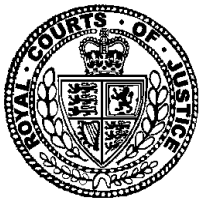

Neutral Citation Number: [2024] EWHC 744 (Admin)

Case No: AC-2022-LON-002522

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 28/03/2024

Before :

THE HONOURABLE MRS JUSTICE COLLINS RICE

- -

Between :

The King (on the application of)

MR GARY PARKIN — **Claimant**

- and -

HIS MAJESTY'S ASSISTANT CORONER FOR INNER LONDON (EAST) — **Defendant**

(1) LONDON BOROUGH OF HAVERING
(2) NORTH EAST LONDON NHS FOUNDATION TRUST — **Interested Parties**

- -
- -

Mr Taimour Lay (instructed by Bhatia Best Solicitors) for the **Claimant**
Ms Bridget Dolan KC (instructed by Waltham Forest Council Legal Department) for the **Defendant**
Ms Julia Kendrick (instructed by DAC Beachcroft) for the **First Interested Party**
Mr Benjamin Bradley (instructed by Kennedys Law LLP) for the **Second Interested Party**

Hearing date: 19th March 2024

- -

Approved Judgment

This judgment was handed down remotely at 2pm on 28 March 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

.....

THE HONOURABLE MRS JUSTICE COLLINS RICE

Mrs Justice Collins Rice :

Introduction

1. Mrs Rosslyn Wolff was found dead in her home on 11th January 2022, following a domestic fire. She was 74 years old. The primary medical cause of her death was given as smoke inhalation; secondary medical factors were ischaemic heart disease and diabetic ketoacidosis.

2. A London Fire Brigade investigation team report of 9th June 2022 concluded the most probable cause of the fire was unsafe use or disposal of smoking materials. The fire was mostly limited to the sofa where Mrs Wolff's body was found. Cigarette butts and empty cigarette packets were nearby.

3. An inquest into her death was formally opened on 27th January 2022 by HM Assistant Coroner for Inner London (East).

4. At a Pre-Inquest Review hearing on 16th August 2022, Mrs Wolff's son, Mr Gary Parkin, made a number of submissions to the Assistant Coroner. Among them, he expressed concerns that his mother had been let down, in the weeks and months leading up to her death, by one or more of the public authorities who had had recent dealings with her, and that their potential responsibility for the tragedy should be fully investigated. He asked for the inquest to be broadened out to consider not just the causes of his mother's death, but all the circumstances of it, on the ground that Article 2 of the European Convention on Human Rights was engaged. By a ruling dated 1st September 2022, the Assistant Coroner declined to do so.

5. Mr Parkin has permission for a judicial review of that decision. The Assistant Coroner is the named defendant but, as is usual, formally takes a neutral position (Leading Counsel instructed by the Assistant Coroner attended the hearing of the review to assist the Court). The public authorities Mr Parkin wishes to have the inquest investigate – the local healthcare trust and local authority social services department – attended as interested parties.

6. The inquest stands adjourned meanwhile.

Factual background

7. The following factual background is uncontroversial and appears from the documents before the Assistant Coroner.

8. Mrs Wolff had lived on her own. Her domestic arrangements were irregular: she was a hoarder, and her home was filled with detritus and debris. It was not maintained or kept hygienic. The London Fire Brigade reported after the fatal incident that it had had multiple referrals for home safety visits over the years. It had tried unsuccessfully to make a visit on 8 or 9 occasions – Mrs Wolff had either refused the visit or had been unable to be contacted. But a visit had successfully been made on 27th November 2019 and smoke alarms fitted. It was the smoke alarms that alerted neighbours and the fire brigade to the fatal fire.

9. Mrs Wolff had come to the attention of her local authority social services in mid-2019, after Mr Parkin raised concerns about her self-neglect and poor living conditions, and about her abusive treatment at the hands of another family member (who in turn was known to the local mental health service). An initial multidisciplinary assessment was carried out: no mental health concerns were identified in relation to Mrs Wolff herself, but '*after much persuasion*', she agreed to a care package to support personal hygiene and medication compliance.

10. As well as being a smoker, she was diabetic. On two occasions in September 2021 she had been detained briefly under the Mental Health Act 1983, but her symptoms of confusion were then diagnosed as not proceeding from mental ill health but from hyperglycaemia – the result of not maintaining her diabetes medication regime. (It was noted during her hospital stay she '*did not comply with nursing interventions, refused her COVID PCR test and would not allow doctors to conduct any physical examinations*'.) The post-mortem report also indicated that her diabetic condition at the time may have played a part in the fire and her possible inability to get up from the sofa and do anything about it.

11. On 7th October 2021, a multi-agency risk assessment conference of health and social care professionals reviewed Mrs Wolff's circumstances. They noted no concerns over her mental health or capacity, but noted '*ongoing risk presented by her unwise decision making*'. These included that she had been '*adamant in her expression of not wishing to engage in conversations about her environmental circumstances*' – which included concerns about the state of her home: poorly looked-after dogs, dog mess, risk of electrical injury, risk of leaking water. It was noted there had been some progress with engagement with her allocated social worker, but this had had to be '*very gentle*' – '*Rosslyn does not respond well to multiple offers of help or professional involvement*'. An action plan was agreed, to include continued offers of follow-up and engagement with her social worker, and a fire assessment was to be made of her home by the fire brigade.

