Neutral Citation Number: [2023] EWCA Civ 289

Case No: CA-2021-003230

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM
THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
DIVISIONAL COURT
LORD JUSTICE WARBY, MRS JUSTICE FARBEY AND HHJ TEAGUE KC
[2021] EWHC 2511 (Admin)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 17 March 2023

Before:

LORD JUSTICE LEWIS
LORD JUSTICE WILLIAM DAVIS
and
LADY JUSTICE WHIPPLE

- -

Between:

Joy Dove	**Appellant**
- and -	
(1) HM Assistant Coroner for Teesside and Hartlepool	**Respondents**
(2) Dr Shareen Rahman	
Secretary of State for Work and Pensions	**Interested Party**

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Jeremy Hyam KC and Jesse Nicholls (instructed by **Leigh Day**) for the **Appellant**
Jonathan Hough KC (instructed by **Middlesbrough Council**) for the **First Respondent**
Pravin Fernando (instructed by **Victoria Lord**) for the **Second Respondent**
Jonathan Dixey (instructed by **Treasury Solicitor**) for the **Interested Party**

Hearing dates: 31 January and 1 February 2023

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Approved Judgment

LADY JUSTICE WHIPPLE:

Introduction

1. Joy Dove is the Appellant and the mother of Jodey Whiting, who died on 21 February 2017 as the result of an overdose of prescription medicine. Jodey was 42 years old when she died. On 24 May 2017, the Assistant Coroner for Teesside and Hartlepool (the First Respondent to this appeal and referred to in this judgment as the "Coroner") held an inquest into her death which recorded her death as suicide.

2. With the authority of the Attorney General by way of *fiat*, on 21 December 2020 Mrs Dove applied for an order under s 13 of the Coroners Act 1988 quashing the Coroner's determination and directing a new inquest. On 17 September 2021 the Divisional Court (Warby LJ, Farbey J and HHJ Teague KC, the Chief Coroner) refused that application. Mrs Dove now appeals to this Court. I granted permission to appeal on the papers.

3. The scope of the appeal before this Court is much narrower than the case advanced before the Divisional Court. Mrs Dove, who is the Appellant, now makes no criticism of the way the first inquest was conducted. She advances two grounds of appeal, both of them contingent on the fresh evidence in this case, received since that first inquest took place. The grounds of appeal are:

    i) First, that the Divisional Court was wrong to conclude that a fresh *Jamieson* inquest was not necessary or desirable in light of the fresh evidence relating to the abrupt cessation of Jodey's benefits by the Department of Work and Pensions (the "Department") and the likely effect of that on Jodey's mental health; and

    ii) Secondly and alternatively, that the Divisional Court was wrong to conclude that a fresh *Middleton* inquest was not necessary or desirable in the light of arguable breaches of the Article 2 operational duty owed to Jodey by the Department.

4. In this Court, Mrs Dove was represented by Mr Hyam KC, who did not appear below, and Mr Nicholls who represented her below. The Coroner was present and represented by Mr Hough KC, who appeared below and adopted a neutral approach, seeking only to assist the Court. Jodey's GP, Dr Rahman, was named as the second Respondent, and was present and represented in this Court by Mr Fernando, but he did not wish to make any submissions and remained neutral on the appeal. The Secretary of State is the Interested Party, being ultimately responsible for the Department; she was present and represented on this appeal by Mr Dixey who remains neutral on the first ground but resisted the appeal on the second ground. I am grateful to all counsel and their legal teams for the care and conspicuous expertise with which this appeal was presented.

5. This case concerns the sad and premature death of a much-loved daughter, mother and grandmother. Mrs Dove and all her family have my deepest sympathies for their loss.

Law

Application for a fresh inquest

6. Section 13(1) of the Coroners Act 1988 provides:

> "13. – Order to hold investigation
>
> (1) This section applies where, on an application or under the authority of the Attorney-General, the High Court is satisfied as respects a coroner ("the coroner concerned") either –
>
> …
>
> (b) Where an inquest or an investigation has been held by him, that (whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise) it is necessary or desirable in the interests of justice that an investigation (or as the case may be, another investigation) should be held."

7. If such an application is successful, the High Court may quash the inquisition and any determination or finding made by the first inquest and order a fresh inquest to take place (s 13(2)).

