Neutral Citation Number: [2009] EWCA Civ 1403

Case No: C1/2009/0867

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE
ADMINISTRATIVE COURT
SIR THAYNE FORBES SITTING AS A JUDGE OF THE HIGH COURT
[2009] EWHC 661 (Admin)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 21/12/2009

Before :

LORD JUSTICE SEDLEY
LORD JUSTICE RIMER
and
LORD JUSTICE ETHERTON

- -

Between :

REGINA on the application of KEITH LEWIS	**Appellant**
- and -	
HM CORONER for the MID AND NORTH DIVISION of the COUNTY OF SHROPSHIRE	**Respondent**
- and -	
THE SECRETARY OF STATE FOR THE HOME DEPARTMENT	Interested Party

- -
- -

Mr Tim Owen QC and Mr Paul Bowen (instructed by Bhatt Murphy) for the **Appellant**
Mr Jonathan Hough (instructed by the Legal Department for Shropshire County Council) for the **Respondent**
Ms Jenni Richards and Mr Colin Thomann (instructed by Treasury Solicitor) for the **Interested Party**

Hearing dates: 9 & 10 December 2009

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Approved Judgment

Lord Justice Sedley :

1. Taking one year with another, well over a hundred prisoners commit suicide every year in the prisons of England and Wales. Among them are many psychiatrically disturbed individuals, some of them under or barely at the age of majority, who ought arguably not to be in prison at all but for whom no other disposal is available. With prisons and young offender institutions overcrowded and under-resourced, and despite repeated efforts by those responsible for the supervision and administration of the prison service, the duty of care owed to such prisoners is too often neglected.

2. What happened to Karl Lewis exemplifies this. On 8 October 2004, just before his 18th birthday, he was sentenced to 6 years' detention for a series of robberies and sent to YOI Stoke Heath. He had not previously had a custodial sentence, but a good deal was known about his background. He had been a looked-after child supported by a local authority, with a history of self-harming which somehow was omitted from the pre-sentence report. The result was that YOI Stoke Heath had no information about this longstanding vulnerability. Because, however, he threatened at trial to harm himself again, a warning went from the Crown Court probation staff to the YOI and a "Self-Harm at Risk" form was opened. Karl was then screened by a mental health nurse, to whom he disclosed his history of self-harming, but on review by a GP the next day he was discharged and the form closed. Instead he was assessed as presenting a high risk to any cellmate and so was placed in a single cell. Thereafter, notwithstanding his becoming involved in fights, being bullied and threatening to harm himself, Karl was not referred to a psychiatrist.

3. In circumstances which are detailed in the judgment of Sir Thayne Forbes [2009] EWHC 661 Admin, §62-4, Karl on the night of 21-22 January 2005 was in a distressed state and again threatening - in fact attempting - self-harm. During the evening a further self-harm form was opened on him, requiring three checks during the night, but he was left in his cell and not moved to the health care wing. The officer on night patrol from 10 p.m., covering three landings on B wing, was OSG (Officer Support Grade) Knowles. Between the checks made by Knowles at 0040 hours and 0120 hours, Karl hanged himself from a light fitting.

4. It was Knowles who at 0120 looked through the observation window and saw Karl hanging. Knowles had a key but elected not to enter the cell. He had received no suicide prevention or first aid training. Nor was he equipped with a tool by then in common use in prisons, known as a fishknife, which is designed to enable suicides to be cut down promptly without further injuring them, and which is now compulsory equipment. Instead Knowles used his radio; but instead of using Code Red (signifying spillage of blood) or Code Brown (signifying the possibility of a loss of life) he used Code Blue, which signifies breathing problems. The result was that assistance took longer than it should have done to arrive. By the time Karl was cut down he was dead.

5. There was and still is no way of knowing whether appropriate and swifter intervention by OSG Knowles would have saved Karl's life: it might have done, but it cannot be said that it probably would have done. What can without the slightest doubt be said is that the failures of training, equipment and procedure described in the preceding paragraph ought not to have occurred.

The inquest

6. The inquest on Karl's death took place over 8 days in October 2006. The coroner identified for the participants 6 substantive issues to be addressed in the proceedings:

> "(i) The information chain as to what information was passed along the process from Social Services to the Probation Service to the Court and to Stoke Heath Young Offender Institution.
>
> (ii) The care which Mr Lewis received from his reception through to the night he died.
>
> (iii) Cell sharing risk assessment both to others and himself.
>
> (iv) The F2052SH procedure.
>
> (v) The action taken after Mr Lewis was found hanging in his cell.
>
> (vi) The Mental Health issues and how Mr Lewis was managed.