12. The social worker visited on 13th October 2021. Mrs Wolff refused to open her door, and declined offers of help with getting her house cleaned or garden cleared. The social worker visited again on 15th October, to much the same effect. On further visits on 26th October, 1st November and 15th November, the social worker was unable to elicit any reply at all.

13. Further multidisciplinary review meetings were held on 22nd October and 1st December 2021. The social worker attempted a visit on 9th December 2021, and observed the state of the house through the windows, but received no reply or admission. A last professionals' meeting was held on 10th December 2021. The record of it includes this:

> NELFT [North East London NHS Foundation Trust] and ASC SW [Adult Social Care Social Worker] provided feedback from attempted visit the previous day. They advised of the fire risk due to the state of the property. The professionals explored options available including whether there were any legal grounds upon which the police or ASC could enter Rosslyn's home without her consent and during her absence. Actions were allocated to various members of the MDT [Multi Disciplinary

> Team] by Director ASC, including a repeat attempt to visit and assess mental capacity.
>
> The NELFT named professional for safeguarding adults suggested an experienced practitioner from the OAMHT [Older Adults Mental Health Team] support ASC with their next visit, so that a MHA [Mental Health Act] assessment could be carried out at the same time if Rosslyn was home.
>
> There were no formal minutes recorded in the EPR (electronic patient record) or uploaded into CareDoc regarding this meeting, therefore not all actions are clear.

14. It is not completely clear from the evidence so far whether the fire assessment commissioned at the 7th October meeting did take place but was not recorded as such, or did not take place. In its own subsequent investigation into the circumstances of Mrs Wolff's death, NELFT recorded the following:

> Care and service delivery problems
>
> Risk assessment
>
> - The risk assessment completed for Rosslyn on the 11/10/2021 identified that Rosslyn's overall risk was low despite significant ongoing risks relating to self-neglect, hoarding, non-engagement and domestic abuse
>
> - …
>
> - There was no fire assessment completed despite it being known Rosslyn was a hoarder and a smoker which does not align with the recommendations in NELFT safeguarding Standard Operating Procedure (SOP)
>
> Assessment
>
> - …
>
> - At the professionals meeting on the 07/10/2021, it was documented that an action for a fire assessment to be triggered for the London Fire Brigade to review Rosslyn's home was to be completed. There is no evidence that this action was completed within the EPR however information provided by the ICD confirms that this action was assigned to ASC and was actioned, but records do not reflect this.
>
> - At the professionals meeting held on the 10/12/2021 there was a plan for a second joint unannounced home visit to be carried out by reference for Rosslyn to be offered a home visit with the adult social worker and an experienced OAMHT practitioner who could undertake a MHA [Mental Health Act] assessment. There is no evidence that the home

> visit was completed, and no sound explanation was provided to the IO [Investigating Officer] during staff interviews for delays in arranging this visit.
>
> - …
>
> Root Cause/s
>
> The fundamental root cause of Rosslyn's death was a small, localised fire at her property. The fire risk was evident to all professionals working together across adult social services, the police and health. Rosslyn was known to be a hoarder and although it is acknowledged that ASC completed fire risk assessments, these were not shared with NELFT which meant that this risk was not thoroughly reflected in assessments within the EPR. Rosslyn was often referred to as vulnerable however attempts to safeguard her were unsuccessful due to a lack of engagement.
>
> …
>
> Conclusion
>
> …
>
> The risk assessments recorded in the EPR lacked depth to reflect the severity of the risk that Rosslyn was experiencing and there was no evidence that fire risk assessments were completed by professionals despite them expressing concern that Rosslyn could die because of her home environment.
>
> NELFT professionals worked hard and undertook thorough risk assessment with other agencies to understand what could be done to safeguard Rosslyn however due to a lack of documentation it was not clear who took responsibility for consulting with the fire service and therefore it may be that NELFT should have completed this action. ...

The legal framework

15. Article 2 of the ECHR protects the right to life. As explained by the Divisional Court in *R (Morahan) v West London Assistant Coroner [2021] QB 1205 (DC)* at [30], it imposes three distinct duties on a state: (a) a negative duty to refrain from taking life without justification, (b) a positive duty to protect life and (c) an investigative duty to inquire into and explain the circumstances of a death.

16. The presenting question raised by Mr Parkin's challenge is whether the Assistant Coroner had an Art.2 investigative duty in relation to Mrs Wolff's death. Domestic effect is given to the investigative duty by section 5 of the Coroners and Justice Act 2009, which provides as follows:

> **5. Matters to be ascertained**
>
> (1) The purpose of an investigation under this Part into a person's death is to ascertain—
>
> (a) who the deceased was;
>
> (b) how, when and where the deceased came by his or her death;
>
> (c) the particulars (if any) required by the 1953 Act to be registered concerning the death.
>
> (2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998 (c. 42)), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.
>
> (3) …

17. It is section 5(2) that Mr Parkin seeks to invoke. The test is one of necessity. The test will be passed if it is arguable that a public authority is in breach of a substantive duty under Art.2 ECHR. So behind the presenting question about the Assistant Coroner's investigative duty, there is a question about whether there is an arguable breach of, in this case, the positive duty of the relevant authorities to protect life.