8. In *R (Sutovic) v HM Coroner Northern District of Greater London* [2006] EWHC 1095 the Court (Moses LJ and Beatson J) discussed the ambit of the power to order a fresh inquest in s 13(1) and held:

> "54. The power in section 13(1)(b) [is] stated in very broad terms. The necessity or desirability of another inquest may arise by reason of one of the listed matters "or otherwise". Notwithstanding the width of the statutory words, its exercise by courts shows that the factors of central importance are an assessment of the *possibility* (as opposed to the probability) of a different verdict, the number of shortcomings in the original inquest, and the need to investigate matters raised by new evidence which had not been investigated at the inquest …"

Further, the Court held that:

> "98. … the function of an inquest is to seek out and record as many of the facts concerning the death as public interest requires. …"

9. In *Attorney-General v HM Coroner of South Yorkshire (West)* [2012] EWHC 3783 (Admin) (the "*Hillsborough* case") the Divisional Court (Lord Judge CJ, Burnett J and HHJ Peter Thornton QC) gave the following guidance on the approach to s 13:

> "10. The single question is whether the interests of justice make a further inquest either necessary or desirable. The interests of justice, as they arise in the coronial process, are undefined, but, dealing with it broadly, it seems to us elementary that the

> emergence of fresh evidence which may reasonably lead to the conclusion that the substantial truth about how an individual met his death was not revealed at the first inquest, will normally make it both desirable and necessary in the interests of justice for a fresh inquest to be ordered. The decision is not based on problems with process, unless the process adopted at the original inquest has caused justice to be diverted or the inquiry to be insufficient. What is more, it is not a pre-condition to an order for a further inquest that this court should anticipate that a different verdict to the one already reached will be returned. If a different verdict is likely, then the interests of justice will make it necessary for a fresh inquest to be ordered, but even when significant fresh evidence may serve to confirm the correctness of the earlier verdict, it may sometimes nevertheless be desirable for the full extent of the evidence which tends to confirm the correctness of the verdict to be publicly revealed."

Purpose and Scope of Inquest

10. Section 5 of the Coroners and Justice Act 2009 provides that the purpose of an inquest is to ascertain the answers to the following questions: (a) who the deceased was; (b) how, when and where the deceased came by their death; and (c) the particulars (if any) required under other legislation to be registered concerning the death. Section 5(3) prohibits a coroner from expressing any opinion on matters other than the section 5 questions, subject only to para 7 of Schedule 5 to the 2009 Act which permits a coroner to make a report to an appropriate person known as a "Preventing Future Deaths" or "PFD" report. The inquest must not, by s 10(2) of the 2009 Act, appear to determine any question of criminal liability of a named person or any question of civil liability.

11. The scope of an inquest will depend on whether or not Article 2 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") is engaged. The scope in cases where Article 2 is not engaged was examined in *R v HM Coroner for North Humberside, ex p Jamieson* [1995] QB 1 which considered the predecessor provision to s 5 of the 2009 Act. The purpose of a *Jamieson* inquest is to answer the factual questions posed in the statute. The "how" question is directed only to the means by which the deceased came by his or her death, it does not encompass the wider circumstances of death. However, inquests which engage Article 2 are required to answer the "how" question more broadly, to address not only by what means, but also in what circumstances the deceased came by their death. That expansion is necessary in order for the state to comply with its investigative obligation under Article 2: *R (Middleton) v West Somerset Coroner* [2004] UKHL 10, [2004] 2 AC 182 and *R (Hurst) v London Northern District Coroner* [2007] 2 AC 189. The approach in *Middleton* and *Hurst* was given statutory effect by s 5(2) of the 2009 Act.

12. Coroners are invited to follow the three-step process set out in the Chief Coroner's Guidance No 17 on "Conclusions: Short Form and Narrative" published on 30 January 2015 and revised on 14 January 2016, see [18]. That process involves: (i) making findings of fact based on the evidence, to be stated in open court but not written on the record of inquest; (ii) distilling from the findings of fact 'how' the deceased came by their death, which will normally be a brief one sentence summary taken from the findings of fact at the first stage, in words chosen by coroners which should be brief,

neutral and clear; and (iii) recording the conclusion which must flow from and be consistent with stages (i) and (ii), to be inserted into box 4 of the record of inquest. Where the inquest is an Article 2 *Middleton* inquest, the second stage is expanded to indicate "how and in what circumstances" the deceased came by their death: see [45]-[55] of the Chief Coroner's Guidance No 17.