7. In due course he gave the jury a written questionnaire containing the following questions:

> 1. Do you agree that on Saturday 22nd January 2005 at about 1.20a.m. Karl Lewis was found in his cell on 'B' Wing of HMYOI at Stoke Heath?
>
> 2. Do you consider that:
>
> a) Karl Lewis hanged himself intending to take his life or
>
> b) Hanged himself or
>
> c) Was found hanging
>
> 3. Was there a failure in the information Chain and, if so, did this cause or contribute to Karl Lewis's death? If so, please identify the same.
>
> 4. Should Social Services have kept in touch with Karl Lewis following his imprisonment and, if so, did this failure cause or contribute to Karl Lewis's death? If so please specify.
>
> 5. Should HMYOI at Stoke Heath have obtained further background information about Karl's history of self-harm at any time after his imprisonment on the 8th October 2004 and if so did this failure cause or contribute to Karl Lewis's death? If so please specify
>
> 6. Should the Probation Service have obtained further background information about Karl Lewis's history of self-harm and passed it to HMYOI Stoke Heath in response to the request from HMYOI Stoke Heath on the 11th October, 29th November and 24th December following the opening of each

F2052SH and if so, did this cause or contribute to Karl Lewis's death? If so, please specify.

7. Should HMYOI Stoke Heath have referred Karl for a full Mental Health Assessment to an appropriately qualified Professional at any time prior to the 21st January 2005 and if so did this failure cause or contribute to Karl Lewis's death? If so please specify.

8. Should Karl Lewis have been transferred to the Health Care Centre on the 21st January 2005 and if so did this failure cause or contribute to Karl Lewis's death?

9. If not, should Karl have had more support on the wing than he was provided with? In particular should there have been more frequent observations? If so, did this failure cause or contribute Karl Lewis's death.

You must only answer the above questions if you believe that (either on its own or with others) that act or omission caused or contributed to Karl Lewis's death.

8. The jury answered question 2 in sense (a) and all the other questions (save 9, which became inapplicable) in the affirmative, giving considered reasons for their answers. The completed questionnaire was incorporated by the coroner in the verdict by completing the entry under *Conclusion of the jury as to the death*:

> "Karl Lewis hanged himself intending to take his life, see questionnaire."

9. What was omitted from the questionnaire was issue (v) of the coroner's agenda for the inquest: the action taken after Mr Lewis was found hanging in his cell. In consequence the jury was given no opportunity to express a view on it. It is the contention of Tim Owen QC, who appears with Paul Bowen for Karl's father, the claimant in judicial review proceedings against the coroner, that this was an unlawful omission. The submission, argued on wider grounds than have been advanced before us, failed before the Administrative Court. It is no disrespect to the detailed and impressive judgment of Sir Thayne Forbes if I turn directly to the issues as they have been canvassed on this appeal, which comes before us by permission of Elias LJ.

Findings about prison deaths

10. Article 2 of the European Convention on Human Rights, which by virtue of s.6 of the Human Rights Act 1998 binds all public authorities in the United Kingdom, lays down that everyone's right to life shall be protected by law. It is now well established that this requires the state not only to abstain from taking life (except as the article itself allows) but to investigate impartially and diligently any death occurring at or in its hands.

11. The purpose of such an investigation, where the death has occurred in the custody of the state, includes ensuring that the administrative framework set up to protect the right to life is properly implemented and that any shortcomings in the operation of the system are ascertained: *Őneryildiz v Turkey* (2005) 41 EHRR 20, §91, §94. The

objective is not only to identify officials or authorities who bear responsibility for what has happened but to learn lessons for the future. Hence the inquest in England and Wales "has a vital part to play in the correction of mistakes and the search for improvements": *R (Sacker) v West Yorkshire Coroner* [2004] UKHL 11, §11, per Lord Hope.

12. The European Court of Human Rights is not prescriptive about how these purposes are to be achieved. Member states are expected to establish their own ways of implementing article 2. The means adopted for England and Wales is set out in the Coroners Act 1988 and the rules made or adopted under it. By s.8(3) the coroner is required to summon a jury to inquire into any death in a prison. By s.11 the coroner is to adduce evidence "as to the facts of the death", and the jury are to "give their verdict and certify it by an inquisition" setting out, among other things, "how … the deceased came by his death". Rule 36 of the Coroners Rules 1984 limits the proceedings to the statutory matters and forbids the expression of an opinion on any other matters.

