has proceeded that both parties should be given the opportunity to set out their case on vulnerability and risk together with the assumption of responsibility as a question of fact in Melissa's case in order that the Decision can be supplemented further.

49. Equally I am satisfied that it would be wrong to quash the Decision at this substantive hearing because I consider it proper and within my powers to invite a further and necessary factual finding process to be undertaken by the coroner in which Mrs Lee and the Trust can fairly and more fully have the opportunity which neither properly engaged upon as is clear from the submissions of both parties before the Coroner. The view I have taken is that it is better for a primary finder of fact namely the Coroner it to undertake this exercise and not this judicial review court. This is particularly so in an area such as this case where there is a developing area of law in issue.

50. Accordingly, I am prepared to make an order remitting this case back to the Coroner only on Ground 2 only and no more and an appropriate order will need to be drawn up indicating the extent and limitations those particular matters that the Coroner is being asked to reconsider.

Ground 8 – Systemic duties.

51. The statement of facts and grounds for judicial review on ground eight, described this as an error in the interpretation/application of *Powell v United Kingdom*, and provide an argument as follows: 'The rationale given by the Coroner… suggests that she abandoned the assertion that the mere existence of a system is enough to satisfy the systemic duty… the observation – in the case of Powell – is of only marginal relevance to the arguments raised about a systemic duty… the effect of *Powell*, is that the absence of a real and immediate risk to life in respect of a medical patient, there is no breach of any aspect of Article 2, provided that the state has made adequate provision for securing high professional standards among health professionals, the protection of life of patients and that, however, is not exhaustive of the state's systematic obligations… the issue raised… is an arguable breach of the systematic obligation did not relate to [Melissa's] treatment whilst in hospital, it rather concerned the adequacy and appropriateness of the care plan that operated when she was not admitted to hospital'. It seems clear from this ground that the focus is on the care plan alone, and on that plan so far as Melissa was not in hospital.

52. I have set out above what was before the Coroner for the Decision, and what appears to be a concession in terms of the system made by Mrs Lee.

53. The series of subsequent arguments and oral submissions by both Mrs Lee, the Coroner and now the Trust on Ground 8, can shortly be summarised as follows; all three parties accept the leading case is now, since the decision in *Powell v United Kingdom*, in respect of this is now *Fernandes v Portugal* (Supra), but disagree as to its meaning and effect on this case.

54. The original skeleton argument in support of the oral hearing for permission before me for Mrs Lee, dealt with the systemic obligations superficially, and did little more than just indicate it relied on the statement of facts and grounds which I have quoted above. I adjourned this part of the case, because it was plainly peripheral and undeveloped.

55. In the skeleton argument in this rolled-up hearing on Ground 8, it set out the different between the test for negligent liability and breach of a positive obligation under Article 2

relevant to the systemic duty under *Powell v United Kingdom* and concluded; 'However, this does not mean that the requirement of an adequate regulatory system is exhaustive of the requirement of the systemic duty. It simply means that occurrence of a negligence act is unlikely to entail a breach of ECHR, unless it can be attributed to the regulatory system'.

56. The oral submissions for Mrs Lee relied upon this as 'the core case' on the systemic failings and developed the case from *Powell v United Kingdom* by reference to, in particular, *Fernandez v Portugal*.

57. *Powell v United Kingdom* was, at the time of the decision, the leading authority of the extent of a positive duty in a clinical context owed by the state under Article 2 vis; 'The court accepts that it cannot be excluded that the acts and omissions of authorities in the field of health care policy may, in certain circumstances, engage responsibility under the positive limb of Article 2. However, where a contracting state has made adequate provisions for security, high professional standards among health professionals and protection of lives of patients, it cannot be accepted that matters such as over judgment on the part of health professionals or negligent among health professionals, and the treatment of particular patients are sufficient in themselves to call the contracting state to account from the standpoint of positive obligations under Article 2 of the convention to protect life'.

58. It is quite apparent from the Decision, that the Coroner was dealing with the systematic duties under Article 2, and followed almost verbatim, the wording of the approach in *Powell v United Kingdom* in the first sentence of the Decision dealing with this issue. There was nor could there be any argument or criticism by Mrs Lee on her interpretation of the *Powell v United Kingdom* in the Decision thus far.