18. 'Arguable' in this context means credible, more than fanciful. It is a low bar. Whether the case for a breach is credible, rather than fanciful, has to be considered by reference to the available evidence. (*R (AP) v HM Coroner for Worcestershire [2011] EWHC 1453* at [60]; *Morahan* at [75].) And of course whether there is an arguable breach depends on whether a relevant duty existed in the first place.

19. The positive duty to protect life has two aspects: (a) a framework, or systems, duty to put in place legislative and administrative frameworks to protect the right to life, and (b) an operational duty to take positive measures to protect an individual whose life is at risk in certain circumstances. It is the second of these (only) which is in issue in the present case.

20. The leading authority on the positive operational duty is the decision of the Supreme Court in *Rabone v Pennine Care NHS Trust [2012] 2 AC 72*, a case about an NHS voluntary psychiatric inpatient, known to be suicidal, who died by suicide on a visit home.

21. It is clear from *Rabone* in the first place that '*the existence of a 'real and immediate risk' to life is a necessary but not sufficient condition for the existence of the duty*' ([21]). This threshold test of 'real and immediate risk to life' was further considered by the Supreme Court in *R (Maguire) v Blackpool and Fylde Senior Coroner [2023] 3 WLR 103* at [241]: '*A real risk is one that is objectively verified and an immediate risk is one that is present and continuing*'. The risk must be a risk specifically of death, not just of harm, even of serious harm ([38]).

22. Next, to return to *Rabone*, the following principles (or, as Lord Dyson JSC put it, relevant factors or 'indicia') appear.

23. First, '*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)*' ([22]). The exercise of control is the paradigm example of the operational duty arising. Where a state body has assumed complete control, for example by detaining, imprisoning or conscripting an individual, it is '*subject to positive obligations to protect the lives of those in their care*' (*Mitchell v Glasgow City Council [2009] AC 874* at [66]).

24. Second, '*the vulnerability of the victim is a relevant consideration*' ([23]):

> In circumstances of sufficient vulnerability, the ECtHR has been prepared to find a breach of the 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 to its knowledge is at risk of abuse…(*ibid*).

The vulnerability in question must be connected to the foreseeable risk identified at the threshold stage (*Morahan*, [129]).

25. Third, the *nature* of the risk to life is relevant:

> [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 is it an exceptional risk? Thus in *Stoyanovi v Bulgaria* (Application No.42980/04) (unreported) given 9 November 2010, the ECt HR rejected an application made by the family of a soldier who died during a parachute exercise. At paras 59-61, the court drew a distinction between risks which a soldier must expect as an incident of his ordinary military duties and "'dangerous' situations of specific threat to life which arise exceptionally from risks posed by violent, unlawful acts of others or man-made or natural hazards". An operational obligation would only arise in the latter situation.

26. Lord Dyson JSC also observed that some or all of these factors may be relevant to considering whether the operational duty has arisen, but that this was an evolving jurisprudence, and the category of cases giving rise to the duty should not be regarded as closed.

27. As to the *scope* of the positive obligation, '*this will depend upon whether the authorities should have foreseen a real and immediate risk and what more they could be expected to do*' (*Rabone*, [101]). The duty '*must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities, including in respect of the operational choices which must be made in terms of priorities and resources*' (*ibid*, [96], citing *Osman v UK 29 EHRR 245* at [116]).

28. So when considering whether the duty has been breached,

> The standard demanded for the performance of the operational duty is one of reasonableness. This brings in 'consideration of the circumstances of the case, the ease or difficulty of taking precautions and the resources available. … In this case, it also required a consideration of respect for the personal autonomy of [the deceased]. (*Rabone*, [43]).

The Assistant Coroner's decision

29. The Assistant Coroner's brief ruling concludes as follows:

> [18] … Citizens who are free to do so, are free to live their lives without restraint or interference from the state. By the same token, the state is not subject to additional scrutiny if it has not incurred obligations or taken on itself the particular responsibilities which the curtailment of rights and freedoms, or the failure reasonably to intervene, involves.
>
> [19] Public bodies such as healthcare foundation trusts and municipal corporations are embodiments of the state for the purposes of recognising the possible application of Article 2 obligations. But the bare fact that such institutions may have interacted with the citizen does not thereby determine whether Article 2 is engaged.
>
> [20] The relevant situations must be identified. That entails a consideration of whether there is evidence to suggest that Rosslyn was at the time of her death in state detention or in real and immediate risk to her life. Neither of those situations is shown on the evidence. The evidence is that she lived in her own home. She had declined additional intervention by the state. Her mental capacity had been assessed and she was deemed to have capacity. She was therefore entitled to exercise choice. She had the right to take unwise or inappropriate decisions. The state does not take on added duties or responsibilities in such circumstances.
>
> [21] The evidence does not support the application to engage Article 2. Any shortcomings or failings which might be established can be investigated within a Jamieson inquiry and scrutinised if necessary within a Report to Prevent Future Death, or even a finding of neglect if the evidence proved as much. I therefore reject the application to engage Article 2.