13. In *R (Middleton) v West Somerset Coroner* [2004] UKHL 10, however, the House of Lords found it necessary to bring the law governing inquests in England and Wales into conformity with article 2 by reading "how" in the Act and Rules as meaning "by what means *and in what circumstances* the deceased came by his death". At the core of this appeal is the proper apportionment of this enlarged inquiry between coroner and jury.

14. Rule 43 as it presently stands provides:

> **Prevention of similar fatalities**
>
> A coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held may announce at the inquest that he is reporting the matter in writing to the person or authority who may have power to take such action and he may report the matter accordingly.

15. The coroner in the present case made an extensive report under rule 43, addressed to the Prisons Minister at the Home Office, the governor of YOI Stoke Heath and the heads of the local social and probation services. But the report was silent about the matters described in paragraph 4 of this judgment.

16. Although, for reasons I will be coming to, this omission is not pursued as a ground of legal challenge, it is relevant to what follows in this judgment that it was in my respectful view a breach of rule 43. The want of equipment, training and effective procedure which the undisputed evidence revealed was so eloquent of action that needed to be taken to prevent similar fatalities that the coroner cannot have believed otherwise (and, to be fair to him, has nowhere suggested that he did believe otherwise). In such a situation the permissive power - "may report" – could only be properly exercised in one way if the purposes of article 2 were to be respected, and that was by making a report on the issue. Jonathan Hough, counsel for the coroner, has responsibly (and not without tactical wisdom) offered no resistance to this conclusion.

17. Before I turn to the issue in the present appeal, two other aspects of the domestic article 2 process need to be noted.

18. For the Secretary of State for Justice, appearing by Jenni Richards as an interested party in his capacity as head of the National Offender Management Service, we are reminded that the police investigation of any prison death will consider any possible criminal implications as well as assemble evidence for the coroner. Governors are required by standing orders to act immediately to rectify any lapses revealed by the death. Moreover, under a protocol agreed with NOMS in 2004 all deaths in custody are investigated by the Prison and Probation Ombudsman, whose terms of reference are wider than the coroner's. (Mr Owen, however, points to the doubts expressed in evidence on behalf of the charity Inquest about the Ombudsman's efficacy as an investigator.) Ms Richards tells us that a new team in the Ministry of Justice coordinates the findings of the Ombudsman, the Chief Inspector of Prisons, the verdicts of inquest juries and the rule 43 reports of coroners. Her description of the latter as an important source of material for this purpose underscores what I have said above about the omission of the immediate circumstances of Karl Lewis's death from the present coroner's report. It is depressing, too, to see from the evidence that after a significant improvement in 2006, the rate of prison suicide recorded by NOMS reverted in 2007 to its previous level of over 100 a year. The problem clearly remains a very serious one.

19. The second development which needs to be noted is the prospective amendment of rule 43, along with much else, by the Coroners and Justice Act 2009. Section 5 adopts the ruling in *Middleton* (ante) about the proper scope of an inquest. It goes on to limit the expression of opinion by coroners and juries to the prescribed issues, but by paragraph 7 of Schedule 5 it makes a coroner's report, and an official response to it, mandatory where in the coroner's opinion action should be taken to prevent the occurrence or continuation of circumstances creating a risk of other deaths. We are told that the prospective commencement date of the material provisions of this Act is April 2012. It follows that our judgment in this appeal is likely to affect a substantial number of inquests in the interim.

Ought the coroner to have put the issue to the jury?

20. The ambit of the claim has been significantly reduced in the course of argument. Although he wishes to keep open the contention that no causative link is required between the material death and any circumstance relevant to it in order to require the jury's verdict, Mr Owen has limited his case before us to a narrower version of the argument: that in order for the jury's verdict to be required on it, a fact or circumstance does not have to have been a probable cause of or contributor to the death, so long as it is capable of having had such a bearing. The facts of the present case clearly fit this template: it could not be shown to have been probable, but it was undoubtedly possible, that better training and equipment and swifter intervention would have saved Karl's life.

21. In an inquiry under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 this submission would probably encounter little opposition. That statute by s.6(1) provides:

> **Sheriff's determination etc**
>
> (1)At the conclusion of the evidence and any submissions thereon, or as soon as possible thereafter, the sheriff shall make a determination setting out the following circumstances of the death so far as they have been established to his satisfaction—
>
> (a) where and when the death and any accident resulting in the death took place;
>
> (b) the cause or causes of such death and any accident resulting in the death;
>
> (c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
>
> (d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and
>
> (e) any other facts which are relevant to the circumstances of the death.