59. Before considering the second sentence of the Decision, it is necessary to return to what, in fact, the Coroner found in the application of *Powell v United Kingdom*. It was quite simply and, indeed, accepted by Mrs Lee that there was, 'no evidence' before the Coroner of any breach of this obligation by the Trust. The written submissions for Mrs Lee, which I have set out above, make no attempt to put forward an oral case on systematic failings by the Trust, in respect of the care plan of Mrs Lee. Accordingly, in that regard the Coroner was quite right to come to that conclusion, because there was no evidence which should give rise to an enquiry as to the adequacy of the provision for securing high professional standards among health professionals for the protection of Melissa's life. In the event that such evidence did become available, the Coroner kept an open mind, and was quite prepared to revisit that accordingly.

60. I therefore come to the second sentence in the Decision of the Coroner, in respect of systemic failings of the Trust, which again, almost verbatim, correctly cites from *Powell v United Kingdom*, but in a different context, not to be confused with how it was originally put by the Coroner by which she simply , 'reminds' herself of the distinction between, effectively, negligence and the statutory duties in Article 2; there can and was no argument at all on behalf of Mrs Lee, to indicate that the Coroner had interpreted *Powell v United Kingdom* anything other than entirely correctly.

61. Insofar as the application of the correct legal interpretation is concerned, Mrs Lee wrongly conflates the two separate parts of the Decision. The second sentence in the Decision does nothing more, when read objectively, than point out a well-established legal distinction; it was a distinction the Coroner rightly made during the submissions of Mrs Lee, in an attempt to concentrate the enquiry on the systemic failures required under Article 2, as opposed to focussing on the negligence otherwise of the Trust which is of no relevance.

62. As pointed out under Ground 8 of the statement of facts and grounds, it was right that the quotation from *Powell v United Kingdom* was not exhausted on the obligation under Article 2. However, the Coroner was only, essentially, asked to consider the evidence

surrounding and concerning Mrs Lee, in respect of the care plan, which was available to Melissa, and was not, in fact, asked to go further.

63. Since, the decision of the Coroner, the decision in *Powell v United Kingdom* has been affirmed and considered further in *Fernandes v Portugal* (Supra) and, therefore, formed the essence of the oral submissions made on behalf of Mrs Lee.

64. It is unnecessary to cite at length from the case, and for present purposes, I quote from the headnote; '(1) The case originated in an application (no. 78103/14) against the Portuguese Republic lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") by a Portuguese national, Ms Maria da Gloria Fernandes de Oliveira ("the applicant"), on 4 December 2014; (2) The applicant was represented by Mr J. Pais do Amaral, Ms A. Pereira de Sousa and Ms C. Botelho, lawyers practicing in Coimbra. The Portuguese Government ("the Government") were represented by their Agent, Ms M.F. da Graca Carvalho; (3) The applicant complained under Article 2 of the Convention that her son, A.J., had been able to commit suicide as a result of the negligence of the psychiatric hospital where he had been hospitalised on a voluntary basis. Under Article 6 she also complained about the length of the civil proceedings she had instigated against the hospital; (4) The application was allocated to the Fourth Section of the Court…. On 28 March 2017 a Chamber of that Section… declared the application admissible. In its judgment, delivered on the same date, the Chamber found unanimously that there had been a violation of the substantive and procedural aspects of Article 2…'

65. Accordingly, under the broad obligation of the state, considered separately and secondly in the Decision, which considered whether there was, 'very exceptional circumstances' which arose on a particular case, it would therefore be sensible to review the Decision on that basis. This was understandably not a matter considered by the Coroner when looking at the circumstances surrounding the death of Melissa, but could, arguably require consideration and during the arguments before me, it was a matter I gave consideration to as a possibility. The possibility was fairly aired by the Coroner in the oral submissions, as the transcript records, and the extent and the limitations to that very exceptional case. I have therefore gone back to the case put before the Coroner by Mrs Lee to ask myself whether this would have been a matter that could require remission to her for further consideration, and whether such very exceptional circumstances could now arguably arise.