Narrative Conclusions

13. *Jamieson* confirmed, in the context of an inquest which did not engage Article 2, that there could be no objection to a verdict which incorporates a "brief, neutral, factual statement" of how the deceased came by their death (p 24, F-G).

14. *Middleton* confirmed, in the context of an Article 2 inquest, that to meet the procedural requirement of Article 2, an inquest ought ordinarily to culminate in "an expression, however brief, of the jury's conclusion on the disputed factual issues at the heart of the case" ([20]). That could be done by inviting a narrative form of verdict ([36]), for example: "the deceased took his own life, in part because the risk of doing so was not recognised and appropriate precautions were not taken to prevent him doing so" (at [37]).

15. In *R (Longfield Care Homes Ltd) v HM Coroner for Blackburn* [2004] Inquest LR 50, Mitting J held that *Middleton* established guidance of general application which was not limited to Article 2 inquests (see [29]). That case did not engage Article 2. At [31], Mitting J said:

> "In cases where the death results from more than one cause of different types, a narrative verdict will often be required. …"

In the same paragraph, he quashed the short-form verdict of natural causes to which neglect had contributed, which had been the inquest verdict, and substituted a narrative verdict in these terms:

> "[The Deceased's] death was probably accelerated by a short time by the effect … of injuries sustained when she fell through an unattended open window, which lacked an opening restrictor, …".

16. The Chief Coroner's Guidance No 17 reflects this case law. It states that a narrative conclusion (the word 'conclusion' follows the language of the 2009 Act and replaces the word 'verdict') can be used as an alternative for the short-form conclusion at box 4 of the record of inquest or can be used in addition to a short form conclusion at box 4. In non-Article 2 cases, a narrative conclusion should be a brief, neutral, factual statement which does not express any judgment or opinion ([31]-[34]). The guidance suggests:

> "36. Narrative conclusions are not to be confused with findings of fact in the three stage process. If the three stage process of (1) findings of fact, (2) the answer to 'how' and (3) a short-form conclusion is properly followed, there will often be no need for a narrative conclusion. In general a narrative conclusion should be used only where the three stage process (culminating in a short-form conclusion) is insufficient to 'seek out and record as

> many of the facts concerning the death as the public interest requires': *per* Lord Lane CJ in [*R v South London Coroner, ex p Thompson* (1982) 126 SJ 625]."

Note (ii) of Form 2 contained in the Schedule to the Coroners (Inquests) Rules 2013) (SI 2013/1616) is consistent with this guidance and reads "As an alternative, or in addition to one of the short-form conclusions listed under NOTE (i), the coroner or where applicable the jury, may make a brief narrative conclusion."

17. The authors of Jervis on Coroners 14th Ed suggest at para 13-26 that:

> "… A narrative conclusion is not confined to art 2 cases, but is useful in other inquiries, for example where death results from two or more causes of different types [referring to *Longfield*]. In general a narrative conclusion should be used only where a combination of the answer to *how* and a short-form conclusion is insufficient to 'seek out and record as many of the facts concerning the death as the public interest requires' [referring to *Thompson*]."

Causation

18. For causation of death to be established, the threshold to be reached is that the event or conduct said to have caused the death must have more than minimally, negligibly or trivially contributed to it. That question is to be determined on the balance of probabilities. Combining the threshold for causation and the standard to which it must be established, the question is whether, on the balance of probabilities, the conduct in question more than minimally, negligibly or trivially contributed to death, see *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin), at [41], *R (Wandsworth BC) v HM Coroner for Inner West London* [2021] EWHC 801 (Admin), [2021] Inquest LR 103 at [32], and note Jervis on Coroners 14th Ed at 14-106 citing *R v Inner London Coroner Ex p Douglas-Williams* [1999] 1 All ER 344 at 350, CA.

Conclusion of Suicide

19. There are two elements which must be proved before a conclusion of suicide can be entered, they are (i) the deceased took their own life; and (ii) they intended to do so (see Chief Coroner's Guidance No 17 at [62], which invites coroners to make "express reference" to both elements). It is noted in Jervis on Coroners 14th Ed at 13-72 that the old form verdict that the deceased had killed him or herself "whilst the balance of his [or her] mind was disturbed" can still be used but should be based on some evidence to that effect given at the inquest; an alternative formulation "whilst suffering extreme anxiety or distress" is suggested; it is recommended that:

> "… if the inquest, on the basis of evidence, finds that the deceased's mind *was* disturbed, then it is a finding that should be recorded."