As can be seen, paragraph (c) would evidently require the matters mentioned in §4 of this judgment to feature in a sheriff's determination on a prison death. And, as I have said in §16 above, it ought to have featured in the coroner's rule 43 report in Karl Lewis's case.

22. But the House of Lords in *Middleton* appears to have taken care to exclude this from its enlargement of the English and Welsh provisions. Lord Bingham, speaking for the Judicial Committee, at §36, explained the consequences of adding "and in what circumstances" in this way:

> 36. This will not require a change of approach in some cases, where a traditional short form verdict will be quite satisfactory, but it will call for a change of approach in others (paragraphs 30-31 above). In the latter class of case it must be for the coroner, in the exercise of his discretion, to decide how best, in the particular case, to elicit the jury's conclusion on the central issue or issues. This may be done by inviting a form of verdict expanded beyond those suggested in form 22 of Schedule 4 to the Rules. It may be done, and has (even if very rarely) been done, by inviting a narrative form of verdict in which the jury's factual conclusions are briefly summarised. It may be done by inviting the jury's answer to factual questions put by the coroner. If the coroner invites either a narrative verdict or answers to questions, he may find it helpful to direct the jury with reference to some of the matters to which a sheriff will have regard in making his determination under section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976: where and when the death took place; the cause or causes

> of such death; the defects in the system which contributed to the death; and any other factors which are relevant to the circumstances of the death. It would be open to parties appearing or represented at the inquest to make submissions to the coroner on the means of eliciting the jury's factual conclusions and on any questions to be put, but the choice must be that of the coroner and his decision should not be disturbed by the courts unless strong grounds are shown.

23. Mr Owen resists what might be called legislation by silence. He submits that paragraph (e) – any other facts which are relevant to the circumstances of the death – is quite sufficient for his purpose. Mr Hough contends that this does not help: the critical question - how relevant? – remains unanswered.

24. There is no answer in the Strasbourg jurisprudence for the good reason that the Court regards questions like this as a matter of domestic law, so long as the issue is addressed in some efficient way. *E v United Kingdom*(2003) 36 EHRR 31, §99, lends clear support to the contention that failing to take measures which "could have had a real prospect of altering the outcome" is within the purview of article 2, but tells us nothing about whose responsibility such findings should be. In my judgment, however, once it is established that the facts about OSG Knowles' equipment, training and use of procedure were so clearly relevant to the possible occurrence of further prison deaths that the coroner was obliged by rule 43 to report on them, the requirements of article 2 are satisfied in this regard. The question whether it should also form part of the jury's verdict is then a question of domestic law.

25. As to this, Mr Owen was willing to accept a formulation of his case to the effect that the coroner should have

> a) added a tenth question to the jury along the lines "Should OSG Knowles have been trained and equipped to intervene or secure assistance more rapidly?"; and
>
> b) altered the final caveat to read: "You must only answer the above questions if you believe that (either on its own or with others) that act or omission *could have* caused or contributed to Karl Lewis's death".

Had this been done, the jury's answer would have formed part of the inquisition, as, it is contended, the law requires.

26. The jury's verdict on this question, Mr Owen submits, would have been, if not an essential, certainly a desirable foundation for any report the coroner might eventually submit. Why else, he asks, canvass such facts at all? Mr Hough's answer is that the inquest process can be visualised as a funnel: wide at its opening, but narrowing as the evidence passes down it so as to exclude non-causative factors from the eventual verdict.

27. Apart from the possibly eloquent silence in *Middleton*, there is nothing in the extensive range of authority which counsel have placed before us which resolves this difference. For my part I see no reason to doubt the propriety of the ruling we have

been shown of the City of London coroner in the case of *Heather Claire Waite* (3 July 2006) that

> "the jury may, in addition to finding the direct or indirect causes or contributions to the death, also find facts relevant to the exercise of the coroner's power under rule 43."

This is likely to be more useful - as the House of Lords suggested in Middleton (§20) - where facts are disputed or uncertain. Indeed it may be in such cases that a finding by verdict is a desirable or even a necessary foundation of any rule 43 report. Here, perhaps unusually, the relevant facts were clear and undisputed.

28. But Mr Owen's case goes beyond a power to leave possibly but not probably causative matters to the jury: he contends for a duty to do so irrespective of whether the relevant facts are unclear or in dispute. I see the force of his foundational proposition that the circumstances of a death are not limited to its probable causes: they extend as a matter of plain English to the surrounding facts; and while it is not contended for the present that this allows the jury to pronounce on facts, however close in time, that can have had no bearing at all on the death, it can be intelligibly said that, in a jurisdiction which is not concerned with the allocation of blame, potentially causative circumstances can be just as relevant as actually causative ones.

