'Elementary, my dear Watson': The duty to investigate in article 2 inquests

Matthew Waszak discusses a recent case on the scope of coroners' investigative duties in an inquest into a death in police custody

Matthew Waszak is a barrister practising from Temple Garden Chambers, where he completed his pupillage. He has a broad experience of practice areas including personal injury, inquests, public law, employment, and costs. He regularly appears in applications, case management conferences, small claims, and fast-track trials.
@TG_Chambers
tgchambers.com

In *R (on the application of Maureen Speck) v HM Coroner for District of York* [2016] EWHC 6 (Admin), handed down on 12 January 2016, Mr Justice Holroyde, with whom Sir Brian Leveson agreed, held that a coroner's investigative duty under section 5 of the Coroners and Justice Act (CJA) 2009 in an article 2 inquest is limited to matters which caused, or at least arguably appeared to have caused or contributed to, the deceased's death.

Miss Toni Speck died while in police custody at Fulford Road Police Station in York on 2 June 2011. She suffered from a history of psychiatric illness and had, on a number of previous occasions, been admitted into a psychiatric hospital in York.

That afternoon, concerned members of the public had alerted patrolling police officers after Miss Speck was seen behaving erratically in the street. She was detained by one of the officers under section 136(1) of the Mental Health Act (MHA) 1983 and taken to the police station. Importantly, York Hospital did not then have a specialist medical facility for those detained under the MHA 1983 (although a specialist facility, known as a health-based place of safety, was established subsequently). Miss Speck later died in a police cell, with two pathologists returning conflicting opinions about her cause of death.

Scope of inquest

An inquest was opened into Miss Speck's death by HM Coroner for the District of York.

The deceased's family wished the inquest to consider a number of issues relating to the initial decision to take her into a police station rather than a hospital.

It was argued on behalf of the family that the jury should consider how it had come about that, in 2011, York Hospital did not have a specialist medical facility and to consider what had become of funding which was said to have been designated for, but not in fact spent on, the provision of that facility.

After hearing submissions on the point, the coroner excluded the issue from the scope of the inquest. Those acting for the family challenged that decision, by way of judicial review, on the basis that it was disproportionate, perverse, and procedurally improper, and because it had been improperly predetermined (decided before the inquest's evidence had been heard).

Central to the cause of death

An inquest is a statutory fact-finding exercise into a person's death, which is required to return answers to four questions: who died; when they died; where they died; and how they died.

It was common ground that the inquest here was an article 2 inquest, where the state was under an enhanced procedural obligation to initiate an effective and independent investigation into Miss Speck's death. Some inquests, such as this one where a person dies in state custody, are clearly article 2 inquests. In other inquests, the enhanced procedural duty under article 2 is engaged where the deceased dies in circumstances in which it appears that one of the substantive obligations under article 2 of the European Convention on Human Rights may have been breached, and agents of the state were or may have been implicated.

Following the House of Lords decision in *R (Middleton) v West Somerset Coroner* [2004] UKHL 10, the question of 'how' the deceased died in an article 2 inquest should be interpreted as meaning 'not simply "by what means" but "by what means and in what circumstances"' they died. The effect of the decision in *Middleton* was expressly incorporated into section 5 of the CJA 2009.

A coroner has a wide discretion as to the scope of investigations that he decides to conduct as >>

>> part of an inquest. However, under section 5, neither the coroner conducting an investigation nor the jury may express any opinion on any matter other than the four questions which the inquest is required to return answers to. In the context of an article 2 inquest, the scope of that consideration extends to the circumstances in which the deceased died. These statutory provisions therefore prescribe that there are certain matters which it is the purpose of an inquest to investigate, but also that there are certain other matters on which the coroner and jury must not express an opinion.

The scope of a coroner's investigative duty in an article 2 inquest was considered by the Court of Appeal in *R (on the application of Allen) v HM Coroner for Inner North London* [2009] EWCA Civ 623, which held that the coroner was 'required to do no more than focus the investigation and the inquisition on the central issue or issues in the case' and 'was only obliged to investigate those issues which were, or at least appeared arguably to be, central to the cause of death'.

The point was considered again by the Court of Appeal in *R (Lewis) v Mid and North Shropshire Coroner* [2009] EWCA Civ 1403 after the judgment in *Middleton*, this time in relation to the extent of a coroner's duty to leave matters to the jury. Lord Justice Sedley held that he was 'unable to find a reason of principle for making it a duty [to elicit the jury's views on matters which were only possibly causative of death]'. Lord Justice Etherton agreed with him.

Both *Allen* and *Lewis* were cited and followed by the Divisional Court in *R (on the application of LePage) v HM Assistant Deputy Coroner for Inner South London* [2012] EWHC 1485 (Admin), after the CJA 2009 had been brought into force. There, the coroner's failure to call a forensic pathologist who could have given some evidence as to the cause of death which went beyond the evidence of other pathologists who had been called was challenged by judicial review. The Chief Coroner, His Honour Judge Thornton QC, with whom Mr Justice Owen agreed, held that the evidence 'did not… pass the threshold of positive assistance to the inquiry. The possibility… raised was no more than speculative, and speculation is no firm foundation for calling evidence.' The court proceeded to reject the submission that in an article 2 inquest there is 'a separate free-standing duty on the part of the coroner to inquire into all possible issues'.

Similarly, in *R (on the application of Wiggins) v HM Assistant Coroner for Northamptonshire* [2015] EWHC 2841 (Admin), the Divisional Court affirmed that a coroner in an article 2 inquest is only obliged to investigate the issues which are, or at least appear arguably to be, central to the cause of death.

Coroner's discretion

A rolled-up hearing was heard by the Divisional Court on 3 November 2015, six days before the inquest was due to start. Permission to apply for judicial review was refused.

Mr Justice Holroyde (with whom Sir Brian Leveson agreed) held (at paragraph 28): 'It is in my judgment clear… that a coroner conducting an article 2 inquest has a discretion to investigate matters which may possibly have contributed to the death, but his only duty is to investigate those matters which caused, or at least arguably appear to have caused or contributed to, the death.'

It follows that where a coroner conducting an article 2 inquest decides that an issue cannot be said to have arguably contributed to the deceased's death, then there is no discretion, or indeed power, for the inquest to investigate that issue.

The court proceeded to hold that the coroner was correct to decline to investigate the issue of there not being a health-based place of safety at the time of Miss Speck's death on the basis that (i) there was no arguable case that anybody was under a duty to provide such a facility at the time of death, and consequently (ii) it could not be argued that the deceased's death was caused or contributed to by a breach of such a duty. The court held, further, that even if the issue had fallen within the coroner's discretion to consider such matters, there was no basis on which it could be said that the decision to decline to investigate the issue was unlawful.

Commentary

The Divisional Court's decision in *Speck* provides an important, authoritative restatement of the law on the scope of a coroner's investigative duty in an article 2 inquest, which will be welcomed by many inquest practitioners.

The specifics of this case demonstrate that although a coroner's discretion as to the scope of an inquest is wide, matters of local policy, resources, and funding (in relation, here, to the provision of a health-based facility for those detained under the MHA 1983) do not fall for coroners to investigate where such matters have no causative connection to the deceased's death.

The effect of the decision in *Speck* should not, however, be overstated. Interested persons may seek to use the coroner's obligation to consider whether a report to prevent future deaths needs to be made under regulation 28 of the Coroners (Investigations) Regulations 2013 as an avenue through which the types of policy issues which arose in the case may justifiably be considered. **SJ**

The coroner 'was only obliged to investigate those issues which were... central to the cause of death'