Mr Parkin's challenge

30. Mr Parkin has permission for judicial review on the single ground that it is arguable that, having considered the State's operational duty under Article 2, the Coroner should have directed that an Article 2 inquest take place into Mrs Wolff's death.

31. In the approved summary of her reasons for granting permission, Farbey J recorded this:

> It is arguable that the Assistant Coroner misdirected himself in law and/or reached conclusions that were not open to him in relation to the operational duty. The question whether Rosslyn was at the time of her death in real and immediate risk to her life was a question about present and continuing as opposed to imminent risk: the distance in time between leaving hospital and the outset of the fire is arguably not determinative. Although living in her own home, the risk of fire was or ought at least arguably to have been obvious to the hospital or other state agencies when they were considering the risks of her returning home and before she left hospital, which arguably gives rise to assumption of responsibility. Even if she had capacity on the day she left hospital, Rosslyn was assessed as a risky case and was arguably vulnerable as a person with fluctuating mental health, a known hoarder and a smoker. In short, it is arguable that the four criteria for the operational duty were met (*R (Morahan) v West London Assistant Coroner [2021] QB 1205 para 44*). This is the only arguable ground.

32. That is permission given in classical public law terms. It was uncontroversial among the parties, however, that on an Art.2 challenge to a coroner of the present nature, the High Court is bound to apply heightened scrutiny to a point equivalent to a full merits review. The Divisional Court in *R (Skelton) v West Sussex Senior Coroner [2021] QB 525* put it this way:

> [91] … Although the standard of review is correctly categorised conceptually in terms of heightened scrutiny, in practical terms the result must be the same as that which would be reached by the court reaching its own conclusion. The court must ask itself whether (on our facts) article 2 required a section 5(2) investigation, and can only do so by an assessment of whether the arguability threshold was reached. This is the same question that the Coroner posed to herself. Thus, in this particular context, a rationality challenge collapses into a merits review because the answer to the question as posed is the same whether the route to it is through *Wednesbury* or an examination of the merits. If the court considers that the arguability threshold is not reached, the Coroner's decision would stand irrespective of whether public law errors were committed on the road to that conclusion. If, on the other hand, the court considers that the arguability threshold is reached, the court will necessarily conclude that the Coroner's view was irrational.

> [92] That is not to say, however, that the conclusion and the reasons given by the Coroner are entirely irrelevant. The authorities referred to above show that the court in reaching its own conclusions will take account of those reasons …. The weight to be accorded to them by the court in reaching its own decision will vary according to their nature and cogency, as well as the degree to which they can properly be regarded as informed by specialist knowledge and experience in relation to the particular factual questions in issue.
>
> [93] In conclusion, therefore, the nature of the exercise being conducted by the Coroner means that her options were limited to one, as are ours. In practice, we must ask ourselves whether her conclusion was right or wrong. …

33. That means my task on this challenge is to consider whether it is indeed arguable (credible, not fanciful) on the facts of this case that one or more of the state agencies involved with Mrs Wolff breached an Art.2 operational duty towards her. If it is, the section 5(2) necessity test is passed. Whether there is an arguable breach in turn depends on identifying whether such a duty arose in the first place and, if so, its scope.

Analysis

34. Mrs Wolff died in a harrowing set of circumstances. Mr Parkin's quest to get to the bottom of all the circumstances, including whether her death was avoidable, and whether others might be to blame, is entirely understandable. The causes of her death, and whether there are any wider lessons to be learned from it, will be for others to determine in due course. My task on the present challenge is a narrow and specific one: to consider, subject to the guidance of the decided authorities, whether the Assistant Coroner was right or wrong to conclude that the section 5(2) necessity test was not passed on the evidence before him.

35. Approaching my task by reflecting on the Assistant Coroner's ruling in the first place, I am bound to agree with the public law critique made by Mr Lay, Counsel for Mr Parkin, to the effect that it takes quite a broad brush to stating the test to be applied and its application to the facts. Rather unusually perhaps, the Assistant Coroner provided a witness statement for the purposes of these proceedings, in which he further explained his analysis. Mr Lay made some objection to my consideration of this statement, and to the weight I am properly able to give to it. But I have read it carefully for such perspective as it provides from the Assistant Coroner's particular professional viewpoint and the assistance it is capable of giving to my task. I am not undertaking a standard public law review of his reasoning. I am considering whether he was right or wrong in his conclusion. His afterthoughts are interesting in relation to the latter, whether or not relevant to the former.

36. The Assistant Coroner particularly emphasises the following *factual* considerations in his witness statement:

> [25] Mrs Wolff was deemed to have mental capacity to make decisions about admission to hospital and treatment and, although she made unwise decisions, she was thought not to be

> suffering with mental illness. She was, however, considered to be at risk of accidental self-harm at her home due to poor smoking habits (Witness Statement Dr Kamel [56-62]). There were also safeguarding issues raised in respect of physical abuse/assault involving her and [a family member] with whom she was said to have a volatile relationship.
>
> …
>
> [29] In the circumstances it appeared to me that all three public bodies involved [ie the hospitals, the local authority and the fire brigade] had offered care and assistance to Mrs Wolff and she, as someone deemed to have mental capacity, was entitled to either accept or refuse:
>
> a. Psychiatric assessment had revealed no lawful basis for keeping her from her home by detaining her in hospital;
>
> b. Mrs Wolff had declined the repeated offers of assistance from a social worker;
>
> c. Mrs Wolff had, eventually, accepted the assistance of the London Fire Brigade to fit smoke alarms in her home in [2019].