Facts

20. I gratefully adopt the summary of the facts set out in the Divisional Court's judgment at [11]-[28], with a few alterations. Jodey had suffered from spinal conditions from her

early twenties which gave her back pain, requiring surgery and regular painkilling medication. She had a history of mental health problems, including depression, drug dependence and a diagnosed condition of emotionally unstable personality disorder. She had a history of suicidal ideation and the expression of suicidal intent. Her medical notes contain references to multiple overdoses, including nine between January 2009 and July 2015.

21. From October 2006 to September 2012, Jodey received Incapacity Benefit and Income Support. In late 2012, she was assessed for Employment and Support Allowance ("ESA") which was being gradually introduced under the Welfare Reform Act 2007. In line with legislative procedures, she underwent a work capability assessment which included an assessment by an approved healthcare professional ("HCP") whose report concluded that she had severe mental health problems.

22. The Department decided to award Jodey ESA from September 2012 for a period of two years. She was placed in a support group, meaning that the Department recognised that she suffered from a severe health condition. As she had been placed in the support group on mental health grounds, the Department put a flag on its system. The flag was intended to trigger a request to her GP to provide medical evidence in future ESA reassessments, which would enable the Department to decide whether a face-to-face medical assessment should be required.

23. In September 2014, Jodey's entitlement to ESA was reassessed. In the questionnaire that she completed for the Department at that time, she stated: "Most days I want to kill myself, if my doctor doesn't get the pain under control asap I plan 2 kill myself, that's why if my medz or doctors don't approve, I'm gunna take my life." She also said: "24/7, don't want to and can't get away from all my illness". Her GP also provided medical evidence that she had an emotionally unstable personality, with stress, low mood and anxiety. In these circumstances, the Department did not ask her to attend a face-to-face medical assessment. Her ESA was extended for a further two years and she remained in the support group. From 29 July 2015, she also received an award of Personal Independence Payment ("PIP"), migrating to PIP from Disability Living Allowance.

24. In September of 2016, Jodey began a further reassessment process. She completed another questionnaire which was received by the Department on 20 October 2016. In the questionnaire, she stated that she needed to be assessed by means of a home visit as she rarely left the house due to mobility problems and anxiety. She referred to her psychiatric care. She stated that she had suicidal thoughts "a lot of the time and could not cope with work or looking for work". The questionnaire was passed to the Centre for Health and Disability Services ("CHDA") which provides HCP reports to the Department.

25. It is not in dispute that the Department should have referred the home visit request to CHDA but did not do so. There was no evidence that CHDA considered the request for itself. On 14 November 2016, CHDA asked Jodey's GP to provide medical evidence, which was supplied on 22 November 2016. In that evidence, the GP stated that Jodey had been referred to a crisis team for intensive treatment due to suicidal thoughts but had been discharged on 25 June 2016 on the basis that she had no suicidal intent or thoughts.

26. The GP recorded having seen Jodey on 3 August 2016, when she appeared to be making an effort to remain stable. The GP had last seen her on 4 October 2016. The GP was apparently unable to comment on how Jodey's mental health affected her daily living.

27. On 15 December 2016, CHDA decided that Jodey was required to attend a face-to-face appointment with an HCP. On that same date, CHDA wrote to her with a request to attend on 16 January 2017. Jodey did not attend the appointment and did not respond to the letter. On 17 January 2017, CHDA sent a standard form to Jodey seeking the reasons for her non-attendance.

28. In accordance with the Department's guidance, where a benefits claimant with mental health difficulties has failed to attend an assessment, the Department should attempt to contact the person by telephone and should consider a "safeguard visit". There is no evidence that either of these steps was taken. The Department does not seek to maintain that they were taken.

29. Jodey completed the standard form on 24 January 2017 and returned it to the Department. She said that she had not received the original letter from CHDA and that she was housebound with pneumonia. She asked the Department to write to her GP for information about her medical and personal problems. The Department did not write to the GP.