66. Based on the arguments for Mrs Lee, maintained under the *Powell v United Kingdom* and now *Fernandes v Portugal*, so far as systemic duties of the Trust owed to Melissa, I have formed the view that no such case is available for argument by Mrs Lee. I do, however, appreciate that the case being put on this ground, relied upon the broader basis on which Article 2 is based, for which there is no disagreement by the Coroner or Trust in principle. However, all cases have to turn on their particular facts and in this particular case, it cannot be said or argued that such a broader case was put before the Coroner by Mrs Lee, and indeed the case was really quite narrow, as I have indicated being limited as it was to the care plan and a further argument which does not appear in the ground before me; namely, the question of hospitalisation and subsequent care.

67. Accordingly, I am quite satisfied, having carefully reviewed all the matters relevant to Ground 8 in some detail, that in this rolled-up hearing I should dismiss this ground on the basis that it is not arguable.

<u>Grounds 4 to 6 – Other peripheral Operational duties</u>

68. The remaining Grounds 4 to 6 essentially concern operational duties of the Trust and can be

dealt with more shortly. Mrs Lee, the Coroner and the Trust dealt with Ground 4, and then 5 and 6 together in their oral presentation shortly, and they all appear to consider it peripheral to the central matters, which was essentially Ground 2 on operational matters and Ground 8 on systemic matters.

Ground 4

69. Ground 4 relies upon an error in the evidential threshold that determines whether there is an arguable breach for the purpose of judicial review. The Ground states as follows; 'In relying upon the interpretation of the facts, the Coroner applied an exceedingly high threshold to the question of whether a breach is "arguable" at a pre-inquest stage… arguability does not arise from the fact of having been argued, but from the possibility of doing so. It is an issue that has been raised and that is relevant to compliance of Article 2, but the evidence has not yet been fully answered and it is admitted that Article extends to the effect of any process and is thereby engaged'. The context of this ground relies upon the response, as opposed to the Decision and all submissions which gave rise to that concern operational duties. Initially, though in matter of submission, they were extended as I will explain.
70. The submission of the Coroner who supported the approach, his response was considered that there was 'an Article breach' established, and that was material to the finding the Coroner had made, and nothing further.
71. When coming to the skeleton argument provided at the last hearing before me, it would appear that the case for Mrs Lee has shifted to include a systematic obligation, as well as operational duty, and argued; 'It is considered that the approach to the question of whether it is arguable there is a breach – on the terms of the judgment of Smith, whether there are the grounds for suspicion that there may have been a breach – must be a tenant for the stage of these proceedings and reached'.
72. Thus places it in context for pre-inquest review, which was carried out by the Coroner. In short, the response in the Coroner's skeleton argument on the first occasion before me was to maintain there was no arguable breach in respect of the matters on Article 2 duties.
73. In the skeleton argument for this hearing on behalf of Mrs Lee, the case was put on the basis that; 'If there is any evidence that the state may be in breach of its obligations under Article 2, it is submitted that the requisite, 'close analysis' may be concerned just as much as seeking evidence rules that out – regardless of what further evidence may be available – and the possibility of breach'.
74. In the skeleton argument for this hearing, the case of the Coroner expanded on the case in this way; '…the claimants make much of one gloss of the test of the arguable breach, as proffered by Lord Philips in *Smith, R (on the application of) v Secretary of State for Defence and Oxfordshire Assistant Deputy Coroner (Equality and Human Rights Commission Intervening* [2011] 1 AC 1, at paragraph 84, in which he said there needed to be, 'a ground for suspicion' that the state may have breached a substantive obligation. By far the most frequent used formulation for tests is that of, 'arguable breach' see for instance, *Gentle, R (on the application of) Anor v The Prime Minister & Anor* [2008] 1 AC 1356, paragraph 6, per Lord Bingham; *Humberstone, R (on the application of) v Legal Services Commission* [2010] EWHC 760 (Admin), paragraph 67 Smith LJ'.
75. In the oral submissions for Mrs Lee, a case was developed by reference to the assertion of Hickinbottom J (as he then was) in *Palmer & Anor, R (on the application of) v Worcestershire County HM Coroner & Ors* [2011] EWHC 1453 at paragraph 60 in which he said; 'Where a death has been caused by an arguable breach of the substantive

obligations under Article 2, Article 2 imposes upon the state a duty to investigate that death, and there was some debate before me as to the arguability threshold. However, I do not find it this difficult, 'arguable' as anything more than 'fanciful' and it is a low threshold'.
It is difficult to see how this case can assist Mrs Lee, as it does no more than repeat the well-known test of arguability adopted in inquest; in the Administrative court; Civil court; indeed, the Court of Appeal and very many other applications.