37. The Assistant Coroner emphasises the following *legal* considerations:

> [30] Throughout the relevant period she was not under the custody or control of the state. Indeed, she was a capable person in the community and it appears that no public body had any power to have control over her in any way.
>
> [31] The relevant authorities on Art.2 had been specifically drawn to my attention in the written submissions of LBH (London Borough of Havering) and NELFT, and I make it clear in §10 of my ruling that I had them in mind when coming to my decision.
>
> [32] Having considered the relevant decided cases set out in the parties' submissions (and in particular the decisions in [*Rabone* and *Morahan*] there was, in my view, no legitimate ground to suggest even an arguable breach of any substantive article 2 obligation owed to Mrs Wolff.

38. I keep these thoughts in mind in the following analysis. But of course, in the end, I must make up my own mind about them.

(a) Real and immediate risk to life

39. The evidence before the Assistant Coroner (and me) was that Mrs Wolff lived a more than usually risky sort of lifestyle. She smoked: a risk to her health and her safety. She was not always careful with her diabetes medication: a risky lack of self-care, producing episodes of debility and confusion, themselves a real risk to her health and safety. The state of her house, its poor maintenance and hygiene, were a risk to her health and safety. Her hoarding of what others would call rubbish was a fire risk – another risk to health and safety. And she was highly resistant to 'official' help and support with eliminating or managing any of these risks, which only compounded the danger. She was certainly, up until the time of her death, a present and continuing risk to herself in many ways. And she lived on her own.

40. That is not to say there were no mitigations in place. She had at least consented to smoke alarms being fitted (albeit some years previously). She had a continuing (if on her side somewhat distant or erratic) relationship with social services. She was well aware of what the authorities thought of her lifestyle and why. She knew she had sources of advice and help available. And she had, on occasion, had cause to be glad of the health service picking her up after her diabetic episodes.

41. Her mental health, cognition and capacity to make decisions about her own wellbeing had been professionally checked on half a dozen occasions at intervals over the previous year and a half, and consistently confirmed to be in working order. Hoarding can be symptomatic of underlying mental or emotional problems, but it appears from the evidence that underlying psychiatric illness or disability had been investigated and ruled out. (Hoarding is itself apparently a recognised mental disorder, with a spectrum of severity, but I was not taken to any evidence that it had been addressed as such.)

42. But none of this *necessarily* goes to the precise risk which is relevant to my task: a real (objectively verified) and immediate (present and continuing) risk *to life* – that is, *of death*. There is little trace of an assessed risk of death as such in the materials before me. The only specific reference I was shown was in NELFT's *ex post facto* review, which refers to professionals having expressed concern '*that Rosslyn could die because of her home environment*'; I was not shown contemporary evidence of professional concerns having been expressed in quite those terms. So it is not clear in terms from the evidence that the authorities at the time consciously viewed Mrs Wolff as being at risk *of death*.

43. The question, however, is whether they should have done, and in particular in relation to the risk that eventuated: the risk of dying in a house fire. As to that, Mr Lay draws my attention to the *cumulative* effect of six pieces of evidence:

    a) the evidence in the witness statement of Dr Kamel, the consultant psychiatrist who saw Mrs Wolff in the autumn of 2021 when she was referred with symptoms of confusion. Dr Kamel records that Mrs Wolff was assessed on discharge as being at risk due to self-neglect, and that the risk of '*accidental harm to self due to poor smoking habits indoors*' was high;

    b) the decision the professionals took on 1st October 2021 that a fire risk assessment of Mrs Wolff's home should be undertaken by the fire brigade;

c) The social worker's report to the multidisciplinary meeting on 10th December 2021 of '*the fire risk due to the state of the property*';

d) The lack of clear evidence that a fire risk assessment was duly undertaken at the time;

e) the indications in NELFT's subsequent review that '*the fire risk was evident to all professionals working together*'; and

f) that indication in the same review of concerns having been expressed that '*Rosslyn could die because of her home environment*'.

44. Reflecting on all the evidence available at present, it seems to me clear enough that the authorities ought to have been aware, and were aware, of a real and present risk *of a house fire* at Mrs Wolff's home. Although never precisely articulated in these terms, that risk was in reality a multifactorial one presented by a combination of known factors. The relevant factors were: (a) Mrs Wolff's poor smoking habits indoors – there was contemporary evidence of a regular smoking habit *and* carelessness with smoking materials, including leaving cigarette butts lying around; (b) Mrs Wolff's hoarding – filling the house with combustible materials and potentially obstructing fire exits; (c) Mrs Wolff's recent history of carelessness with her diabetes medication, producing spells of confusion and debility, relevant to her *ability* to deal with any fire risk or actual fire, and (d) her known *unwillingness* to be advised or take action on some or all of these issues. The authorities were sufficiently concerned latterly about the risk of a house fire to agree that the brigade should be asked to (attempt to) conduct another home safety visit.