29. All of this speaks strongly in favour of a power to take the jury's verdict on such questions. But I am unable to find a reason of principle for making it a duty. It would be quite different if rule 43 were not there, backed as it always is by the supervisory power of the High Court to ensure that it is properly operated. There would then be a significant failure (assuming that no other satisfactory mechanism existed) to implement the investigative requirement of article 2. But it seems to me in the end that the present legislative allocation of functions between coroner and jury, properly interpreted and properly implemented, will fulfil the functions which Mr Owen correctly submits are required by the Convention to be fulfilled.

30. Among the authorities placed before us has been the judgment of this court in R (Allen) v Inner North London Coroner [2009] EWCA Civ 623, the reasoned decision of a full court refusing permission to appeal. Without embarking on issues which may arise from the citation of such decisions, it is right to indicate that I have taken account of it and that no part of the foregoing judgment appears to me to conflict with it.

31. Although it has therefore served a useful purpose, I would dismiss this appeal.

Lord Justice Rimer:

32. I agree.

Lord Justice Etherton:

33. I agree that this appeal should be dismissed.

34. The issue on the appeal, as reformulated in the way set out in paragraph 25 of the judgment of Sedley LJ, is a narrow but important one: namely, whether a coroner is obliged to leave to the jury a fact or circumstance which could have caused or contributed to the death but cannot be shown probably to have done so.

35. Article 2 of the European Convention on Human Rights requires that, in circumstances such as those of Karl Lewis' death:

> "the competent authorities must act with exemplary diligence and promptness and must of their own motion initiate investigations capable of, first, ascertaining the circumstances in which the incident took place and any shortcomings in the operation of the regulatory system and, secondly, identifying the state officials or authorities involved in whatever capacity in the chain of events in issue": *Öneryildiz v Turkey* (2005) 41 EHHR 20 at para. 94; see also *Trubnikov v Russia* App No. 4979/99, 4 July 2005 at paras. 85 and 88."

36. It is a matter of domestic legislation and law precisely how those requirements are fulfilled, and, in particular, the role required to be played by the jury at an inquest. The latter turns on the proper interpretation of s.11(5) of the Coroners Act 1988 ("the 1988 Act"), which so far as relevant is as follows:

> "(5) An inquisition –
>
> shall be in writing under the hand of the coroner and, in the case of an inquest held with a jury, under the hands of the jurors who concur in the verdict;
>
> shall set out, so far as such particulars have been proved –
>
> who the deceased was; and
>
> how, when and where the deceased came by his death, and
>
> ….."

37. The scope for comment by a coroner on failures of the system in order to prevent similar deaths in the future is a wide one, and is certainly not limited to circumstances which probably caused or contributed towards the death. Rule 43 of the Coroners Rules 1984 ("Rule 43") provides as follows:

> "43 Prevention of similar fatalities
>
> A coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which

> the inquest is being held may announce at the inquest that he is reporting the matter in writing to the person or authority who may have power to take such action and he may report the matter accordingly."

38. Although Rule 43 is expressed in permissive language, the circumstances, particularly in the light of the Article 2 obligation, may be such that the failure to report on a systemic failure would be a breach of duty.

39. It is doubtless with a view to the Article 2 obligation that the permissive language of Rule 43 has been changed into one of obligation in paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009.

40. Returning, then, to the central issue of the proper scope and meaning of section 11(5) of the 1988 Act, the language of section 11(5)(b) is more naturally confined to actual, that is to say, probable causes of death rather than all possible causes, even if less than probable. That also fits naturally into a scheme in which limited issues are left to the jury, but a much wider power is given to the coroner, a professional adjudicator, to report on systemic failures. As I have said, Strasbourg jurisprudence does not require a different conclusion.

41. Moreover, such domestic authority as bears on this issue does not assist the Appellant's case. In that connection, Sedley LJ has referred to the very different language of section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 ("the 1976 Act"). As he has pointed out, Lord Bingham, when delivering the opinion of the Appellate Committee in *Middleton*, giving "how" in s.11(5)(b)(ii) of the 1988 Act a more extensive meaning than it had previously been thought to bear, appears deliberately to have omitted from the matters which might be left to the jury those in section 6(1)(c) of the 1976 Act. The Judicial Committee would seem, therefore, to have anticipated precisely the approach for which the Appellant contends on this appeal and not to have adopted it.