76. Further reliance was placed on *R (Fullick) v HM Senior Coroner for Inner North London* [2015] EWHC 3522 in which His Honour Judge Thornton in the context of the mandatory conditions of Section 7(2)(A), of the Coroners and Justice Act 2009 and in particular, paragraphs 34 and 36, which I do not need to quote, but considered and used in that section, in that Act, (reason to suspect) and other comparable context.
77. In the reply reference is also made to *R (Letts) v The Lord Chancellor* [2015] 1 WLR, and in particular page 4591, which, again I do not need to quote.
78. I have not been able to find anything in Ground 4 and in this argument which would induce me to apply a test anything other than, 'arguable breach' as rightly submitted by the Coroner and supported by the Trust. This was the formulation that the Coroner followed in respect of the operational duty that was before her, and as argued before her on behalf of Mrs Lee. There were times when there was a slightly different formulation in respect of systemic duty which, in fact, is not part of these grounds for appeal. Though subsequently either way I am quite satisfied that the Coroner rightly proceeded on the basis of no arguable breach, and there is no substance in the argument put by Mrs Lee.

Grounds 5 and 6

79. I propose to deal with this matter even more briefly because that is how it was dealt with by Mrs Lee, the Coroner and the Trust, which is entirely appropriate.
80. In the statement of facts and grounds of Mrs Lee, Ground 5 is described as, 'Errors as to the nature of operational duty' and refers solely to the response in respect of the operational duties of which compliant is made then the case was clarified. It was said, 'The operation of duty requires only that the state all that could be reasonably expected of them to avoid a real and imminent risk'.
81. Likewise, the statement of facts and grounds for Mrs Lee, Ground 6 is entitled, 'Errors as to Article 2 causation tests'; and, again refers to the response and deals with operational duties and the submissions that were before the Coroner which gave rise to the decision. It relies on a line of authority and, particular, as also orally submitted and quoted from, *Sarjanston v Chief Constable of Humberside Police* [2013] EWCA 1252 per Lord Dyson MR, and as particularly argued and quoted from paragraph 28 which provides shortly, 'The fact the response would have been made, no difference is not relevant to liability. That is the correct approach as illustrated in the decision of European Court of Human Rights, such as *Kilic v Turkey* [2000] ECHR 128…'
82. The submission on behalf of the Coroner on Ground 5, acknowledged that the response explained shortly, and by means of a simple shorthand. However, when read fairly, and in context, it is referring to and intended to refer to a, 'duty to take reasonable steps in preventing suicide'.
83. In respect of the submissions of the Coroner on Ground 6, it explains that the words used in the Response were, in fact, taken from Lord Brown, in *Van Colle v Chief Constable of Hertfordshire Police* [2009] 1AC 255 at paragraph 138; this was the basis of the point being made, and nothing further.
84. Apart from reviewing the Response in the context of the arguments before the Coroner, the

oral submission before me, added little to Ground 5 and 6, which were illustrated also by reference to *Van Colle*, for which little more needs to be said.

85. I am quite satisfied there is nothing in Ground 5 or Ground 6, when explained by reference to the Response, which would give rise to any substantive case, and therefore I decline this Ground as well as unarguable.

Grounds 7 and 9- Other peripheral Systemic duties

86. I am also going to deal very shortly with the systemic grounds which can be taken together as they were, essentially, by all of the parties.

87. The statement of grounds and facts relied upon by Mrs Lee on Ground 7, concern the failure to consider the adequacy of the applicable system, as opposed to the existence of a system, and relies in respect of the response and the submission before the coroner, he rejected a breach of systemic obligation as, 'There was a system in place', which was said to be wrong and reliance was placed again on *Osman* (Supra). There was, 'Putting into place effective criminal law provisions to deter the commission of offences against a person'. It was considered the Coroners promise to deal with this further, and the enquiry was unsatisfactory.

