Hospital Inquests and Article 2 of the European Convention of Human Rights

Article
15 June 2012

Article 2 (1) of the Convention provides “Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a Court following his conviction of a crime for which this penalty is provided by law”.

Implications of an Article 2 Inquest

The Coroner’s Rules (Rule 36) limit the matters to be decided at an Inquest to establishing:

1. Who the Deceased was
2. How, when and where the Deceased came by his death
3. The particulars required for registering the death

A traditional Inquest (often referred to as a “Jamieson” Inquest) requires the Coroner, when considering the issue of "how" to take this as meaning "by what means". At an enhanced Article 2 Inquest (often referred to as a “Middleton” Inquest) it was held that interpreting "how" means not simply "by what means" but "by what means and in what circumstances". This therefore allows a wider reaching enquiry into the circumstances surrounding death.

To investigate the wider circumstances of the death many Coroners are now instructing experts themselves, or allowing the parties (usually the family) to do so. In our experience, many reports provided for the Coroner’s Court often go way beyond the scope of the Inquest (even if a wider enquiry) and often comment on matters such as liability.

Obligation to hold an Article 2 Inquest for hospital deaths

In relation to hospital deaths, in the case of Powell v United Kingdom (2000) 30 EHRR CD362, it was held that ‘mere’ negligence does not breach Article 2 and hence does not trigger an enhanced investigation. To trigger the enhanced investigation the interested party must establish that the treatment (or lack of) went beyond “mere” negligence and represented a failure by the State to meet its Article 2 obligations to make adequate provisions to protect the lives of patients.

This issue was considered by the Court of Appeal in the case of R (Takoushi) v H M Coroner for Inner North London (2005) EWCA CIV 1140. The Court stated that:

“...However it is analysed, the position is that, where the person dies as a result of what is arguably medical negligence in an NHS Hospital, the State must have a system which provides for the practical and effective investigation of the facts of the determination of civil liability. Unlike in the case of death in custody, the system does not have to provide for an investigation initiated by the State but may include such an investigation. Thus the question in each case is whether the system as a whole, including both any investigation initiated by the State and the possibility of civil and criminal proceedings and/or a disciplinary process, satisfies the requirements of Article 2 ...”

There are three different scenarios in relation to hospital deaths which should be distinguished:

1. Where the potential culpability is one of gross negligence or carelessness the State may be obliged to initiate an investigation. If so a Middleton type Inquest may be required to discharge that obligation (R v (Goodson) v Bedfordshire & Luton Coroner (2004) EWHC 2931).
2. Deaths which occur in a situation of compulsory hospital detention. This situation is considered to be closely analogous to that of a prison detainee. The cases of Savage v South Essex NHS Trust (2009) 2 WLR 115(II) and Rabone v Pennine Care NHS Trust (2012) UKSC 2 confirm that Article 2 imposes an operational obligation on the State to protect mentally ill patients both who are detained and who are not detained under the Mental Health Act 1983 where there was a real and immediate risk of suicide. The Court felt that as the patients were deprived of their liberty more so than other patients the State was obliged to take positive steps to safeguard their life.
3. Cases of ordinary medical negligence. In these cases the State’s positive procedural obligation has been held discharged by an effective investigatory machine in respect of negligent or systemic errors i.e it meets the criteria for “a satisfactory system under which the death can be properly investigated by civil, criminal, disciplinary or other procedures, or a combination of all them”.

Article 2 - the minimum requirements

The case of Edwards v UK (2002) 35 EHRR 487 confirms that an Article 2 investigation of central purpose was to comprise of two matters:

- To secure the effective implementation of the domestic laws which protect the right to life and, in those cases involve State Agents or bodies.
To ensure their accountability for deaths occurring under their responsibility.

In the domestic context Lord Bingham explained the importance of these safeguards in R (Amin) v Secretary of State for the Home Department (2003) UKHL51 as “to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrong doing (if unjustified) is allayed; that dangerous practices and procedures are rectified and that those who have lost their relative may at least have the satisfaction of knowing that lessons learnt from his death may save the life of others”.

To ensure an effective investigation the circumstances may further require the following:

- The authorities must act of their own motion
- The investigation must be independent
- The investigation must be effective in the sense that it must be conducted in a manner that does not undermine its ability to establish the relevant facts
- The investigation must be reasonably prompt
- There must be a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory
- There must be involvement of the next-of-kin to the extent necessary to safeguard his/her legitimate interests

These facts highlight the relevance and importance of a full and effective investigation being carried out by the Trust. The investigation should address all of the relevant issues and not be conducted by anyone who was in any way connected to the care of the Deceased patient.

What does this mean in reality?

In both Middleton and Jamieson Inquests, the Coroner is given a wide discretion as to the nature and scope of the investigation (as opposed to the available verdicts). This allows the flexibility to ensure that whatever Article 2 obligations have arisen or remain can be met.

If the enhanced investigative duty is triggered then this will give the family or legal representatives instructed on their behalf a greater range of scope for questions which would be the most important difference between the two Inquests for those who are involved. It is therefore often very helpful, when arguing against a wider scope of Inquest, to show to the Coroner that an effective investigation has already been carried out.

For the family, particularly those who may be contemplating a claim (but of course have not yet instigated one so will continue to argue that Article 2 should be applied to the Inquest), this will give them a greater scope to ask questions which may assist them in subsequent clinical negligence claims and civil procedures. There may be occasions where the more enhanced investigation satisfies the family to the extent they decide not to pursue a claim further.