30. On 6 February 2017, the Department decided that Jodey had not shown "good cause" for failure to attend the HCP appointment on the basis that the appointment letter had been correctly addressed and no medical proof of pneumonia had been supplied. The Department decided that Jodey had not shown limited capability for work and stopped her ESA. By letter of the same date, the Department informed Jodey of the decision. The letter referred to the usual procedures for mandatory reconsideration by the Department and to appeal rights.

31. In accordance with the Department's guidance, the decision-maker deciding whether good cause had been shown for Jodey's failure to attend the HCP appointment should have determined whether her medical condition had affected her cognition. The Department was also required to give consideration to her mental health problems before making the decision to stop her ESA. The decision letter sent to Jodey made no reference to her mental health condition.

32. Jodey's ESA was stopped with effect from 7 February 2017. As a result of the Department's decision, Jodey received letters from her local authority informing her that her housing benefit and council tax benefit (both linked to her ESA) were being terminated.

33. On 10 February 2017, she telephoned the Department and the decision letter was read to her. She said that she was ill in hospital. The Department's call-handler advised her to request reconsideration in writing with medical evidence.

34. On 13 February 2017, Jodey returned the decision letter with a request for reconsideration. That reconsideration in fact occurred on 25 February 2017 (and the refusal was maintained). There is no evidence about when the request for reconsideration was actually received by the Department. On 15 February 2017, a representative from the Citizens Advice Bureau ("CAB") wrote to the Department

explaining that Jodey had attended their office with a number of letters, including the HCP appointment letter which was unopened. The CAB emphasised that, as a result of her anxiety and depression, Jodey was not always able to deal with her post. The letter asked the Department to reconsider its decision. There is no record of the Department having received this letter at the time; it appears that it was received later, when Mrs Dove appealed the Department's withdrawal of benefits by a notice of appeal submitted in March 2017 which attached a copy of the CAB's letter.

35. On 21 February 2017, Mrs Dove found Jodey lying unresponsive on a sofa in her flat. Paramedics were called but they pronounced Jodey dead. The medical cause of death was recorded as being the synergistic effects of morphine, amitriptyline and pregabalin together with cirrhosis. Jodey made a number of notes before her death, which Mrs Dove found and which are available to this Court.

36. On 25 February 2017, the Department belatedly carried out a mandatory reconsideration of Jodey's case but adhered to its original decision that she had not demonstrated good cause for failing to attend the appointment with the HCP on 16 January 2017. The Department decision maker again failed to consider Jodey's mental health.

37. By notice of appeal filed on 23 March 2017, Mrs Dove appealed to the First Tier Tribunal (Social Entitlement Chamber) against the Department's decision. On 31 March 2017, the Department revised its decision on the basis of the CAB letter of 15 February 2017 and reinstated Jodey's ESA from 17 January 2017. The appeal to the Tribunal consequently lapsed.

38. Merry Varney, solicitor to the Appellant, filed a witness statement in these proceedings dated 17 December 2020. Ms Varney had served a request under the Freedom of Information Act 2000 and obtained disclosure of a number of the Department's documents relating to safeguarding policies and procedures in place at the material time. She summarised those policies and procedures in her statement and exhibited the relevant documents to her statement. She demonstrated how, in a number of respects, the Department had failed to follow its own procedures in its dealings with Jodey.

The Inquest

39. The inquest into Jodey's death was opened on 30 March 2017 and adjourned until 24 May 2017. It was conducted by Mrs Jo Wharton, Her Majesty's Assistant Coroner for Teesside and Hartlepool. We were provided with a full transcript of the inquest. Mrs Dove was present at the inquest, together with some of Jodey's children and Jodey's father. The Coroner said at the outset that it was not her function to question any decisions made by the Department. Mrs Dove's statement was read; it included reference to the way Jodey's benefits had been stopped by the Department and a statement by Mrs Dove that "I blame the Department of Work and Pensions for her death". Under questioning from the Coroner, Mrs Dove confirmed that she believed that the ESA claim put stress on Jodey and was a contributing factor in her death. A statement from her GP was also read detailing her various medical complaints including multiple overdoses documented in the notes and multiple entries for mental health issues. The Coroner referred to the notes written by Jodey and found after her death. The toxicology section of the post-mortem report was read, detailing the various drugs which were found in Jodey's body after death; the pathologist's opinion was that the

cause of death was the synergistic effects of morphine, amitriptyline and pregabalin. Mrs Dove addressed the Coroner about the way Jodey had been treated by the Department, saying that Jodey had been poorly for a long time but that having her benefits stopped was the "last straw", causing "extra stress" which was a contributing factor to her death. Her sister also addressed the Coroner to say that Jodey had not left her flat for months and that having her benefits stopped was a "triggering factor" in taking her own life. Jodey's daughter addressed the Coroner and said that the Department was "bang out of order". The Coroner again said that it was not the Coroner's position to question any decisions made by the Department and that was outside the remit of the Coroner's Court.