88. Equally, the statement of Grounds and facts for Mrs Lee on Ground 9, concerned the failure to consider the adequacy of the system applicable to Melissa and relies only on the response, not the decision, and all arguments, not the arguments before the Coroner. Further, considered there was misunderstanding of Mrs Lee's case, in which it was flawed by making reference to the National Guidance which was not relevant to the care regime which concerned this case and Melissa's case and also made reference to the adequacy of the system to allow Melissa to return to hospital exceptionally.

89. The submissions for the Coroner on Ground 7 indicated that the Coroner had clearly and carefully considered where the breach of the general duty, by reference to Mrs Lee, indeed there was no specific criticism made of that, in respect of the care planning or discharge planning.

90. Equally, in respect of Ground 9, it was asserted in response by the Coroner, that the case had not been abandoned, and the Decision as to deficiency in the system and policies governing this case was, in fact, simply made reference to two National Guidelines which were in place for Melissa, and in respect of none of that were there any failings on the part of the Trust.

91. In his oral submissions, in respect of both Grounds 7 and 9 for Mrs Lee it was said that one could not rule out, in respect of Article 2, systemic duties, which 'may' give rise to a breach and it was not enough simply to have a system in pace without more. There was no authority relied upon in addition to those set out above, and it turned out to be a very short argument indeed.

92. The response in the oral arguments of the Coroner was to reaffirm that under Grounds 7 and 9 there was in fact, 'no evidence' that was open to argument in respect of the system of the Trust. In respect of Ground 9 it had been pointed out (as had been apparent from the analytical and detailed opening of this case), that there was, in fact, a care plan in place, and that all the activity for us had followed best guidance. There was no basis or any argument in respect of the system or its functionality.

93. Both the skeleton argument and the oral submission of the Trust entirely supported this case of the Coroner.

94. I have not found anything, neither Ground 7 nor Ground 9, that would give rise to any argument on behalf of Mrs Lee. In addition to those systemic arguments, of which

Ground 8 has been a core, now dealt with above in this case, which was derived in any case in substance, and certainly not to induce me to quash this decision.

Conclusions

95. I have come to some clear conclusions in this case which largely follow on from my earlier judgment, which I found to be an arguable case in respect to the approach of the Coroner in respect of the extension of the law following *Rabone v Pennine Care NHS Trust*, sought to be argued by Mrs Lee. I am equally satisfied that at this substantive hearing, the approach taken to Ground 2 is not to quash the Decision, for which I do not find a case to have been made out by Mrs Lee, but to remit the matter to the Coroner to allow her to reconsider, not just the assumption of responsibility, which may have been limited to control, but also the question or the factors of vulnerability and risk to Melissa. The Coroner, necessarily, will have more detail and a full appreciation of those facts than I can, for the purpose of a judicial review claim. In my judgement, she will be in a much better position to consider all these factors individually and cumulatively, to form a better platform on which to consider in this particular case, and Melissa's particular facts of both vulnerability, risk and assumption of responsibility which gave rise to her death, there should arguably be a further extension of *Rabone v Pennine Care NHS Trust* along the basis suggested by Lord Dyson, in particular paragraph 34.

96. Equally, I am quite satisfied that on any analysis of the facts before the Coroner there can be no basis to argue that this is an 'exceptional case' in accordance with the most recent authority of Fernandes v Portugal decided subsequent to the Decision and so Ground 8 cannot possibly be arguable.

97. Insofar as the balance of the peripheral operational duties in Grounds 4 to 6, I have found no substance or any argument in any of the grounds put forward by Mrs Lee.

98. Equally in respect of the peripheral systemic duties on Grounds 7 to 9 I have found no arguable case from Mrs Lee.

99. It therefore follows that none of the remaining grounds of Mrs Lee have proved successful such that they will give rise to a quashing of the Decision.

Order

100. Counsel for the Coroner has kindly offered to draw up an order on the basis of this judgment which, if not agreed, I can resolve promptly and will include the question of costs.

End of Judgment

Transcript from a recording by Ubiqus
291-299 Borough High Street, London SE1 1JG
Tel: 020 7269 0370
legal@ubiqus.com

This transcript has been approved by the judge.