45. It also appears to me from the evidence that the real and present risk of a house fire *was*, in all these circumstances, a real and present risk to Mrs Wolff's life, objectively evidenced. The fact that the risk did not eventuate in exactly the way the authorities might have expected – and especially as there is no evidence so far that her hoarding in the end played any part in it – is not in my view inconsistent with that. Even if the second factor identified above turned out not to be operative in the loss of life that actually occurred, the evidence is that the first and fourth were, and the third may have been.

46. But in any event, I am satisfied that the risk of death, not just the risk of harm, was *inherent* in the risk of a house fire at Mrs Wolff's home, and the risk of a house fire was real, continuing and present – and recognised as such. There was nothing in her home environment, apart from the smoke alarms, recognisable as capable of limiting the effects of any house fire there to one of non-fatal harm alone. And the smoke alarms proved insufficient by themselves in the event.

47. The 'real and immediate risk of death' threshold test is a high one. But in my judgment, it is passed here. So I disagree with the Assistant Coroner about that. However, passing that threshold test is a necessary, but not a sufficient, step for establishing an Art.2 duty. I turn next to the guidance of ***Rabone*** on the question of whether that duty arises on the present facts.

(b) The Article 2 operational duty

48. It is not every risk to life – even in the case of a social services client or an NHS patient – which gives rise to an operational duty on the state to prevent it. And it is clear that Mrs Wolff's circumstances were not the 'paradigm' for the operational duty arising. She was not a person over whom the state exercised '*control*'. She was not in the custody of the state. She was a private citizen who died in her own home living the independent life she had chosen for herself, free from state interference.

49. But that is not the end of the matter. Being subject to state control is only the paradigm case. The authorities do not say that being under state control is *necessary* for the duty to arise. The deceased in ***Rabone*** was not herself under formal state control at the time of her suicide. She too was in her own home, and she had been a voluntary, not a detained, psychiatric inpatient. But her circumstances were rather special. Lord Dyson JSC said this, about them (at [34]):

> She had been admitted to hospital because she was a real suicide risk. By reason of her mental state, she was extremely vulnerable. The trust assumed responsibility for her. She was under its control. 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 [Mental Health Act] to prevent her from doing so. In fact, however, the judge found that, if the trust had refused to allow her to leave, she would not have insisted on leaving. This demonstrates the control that the trust was exercising over [the deceased]. In reality, the difference between her position and that of a hypothetical detained psychiatric patient, who (apart from the fact of being detained) was in circumstances similar to those of [the deceased], would have been one of form, not substance.

So that was a case in which the court could be satisfied, on the evidence, that the state did exercise control over the patient because (a) they had legal power to detain her in hospital if necessary and (b) in practice they need not have had formal recourse to those powers because she would have followed their advice in any event.

50. Mrs Wolff's circumstances were very different from these. The state had no verifiable power to control or detain her. It had been professionally established, including relatively recently, that there were no Mental Health Act powers to do so. The professional team had reflected on whether it had any powers to enter her premises without her consent and/or in her absence, and seem (perhaps unsurprisingly) to have drawn a blank there. There was no other apparent basis in law for exercising control over her. And she was *not* willing to remain in hospital, or to co-operate with the authorities to any clear extent, or even to follow their advice. She was wholly resistant to what might be called *de facto* state control.

51. Mr Lay put it to me that the state had nevertheless assumed responsibility for Mrs Wolff's welfare and safety, even if not by the exercise of control. The multidisciplinary team had addressed itself to the relevant risk to life and put together a plan for her welfare and safety in that very context. I have reflected on the implications of that state of affairs. But I am not in the end persuaded by the proposition that it amounts to an assumption of responsibility, for the following reasons.

52. First, I was shown no authority on Art.2 which comes close to supporting the establishment of the positive operational duty on the basis of the existence of a welfare plan, even one relevant to managing a risk to life. No doubt the public authorities in this case owed professional duties to Mrs Wolff. But it is not every case in which health and social care professionals draw up care plans for individuals, or patients spend time in hospital, that the Art.2 duty arises. Helping and supporting an individual, even in the discharge of legal duties, does not routinely give rise to the operational duty. Something more is needed. And it cannot just be a real and present risk to life because that is necessary *but not sufficient* for the duty to arise.

53. Second, this particular care plan was addressed to the *mitigation* of the risks Mrs Wolff's lifestyle posed to her, including to her life, not their elimination. That is another reason why her case is different from ***Rabone***. And it was a plan that necessarily had to negotiate Mrs Wolff's resistance to state interference. It was a relatively modest and realistic plan, based on experience. Visits (including from social services and the fire brigade) were to be *attempted*. Mr Lay argues it should not be assumed the plan would have been ineffective to preserve life (Mrs Wolff had ultimately consented to the smoke alarms in 2019). But the evidence does not support a conclusion that it is more probable than not that this plan would have preserved Mrs Wolff's life, or was conceived at the time as capable of doing so. So it is difficult in these circumstances to recognise in it an assumption of state responsibility for her health and safety, or indeed her life.

54. Then Mr Lay reminded me of the statement in ***Rabone*** that, '*in circumstances of sufficient vulnerability, the ECtHR has been prepared to find a breach of the operational duty even where there has been no assumption of control by the state*'. And I have reflected further on that. But this point has two important limitations.