40. The Coroner summed up the evidence, recording that Jodey had her ESA claim turned down in the weeks before her death and that her mother and sister believed that this caused her extra stress which was a contributing factor in her death. On the record of inquest she recorded Jodey's name in box 1, the medical cause of death in terms which reflected the pathologist's opinion in box 2, box 3 was left blank, and she entered her conclusion as to the death with one word, "Suicide", in box 4.

Fresh Evidence

41. Since the date of the inquest, two pieces of evidence have been obtained by Mrs Dove and her legal team. First, there is a report from an Independent Case Examiner, Ms Joanna Wallace, dated 14 February 2019 (the "ICE Report"). In the cover letter, Ms Wallace said that the handling of Jodey's case was not as it should have been, not just in the areas Mrs Dove was concerned about after Jodey's death but also in the Department's handling of her case before she died. At [79]-[87] of her report, Ms Wallace set out a number of criticisms of the Department in the weeks before Jodey's death, relating to the Department's breach of its own guidance for dealing with vulnerable claimants, the Department's failure to act on the mental health flag which was placed on Jodey's referral to CHDA, the Department's failure to tell CHDA that Jodey had requested a home visit, the failure of CHDA to offer Jodey a home visit, the decision that she should attend a face to face assessment which was not in accordance with the Department's own procedures, the fact that no one telephoned her or conducted a safeguard visit to inquire about her wellbeing when she did not attend that face to face assessment, the Department's failure to contact Jodey's GP even after Jodey wrote to the Department asking them to do so, and the Department's apparent failure to take into account her mental health when deciding to disallow her benefits claim. The ICE report concluded:

> "In total, there were five opportunities for [the Department's] processes to prompt particular consideration to Jodey's mental health status and give careful consideration to her case because of it – none of these were taken."

42. The Secretary of State, by Mr Dixey, accepts the findings of the ICE Report.

43. Farbey J, who gave the lead judgment in the Divisional Court (with which the other members of the Court agreed) said that the Department's failures identified in the ICE Report were "shocking" and that the withdrawal of ESA from Jodey "should not have happened" ([34]). Those were conclusions to which Farbey J was plainly entitled to come; no party to this appeal seeks to challenge them.

44. The second piece of fresh evidence is an expert report from Dr Trevor Turner, consultant psychiatrist, dated 19 November 2019. He had access to the ICE Report, Jodey's medical records and other material. He recorded Jodey's long-standing history of psychological health problems including repeated overdoses, misuse of morphine in the context of chronic back pain, depression and a presentation consistent with Borderline Personality Disorder ("BPD") characterised by "a definite tendency to act impulsively and without consideration of the consequences…". Further, BPD was characterised by disturbances in self-image, aims and internal preferences and by a tendency to self-destructive behaviour including suicidal gestures and attempts. He noted that other criteria for BPD include "excessive efforts to avoid abandonment, recurrent threats or acts of self-harm, and chronic feelings of emptiness" ([18]).

45. Dr Turner was asked a series of questions by Mrs Dove's solicitors. The third question related to the impact of the Department's negative decisions on Jodey's mental state, in answer to which Dr Turner stated that Jodey's vulnerabilities would have been "substantially affected" by the decisions of the Department, with a "likely deterioration in her mental state in terms of her negative sense of herself and her suicidal ideation", and her sense of abandonment, intrinsic to those with BPD, would have been "especially enhanced". The fourth asked Dr Turner about the existence of a causal link between the Department's failings as identified by the ICE Report and Jodey's state of mind immediately before her death, to which he replied:

> "On the balance of probabilities … I consider that there was likely to have been a causal link between the [Department's] failings … and [Jodey's] state of mind immediately before her death. This is based upon my understanding of the psychological effects on someone with a Borderline Personality Disorder and chronic pain, and the sense of isolation and abandonment that would have been reinforced by the [Department's] failings".

