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Inquests and Article 2 of the ECHR: A practical guide following the case of Maguire

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On 21 June 2023, the Supreme Court handed down its judgment in *R* (on the application of Maguire) (Appellant) v His Majesty's Senior Coroner for Blackpool & Fylde and another (Respondents) [2023] UKSC 20.

The key question their Lordships considered in this case was whether an inquest into the death of a woman (Jackie), who had Down's syndrome, learning disabilities and who was deprived of her liberty at a residential care home at the time of her death, should have "engaged" Article 2 procedural obligations. They decided that it should not have.

In returning this judgment, the Supreme Court maintained that an enhanced Article 2 inquest is not required when someone who was living in the community dies, even if they were vulnerable, subject to a Deprivation of Liberty Safeguards (DoLS) authorisation and there were some delays in them receiving care and treatment. As Article 2 is a complex area, in this article we have provided a brief overview of what an Article 2 inquest is and how it differs practically from a non-Article 2 inquest, before discussing the facts of the case, the implications of the Supreme Court's decision and some practical tips. Article 2 is also covered in our Mock Inquest Training Sessions.

Brief recap – inquests and enhanced Article 2 inquests

An inquest is a factual investigation into a person's death, led by a coroner. By law, the coroner needs to ascertain the answers to four factual questions – who is the person that has died, when, where and how did they die. "How" someone came by their death is usually interpreted narrowly as meaning "by what means" did the person die. However, in 2004, the case of R (Middleton) v West Somerset Coroner held that in order to comply with the state's obligations under Article 2 ECHR (the right to life), in certain circumstances there will be an enhanced duty of investigation and the inquest must ascertain not only "by what means" a person died but also "in what circumstances". When a coroner is required to ascertain "in what circumstances" a person died, this is commonly known as an "Article 2 inquest".

How is an Article 2 inquest different?

Practically speaking, there is sometimes not much difference between a non-Article 2 inquest and an Article 2 inquest. Article 2 ECHR imposes a general duty on the state to set up a judicial system that allows for an independent, practical and effective investigation into the facts of any death. Therefore, all inquests must be sufficiently thorough.

However, as above, a key difference is that an Article 2 inquest must ascertain "in what circumstances" a person died, meaning that the inquest will often conclude with an expanded narrative conclusion (rather than a short form conclusion such as "natural causes" or "suicide"). Further, in Article 2 inquests, judgmental language such as "missed opportunities" or "inadequate failures" can be used in the conclusion – in non-Article 2 inquests, any such language ought to be avoided. Article 2 inquests tend to have a higher level of scrutiny and will likely look at wider procedural and policy issues. More witnesses tend to be called to give evidence, meaning the inquest itself lasts longer. It is more likely (though not mandatory) that a jury will be called. If an inquest is deemed to engage Article 2, then the bereaved family is entitled to legal aid, meaning they are more likely to be legally represented at the inquest hearing. There are therefore some critical differences between an Article 2 and a non-Article 2 inquest.

When is an enhanced Article 2 inquest required?

There are some circumstances where an enhanced Article 2 inquest will automatically be required. In particular, where a person has died whilst detained in prison or in hospital under the Mental Health Act, and the death is from suicide or at the hand of another person, then an enhanced Article 2 inquest will be required. An enhanced Article 2 inquest will also be required if it appears that there is an arguable breach of the “substantive duties” that are placed on the state by Article 2. There are two substantive duties as follows:

- an obligation to have appropriate systems in place to protect life generally (“the systems duty”) and
- an obligation to take steps to protect a person when it is known that there is a real and immediate risk to their life (“the operational duty”).

Therefore, an Article 2 inquest will need to be held if it is considered that either a state body (such as an NHS Trust or local authority) involved in the care of the deceased did not have appropriate systems in place to protect the lives of those under their care, or knew about a real and immediate risk to the person’s life, and failed to take steps to protect that person from that risk.

The facts of the Maguire case

Jacqueline Maguire (Jackie) was a 52 year old woman with Down’s Syndrome, learning disabilities and cyclothymic personality disorder. She lacked capacity in various respects. She lived in a residential care home, managed by United Response. For her own safety and care, Jackie was not permitted to leave the care home without supervision, and she was therefore subject to a DoLS standard authorisation.

In February 2017, Jackie’s health began to deteriorate. On 21 February, she experienced breathing difficulties. A care support worker called NHS 111 and reported Jackie had coffee ground type vomit, pains in her stomach and had had a fit. 111 advised a home visit from the GP. The GP did not visit, but called later in the day and prescribed medication.

That evening, Jackie's condition deteriorated and the emergency services were called. The paramedics wanted to take Jackie to hospital, but she refused to go and the paramedics deemed forceful intervention unnecessary at that time. Advice was sought from an out of hours GP, who said that while they should try to convince Jackie to go to hospital it would be inappropriate to manhandle her; she should be monitored during the night and her GP should be called in the morning.