55. First, the example given in ***Rabone*** of 'sufficient vulnerability' is that of a local authority failing to *exercise its powers* to protect a child at known risk of abuse. In those circumstances, the state's power includes assuming control over the child (taking it into care). The child ultimately lacks autonomy in the matter; the necessary welfare decisions can ultimately be taken on its behalf. That was not Mrs Wolff's situation.

56. Second, and relatedly, the qualifier of '*sufficient*' vulnerability indicates that not every degree of vulnerability will be relevant. Mrs Wolff was from time to time referred to as vulnerable, and it is plain enough from the evidence that to a degree she was. She was not identified as vulnerable on account of her mental health. She did not, Mr Lay accepts, lack competence to make her own decisions about her lifestyle. She *was* identified as vulnerable as a victim of past domestic abuse (although that is not obviously '*connected to*' the fire risk to her life). But her hoarding habit perhaps signals a degree of relevant vulnerability. And, importantly, her irregularity with her diabetes medication had certainly rendered her significantly vulnerable from time to time.

57. That raises the question of whether the *degree* of vulnerability which would support the inference of a state duty in respect of the risk to her life is made out on the evidence in this case. I have to bear in mind that Mrs Wolff was an adult of *confirmed* competence and psychiatrically sound mind, even though attempting further mental health assessment appears in her plan. She ran many risks with her health and safety. Aside from smoking, hers were socially atypical risk-taking behaviours. But she was fully informed as to the risks she was running, and targeted help to eliminate or mitigate them had been made available to her over a sustained period of time.

58. I also bear in mind that Baroness Hale JSC in *Rabone* (at [100]-[101]) underlined that there is no general duty of the state to protect an individual from *deliberate* self-harm, even where the authorities know or ought to know that it entails a real and immediate risk of death. The authorities are unanimous that the autonomy of properly autonomous individuals must in the end be respected. In my view, the situation is *a fortiori* in relation to consciously adopted behaviours which pose a *risk* of self-harm, and to self-neglect. If (and it is an important 'if') these are properly autonomous choices, and there is no state power to intervene and overbear them, then they fall to be respected. Indeed, they may positively demand to be respected, as an aspect of an individual's autonomy protected by Article 8 of the Convention.

59. There is no evidence that Mrs Wolff's choices were other than properly autonomous. She was plainly a risk to herself. There is evidence that she was to a degree vulnerable. But the fact that her behaviours, by general social norms, could be labelled unusual, unattractive, unwise or unreasonable – or even disorderly – is neither itself inconsistent with their being autonomous, nor indicative that her autonomy was materially compromised. I was shown no decided authority in which properly autonomous risk to the self was nevertheless made subject to implied transfer to the state by way of the Art.2 duty. On the contrary, the authorities point to the two being mutually exclusive.

60. I turn then to the question of the nature of the risk here, and whether it was an ordinary risk of the kind that individuals should reasonably be expected to take, or whether it was an exceptional risk, such as to give rise to the Art.2 duty. I remind myself of the guidance that I am looking for 'dangerous' situations of specific threat to life which arise exceptionally from risks posed by violent, unlawful acts of others or man-made or natural hazards – here, the danger of a house fire.

61. The risk of a house fire is of course one we all run. In some circumstances, the risk is heightened, whether because of the nature (or state) of the house, or because of factors particular to an individual – for example age or disability. I can see that the risk of a fatal house fire was heightened in Mrs Wolff's case. But it is hard to recognise as out of the ordinary. The risk of carelessness with a cigarette and flammable furniture is ordinary. The risk of carelessness with diabetes medication is ordinary. Even in combination, it is hard to recognise this as other than an ordinary risk of the kind that individuals, rather than the state, are reasonably expected to deal with. And even if an (autonomous) individual is known not to be accustomed to acting reasonably in such matters, again I was shown no authority to suggest the imposition of an Art.2 duty on the state as a result.

62. I remind myself finally of what is said in the most recent authorities – *Maguire*, *Morahan* and the recent decision of the Court of Appeal in *Dove v HM Assistant Coroner for Teesside and Hartlepool [2023] EWCA Civ 289* – about the possibilities of the Art.2 duty arising even where the state has not 'assumed responsibility' in any statable way for an individual nor for a hazard not of its own making. But I cannot see that any of them supports the case Mr Lay makes in the present case: that the extent of ongoing involvement by state agencies, the appreciation of the specific risk of fire, and the degree of Mrs Wolff's vulnerability, impose the Art.2 operational duty, when the relevant risk factors were at all times under the properly autonomous control of an individual, in her own home, who was positively resistant to attempted state intervention and upon whose consent to intervention the authorities were ultimately dependent.

63. In all these circumstances, I am unpersuaded that the Art.2 operational duty arose on the facts of this case. I accept Mr Lay's submissions that the three 'indicia' in ***Rabone*** (over and above the threshold test) are not, individually or together, to be regarded as an exhaustive and comprehensive statement of the test for the duty arising. But the facts of the present case are a long way indeed from those of ***Rabone*** or any of the other authorities I was shown, and from any of the indicia. I do not consider that I have the authority of the decided caselaw for the extension of the duty to the facts of this case. Mr Lay accepts that would not be squarely precedented. On the contrary, in my judgment the caselaw provides firm guidance that to do so would be to cross the proper boundary between personal liberty and state intervention.