Divisional Court's Judgment

46. Before the Divisional Court, the Appellant advanced four grounds for seeking a fresh inquest. The focus of the case below was that the inquest should have investigated the Department's conduct in the weeks prior to Jodey's death, and that the first inquest was flawed because the inquiry conducted at that inquest was insufficient at common law; alternatively, the inquest should have been an Article 2 inquest on grounds that both the operational and the systems duty within Article 2 were breached (these were grounds 1 and 2). It was then argued that in light of the fresh evidence, a second inquest should take place because that fresh evidence served to show that the first inquest had not revealed the substantial truth about Jodey's death (ground 3) and a different conclusion would be likely at a fresh inquest (ground 4). As can be seen, the grounds of appeal before this Court are significantly narrower, touching only on parts of the previous grounds 2 and 3.

47. The Divisional Court rejected the submission that common law required a broader inquest than had in fact been undertaken and so dismissed ground 1 [77]. It rejected the submission that the first inquest should have been an Article 2 inquest holding that the Department had not assumed responsibility for Jodey, her vulnerabilities were not exceptional, and the risk to her life by suicide was of long-standing and did not engage the Article 2 operational duty ([78]-[86]). The Divisional Court held that there was no

arguable breach of the Article 2 systems duty because the Department's failings were individual, not structural or systemic in nature ([87]-[88]). In those circumstances, there was no Article 2 procedural duty ([89] per Farbey J, and [101]-[102] per Warby LJ). They dismissed ground 2.

48. As to the fresh evidence, which was the basis only of ground 3 as the grounds were understood by the Divisional Court, Farbey J held that the ICE Report had found substantial failings and there was no reason now to hold another inquest to adduce substantial further evidence about those failings ([91]). Of Dr Turner's report, Farbey J said this:

> "92. It is important to analyse what Dr Turner's report says. His conclusion is that there was likely to have been a causal link between the Department's failings outlined in the ICE report and Jodey's state of mind immediately before her death. As Mr Hough submitted, the causal link which Dr Turner draws relates to Jodey's state of mind and not to her death. Dr Turner does not go as far as to say that the Department's decision to stop Jodey's ESA caused her to take her own life. He did not rule out other stressors as causative of her suicidal state or her suicide.
>
> 93. While my sympathies go out to Mrs Dove and the family, I have to take into consideration the evidence before the court. I agree with Mr Hough that it is likely to remain a matter of speculation as to whether or not the Department's decision caused Jodey's suicide. In my judgment, it would be extremely difficult for a new inquest to conclude that the Department caused Jodey's death."

49. In a short concurring judgment, Warby LJ agreed with Farbey J and held that:

> "100. The fresh evidence does not alter the position in that respect. Indeed, rather the contrary. There has been an investigation by the ICE, leading to a detailed report which is not a private or confidential document. This shows, starkly, that there were multiple failings by staff at the Department before (as well as after) Jodey's death. The nature of the errors is clearly set out in the ICE report, and in the judgment of Farbey J, and is not in dispute. The Department does not seek to defend them. I see no reason to believe that the ICE's findings are incomplete or inadequate, or that a further coronial investigation is necessary or desirable to supplement them, or to provide further publicity, or for any other reason. Dr Turner's report links the Department's errors with the stress that Jodey was clearly suffering when she took the decision to end her life; but it would not support a finding that the Department was responsible for that decision, assuming such a finding would be open to a coroner as a matter of law."

50. Farbey J held that the first inquest was short but fair and that nothing further was required, which disposed of ground 4 ([95]).

51. Warby LJ agreed with Farbey J. The Chief Coroner agreed with both judgments. The application under s 13 for a fresh inquest was accordingly dismissed.