By the next morning, Jackie was severely unwell. An ambulance was called, and she was eventually taken to the hospital, where she received treatment for presumed sepsis. Tragically, Jackie passed away later that day. A post-mortem recorded a stomach ulcer which had perforated Jackie’s stomach and resulted in peritonitis.

Subsequent investigations and inquest

Following Jackie’s death, a series of investigatory steps were taken, including an internal review by United Response and an investigation by CQC, which did not find any lapse in the standard of care provided by the care home.

An inquest was opened and the coroner initially decided that Article 2 was engaged on the grounds that there had been an arguable breach of the substantive obligations by the healthcare organisations involved with Jackie. The coroner identified a number of areas that needed to be explored at the inquest. The inquest hearing itself took place over several days, with a jury. Numerous witnesses were called. The coroner heard evidence about the systems and training in place within the care home and within the various other healthcare services engaged in Jackie’s care. An expert in emergency medicine was called to give his opinion.

At the close of evidence, the coroner decided that there was no failure by either the care home or the ambulance service to have appropriate systems in place. Therefore, the coroner decided that there was no breach of the “systems duty”, that Article 2 was not in fact engaged and accordingly he directed the jury to return a short conclusion, determining solely “by what means” Jackie came by her death. The jury concluded that Jackie had died of natural causes.

The judicial review proceedings – arguments before the Supreme Court

Jackie’s mother, Mrs Maguire, issued judicial review proceedings against the coroner, arguing that Jackie’s inquest should have been held to engage Article 2. The case went all the way up to the Supreme Court. In short, the Supreme Court agreed with the coroner and the

lower courts that Jackie's inquest did not engage Article 2.

In reaching its conclusion, the Supreme Court considered whether there was an arguable breach of the systems duty on the part of the care home, or any other healthcare providers, so as to trigger an Article 2 inquest. The Court decided that there had been no such breach. There clearly were systems in place at the care home, which could be operated in a way that would ensure that a proper standard of care was provided to residents, even though there may have been individual lapses in this case. This did not mean there was a deficiency in the system itself. The Court noted that CQC had carried out an inspection of the care home shortly after Jackie's death, and had been satisfied with the systems in place and the standard of care provided. The Court highlighted that a regulator's view that suitable systems are in place will usually be "powerful evidence" that the systems duty has not been breached. The coroner had also examined the training and understanding of paramedics in relation to dealing with individuals lacking capacity and identified no problem with this. Criticisms could be made of aspects of the conduct of the GPs, but these related to lapses in individual performance, rather than a failure with regards to systems.

The Supreme Court also considered whether there had been an arguable breach of the operational duty on the part of the care home, or any other healthcare providers, so as to trigger an Article 2 inquest (i.e., the Court considered whether there had been a real and immediate risk to Jackie's life that the healthcare providers knew about and failed to take steps to protect her from.) Jackie's family contended that Article 2 was engaged because of an arguable breach of the operational duty, which arose due to Jackie being deprived of her liberty, vulnerable and because the state had assumed responsibility for her care. The Court however decided that when a person is placed in a care home, a nursing home or a hospital, that does not mean that the state is assumed to have responsibility for all aspects of their physical health to the extent that if the person dies from some medical condition that was not diagnosed and treated in time, an Article 2 inquest is triggered. In other words, even if a person is vulnerable and under a DoLS authorisation in the community, and there is some delay in them receiving care and treatment before they die, that does not mean an enhanced Article 2 inquest will be triggered.

The Supreme Court also held that none of the healthcare professionals involved were on notice that Jackie's life was in danger, so there was no "real and immediate risk" to life that they were aware of, thus meaning the operational duty was not breached.

Lastly, the Supreme Court held that the case did not fall within the "very exceptional circumstances" where Article 2 may be found to be engaged in respect of the acts and omissions of healthcare providers, namely:

- where an individual patient's life is knowingly put in danger by denial of access to life-saving emergency treatment, and
- where a systemic or structural dysfunction in hospital services results in a patient being deprived of access to life-saving emergency treatment and the authorities knew about or ought to have known about that risk and failed to undertake the necessary measures to prevent that risk from materialising.

Accordingly, the appeal was dismissed, and the Supreme Court held the coroner was right to rule that Article 2 was not engaged in Jackie's inquest.

Practical tips from this case

- This case confirms that an inquest will not automatically engage Article 2 when a vulnerable person who was living in the community subject to DoLS dies, even if there was some delay in them receiving treatment.
- When considering whether an organisation has breached its "systems duty", any recent inspections by a regulator (such as CQC) will be highly relevant to the coroner's decision as to whether there should be an Article 2 style inquest.
- Evidence of good and effective staff training is also likely to be relevant to the coroner's decision as to whether the organisation involved has breached its systems duty.
- Even when there have unfortunately been individual failings in implementing or complying with systems, such as organisational policies or procedures, that does not necessarily mean that there has been a breach of the systems duty itself, and that Article 2 is therefore engaged.

If you have any questions about this case, Article 2 or inquests in general, please contact us.

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