64. The evidence is that Mrs Wolff was a fiercely independent lady of sound mind who did not want well-intentioned health and social work professionals judging or interfering with a lifestyle she was well aware was a risky one. The tragic circumstances of her death, and the natural dismay that this was, on at least some level, an avoidable disaster befalling an unfortunate and perhaps disadvantaged individual, do not mean it was one which it was the duty of the state to prevent.

(c) Arguable breach

65. If I am right that no Art.2 duty arose on the facts of this case, that is the end of the matter. The section 5(2) necessity test is not passed, and the Assistant Coroner's decision must stand.

66. But if I am wrong, the next step would be to consider the scope of any such duty, and whether it is arguable that the duty had been breached. So I turn to that, in the alternative. I remind myself of the guidance of the authorities that the scope of the operational duty, and the standard of what state authorities are expected to do faced with a real and present risk to life, is one of reasonableness. I have to look at what they could, in all the circumstances, have been expected to do, bearing in mind (a) that operational choices have to be made in terms of priorities and resources, (b) the ease or difficulty of taking precautions and (c) the respect due by the authorities to the personal autonomy of the deceased.

67. Here, Mr Lay does not dispute the reasonableness of the multi-agency plan that was in fact prepared. But he objects that, in the month that elapsed between the formulation of the plan on 10th December 2021 and Mrs Wolff's death on 11th January 2022, it was not reasonably implemented.

68. If I take Mr Lay's case at its highest, nothing happened in those weeks. Having said that, on any basis it is not a *very* long period of time, and some reasonable allowance has to be made for the Christmas and New Year period, well-known to be one of particular pressure on the health and social care services' resources and priorities. I have already alluded to the fact that the plan was on any basis a modest one. The authorities had a clear evidence base for expecting it to be low-impact. The trajectory of their interaction with Mrs Wolff on the particular issues going to fire risk had been one of dogged persistence over months and years in the face of very limited progress. They had no power to force the pace or to bypass Mrs Wolff's resistance. They were reliant on patiently trying to build a relationship with her and returning again and again to offers of help and support notwithstanding persistent disengagement and/or rebuff. Such progress as had been made in achieving change was non-linear and unpredictable:

occasional engagement did not obviously lead to a building pattern, and was sometimes followed by periods of enhanced disengagement. Even when she was in the total environment of a hospital stay, she was strongly resistant to co-operation.

69. The authorities' strategy was therefore necessarily long term, patient and opportunistic, based on nudging Mrs Wolff towards wiser choices, and making the most of such chances as she permitted for intervention. The evidence discloses no reason to expect that the execution of the December plan needed to be prioritised at a pace demanding renewed attempts at engagement over the particular few weeks in question – or that there was reason to believe it would have achieved anything relevant if it had. The fact that Mrs Wolff had given the fire brigade access more than two years previously to fit smoke alarms has to be seen in the context of her more recent sustained pattern of firm and settled reluctance to engage with any sort of state help. Her smoking habits were evidently deeply ingrained and her sofa was flammable. She had not long previously been given the clearest of reasons, and offers of support, for taking her diabetes medication. It is hard indeed in all these circumstances to see, on an evidenced basis, what more the authorities could have been expected to do that they did not do – and what basis they could have had for expecting it to have made a material difference if they had implemented their plan any more quickly.

70. In these circumstances, and applying the standard of reasonableness, even if the authorities were under an Art.2 duty in the first place, its scope was a limited one – and necessarily included respect for Mrs Wolff's autonomy – and I do not consider it arguable that they breached it on the facts of this case. The threshold of arguability is a low one, but to be credible it must have some evidence base. Here, the case that the authorities could and should have done more in the final month leading up to Mrs Wolff's death does not at present advance beyond the speculative to the credible.

Conclusions

71. For the reasons given, my conclusion is that the Art.2 positive operational duty did not arise on the facts of this case. But even if it did, I do not consider it arguable that any statable duty was breached. That means that the necessity test for holding an inquest under section 5(2) is not satisfied and the Assistant Coroner's decision must stand.

72. As the Assistant Coroner explained, that does not necessarily mean that the matters about which Mr Parkin is concerned cannot be addressed by other means. Issues of potential shortcomings or failings leading up to Mrs Wolff's death can be investigated in the context of a traditional inquest and scrutinised if appropriate in a prevention of future deaths report. That can include identification of neglect, if any. So this is not necessarily the end of the road for pursuing his concerns. But as I have explained, my task is the narrow one of reviewing whether the Assistant Coroner was entitled to conclude that this was not an Art.2 case. I have set out my review and explained why, applying the caselaw guidance which binds me, I come to the same conclusion as the Assistant Coroner.

73. In these circumstances, I must dismiss Mr Parkin's claim for judicial review. He has pursued this particular route as far as it can be made to go. He can be assured Mr Lay and his legal team put the case for an Art.2 inquest at its highest, and I am grateful to him, and to Counsel for the other parties, for their considerable assistance to me in my

task of applying the law to the available facts of this sad matter. The conclusion I have reached is the one which, I am clear, I am required by law to reach.