CASE NOTES

Article 2 ECHR – right to life - inquest determination – mental health services

R (Patton) v HM Assistant Coroner for Carmarthenshire and Pembrokeshire 1377 (Admin)

Administrative Court

Facts and Decision

Aged 16, Kianna had been found hanging at a time when she was under the care of Specialist Child and Adolescent Mental Health Services with a history of self-harm. She was living with a friend, whose mother had let her use cannabis. This caused her mother (the claimant) significant anxiety, given Kianna's mental health issues. Her mother had sought assistance in relation to Kianna from social workers and police officers before her death. She believes there were serious failings in the way they responded, and in the care S-CAMHS provided to Kianna. Following the Coroner's ruling that Article 2 ECHR was not engaged, a disclosed Health Board's report identified several issues with care delivery and the way that Kianna's risk had been assessed, in particular noting that safeguarding screening had not been completed once it was identified that she was no longer living at home.

Mrs Justice Hill referred to the decision in *R (Morahan) v West London Assistant Coroner* [2021] EWHC 1603 and the 'distillation' of relevant principles by Popplewell LJ at [122] namely:

> (1) There is a duty on the state to investigate every death. This is part of its framework duty under Article 2 ECHR by way of a positive substantive obligation. This duty may be fulfilled simply by identifying the cause of death. It may require further investigation and some explanation from state entities, such as information and/or records from a GP or a hospital.
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> (2) In certain circumstances there is also a distinct and additional enhanced duty of investigation that requires the scope of the investigation to have the minimum features summarised by Lord Phillips in [*R (Smith) v Oxfordshire Assistant Deputy Coroner* [2010] UKSC 29, at paragraph 64. In this country, the enhanced investigative duty is usually, but not always, to be fulfilled by a Middleton request
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> (3) The enhanced investigative duty is procedural and parasitic on a substantive duty. It cannot exist where there is no substantive duty.
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> (4) The circumstances in which an enhanced investigative duty, as a procedural parasitic duty, arises: (a) whenever there is an arguable breach of the state's substantive Article 2 duties, whether the negative, systemic or

positive operational duties; and (b) in certain categories of circumstances, automatically.

Mrs Patton relied on [4] (a), namely, that there was an arguable breach of the state's systemic duties and referred to the statutory context concerning 'looked after children'. That context was in particular the duties under s.76 (1) (c) of the Social Services and Well-being (Wales) Act 2014. This was to provide accommodation where the person who had been caring for the child was prevented from providing suitable accommodation or care. In addition, under s.76 (3) to provide accommodation for any child within its area who has reached the age of 16 and whose well-being the authority considers is likely to be seriously prejudiced if it does not provide the child with accommodation. Mrs Justice Hill referred to a number of relevant cases concerning the systemic duty in the healthcare duty: essentially being a duty to have appropriate administrative and regulatory systems in place, which should in turn provide an effective system of rules, procedures, guidance and control.

Mrs Patton argued that the Local Authority had information about Kianna staying at the friend's house without her mother's consent and that she was being allowed to take some cannabis there. Accordingly, it was arguable that the Local Authority had a statutory duty to accommodate Kianna. Had such accommodation been provided, Kianna would have become a 'looked after' child, and the Local Authority would have had concurrent parental responsibility, with duties to safeguard and promote her wellbeing and to implement a care and support plan following a medical assessment. Mrs Patton's core submission was, therefore, that it was arguable that there was a failure to take the steps the Council ought to have taken, which would have meant that it exercised a significant degree of control over a most vulnerable child who had proven to be a suicide risk. That relationship, it was argued, is sufficient to engage the general duty under [Article 2] and indicates state responsibility in Kianna's death. Mrs Patton went on to outline a number of alleged specific breaches of the systemic duty.

The Council relied on the decision in *R (Parkinson) v HM Senior Coroner for Kent* [2018] EWHC 1501, and, in particular, argued that Kianna's case was not one that involved a breach of the general duty. There clearly were systems in place. In a wide sense, there was a regulatory framework created and imposed by the state to which the Council was subjected. In a narrower sense, the Council's Children Services teams had engaged with Kianna and her family pursuant to their statutory obligations, in the context of the active involvement of other agencies, including S-CAMHS, the Police, and Kianna's school, college and GP.

The specific breaches relied on by Ms Patton were denied, but in any event it was submitted that they were, at their highest, examples of individual and not systemic failings, and were thus outwith Article 2 ECHR. The Health Board relied on the fact that Kianna was neither detained under the Mental Health Act 1983, nor a voluntary in-patient at the time of her death. It also submitted that Article 2 had not previously been held to be engaged in an inquest on the basis of an arguable breach of the general duty, where the person was living in the community and able to function to a reasonable level, that is to continue with studies and work, as Kianna was.

Mrs Justice Hill began her substantive judgment by holding at [87] that it was appropriate and not premature to challenge the Coroner's ruling that Article 2 was not engaged by way

of judicial review even where it was expressly stated to be provisional and that it would be kept under review:

> If the ruling is wrong in law, it is more sensible for it to be corrected now, so that the inquest can proceed on a proper basis, in accordance with general public law principles.

She went on at [103-105] to hold that issues around assumption of responsibility, vulnerability and matters of that nature were more pertinent to the triggering or existence of the operational duty than the general duty. At [106] she referred to the formulation of the general duty in *Morahan* and held that it did:

> … not require that the element of the state in question has assumed responsibility or exercised control over an individual, or that they are particularly vulnerable: rather the focus is on ensuring that the state, through a range of entities, has in place an adequate legislative and administrative framework for the protection of life. In the healthcare context, the general duty was described in Morahan at [30(2) (a]) as simply requiring "effective administrative and regulatory systems". Again, no reference was made to assumptions of responsibility or particular vulnerability.

Mrs Justice Hill then held at [115-119] that the Coroner's approach to whether there had been a failure to provide accommodation had been flawed as he had failed to conduct his own assessment as to whether Kianna should have considered to be a 'looked after' child. Further, his decision that the general duty was not engaged was flawed, as a breach of the duty to provide accommodation was not an essential element of the existence of the general duty. Further, she held at [125-129] that the Coroner had failed to give sufficient reasons for finding that there was no obligation on the Local Authority to provide accommodation, either by virtue of a lack of accommodation or because her well-being was likely to be seriously prejudiced:

> Here, the Coroner simply re-stated the statutory test … saying, "no obligation to provide accommodation arose because … Kianna's well-being was likely to be seriously prejudiced". Thus, he gave no reasons for his decision that no obligation arose. The main, if not the only, point advanced by Ms Patton was that accommodation where Kianna was permitted to smoke cannabis, despite her mental health issues, would self-evidently seriously prejudice her well-being. Accordingly, this was the "principal important controversial issue" and it was therefore incumbent on the Coroner to explain, even in brief terms, how he had resolved it.

Accordingly, the Coroner's ruling was quashed, and the decision was remitted for a fresh ruling as to whether Article 2 ECHR was engaged.

Commentary

Mrs Justice Hill's quashing of a ruling that the Article 2 general (or systemic) duty had not been potentially engaged by the death of Kianna Patton is significant in terms of imposing strict duties on health authorities for protecting individuals from self-harm. This case is also useful in illustrating the importance of interested parties (and coroners) being clear about

the precise basis for an Article 2 inquest. In particular in distinguishing between the principles underpinning the imposition of an operational duty from those of a systemic duty, as well as between instances of potential breaches from the factual matrix supporting a possible engagement of the systemic duty.

Dominic Ruck Keene, Barrister, 1 Crown Office Row