Ground 1: Fresh Evidence

Submissions

52. By this ground, the Appellant argues that the fresh evidence reveals at least the possibility that the abrupt cessation of Jodey's benefits was a factor that contributed to the deterioration in her mental state which led to her taking her own life. In this Court, the Appellant does not suggest that a coroner hearing a fresh inquest should embark on an investigation of the conduct of the Department; rather, it is suggested that the coroner could take the Department's failings as established by the ICE Report, which the Department does not dispute; the ICE Report sets out the sequence of failures which pre-dated (as well as those which post-dated) Jodey's death; to rely on the ICE Report as establishing those matters would be in accordance with the approach of the Divisional Court in *R (Secretary of State for Transport) v Her Majesty's Coroner for Norfolk, British Airline Pilots Association intervening* [2016] EWHC 2279 (Admin) (see [49], [56] and [57]) and is permitted by Rule 23 of the Coroner's Rules 2013). The point of the fresh inquest would be to investigate whether there was a causal connection between the failings identified in the ICE Report and Jodey's death. Dr Turner's report provides objective evidence of the sort that a coroner could rely on to make a finding about causation.

53. The Appellant relies on two cases in particular to demonstrate the breadth of a coroner's discretion to record facts which form part of the circumstances leading to death. First, in *Longfield* the Court substituted a narrative verdict which recorded a factor, namely that there was an unattended open window that the deceased fell through, which factor had formed part of the wider circumstances leading to death but was not directly causative of death (see para 15 above). The second was *R (Paul Worthington) v HM Senior Coroner for Cumbria* [2018] EWHC 3386 (Admin), where the Divisional Court upheld the coroner's decision to record in box 3 a factor which was not directly causative of death. The coroner had recorded the fact that the 4 year old child had been sexually assaulted prior to death in box 3, but held that the cause of death in box 4 was compromised breathing due to her being placed in an unsafe sleeping environment. The Divisional Court (Hickinbottom LJ, Farbey J and HHJ Lucraft QC, the Chief Coroner) refused the application for judicial review, holding that the coroner in that case was entitled to record the fact of sexual assault by anal penetration in box 3 because that fact "was essential to explain why [the child] was in the unsafe sleeping environment which caused her death" [46]. In that case, the Court repeated that the scope of a *Jamieson* inquest should not be especially narrow, and that case law established that "it is the function of an inquest to seek out and record as many of the facts concerning the death as the public interest requires" [49].

54. The Appellant also placed substantial reliance on *Davison v HM Senior Coroner for Hertfordshire* [2022] EWHC 2343 (Admin) as an example of the Divisional Court ordering a fresh inquest in light of fresh evidence. In that case, the Divisional Court (Holroyde LJ and Garnham J) directed a fresh inquest in the light of fresh evidence from a medical expert which linked diabulimia, from which the deceased had suffered, with multiple other deaths of type 1 diabetics as the deceased was. The Court ordered a fresh inquest because: there was a possibility that the fresh inquest would lead to a

PFD report, the expert's report went to an issue of public interest, the fresh evidence might lead to a different view being taken by the coroner as to whether any acts or omissions in her care may have contributed to her death, and it was possible that a different and more detailed narrative conclusion would be recorded (see [29]-[37]).

55. The Appellant argued that the Divisional Court in this case had been in error in two fundamental ways. First, the Divisional Court had adopted the wrong approach to causation by looking at whether the Department's failures caused Jodey's death, when the central question was whether those failings were a more than trivial cause of her mental health deterioration, accepting that there could be multiple causes of her ultimate death. Secondly, the Divisional Court had drawn an artificial distinction between Jodey's mental health state and her ultimate death, when these were really one and the same, with a deteriorating mental state being the reason for her death. The Appellant invited this Court to allow the appeal and order a fresh *Jamieson* inquest to investigate the issue of causation of Jodey's mental health crisis that she must have suffered just before she took her own life.

56. The Coroner submitted that the focus of an inquest should be on the means of death. *Longfield* and *Worthington,* the high points of the Appellant's case on appeal, were both examples of coroners recording a fact which had contributed to death in a physical sense: the open window in *Longfield,* the assault leading to an unsafe sleeping environment in *Worthington*. This court had been shown no case, and Mr Hough was not aware of one, where a coroner had recorded factors contributing to a deteriorating mental health state leading to suicide. To allow this appeal and direct a second inquest to investigate that matter would be to extend the existing jurisprudence substantially; further, such an extension would pose practical difficulty for coroners in future, because they might come under pressure to investigate the causes of a person's psychiatric problems in suicide cases, which in many cases would be a difficult and controversial task.

57. The Coroner accepted that the Appellant did not need to show that a different verdict would be probable, but still the possibility of that was still a matter of the first importance, (noting *R (Mulholland) v HM Coroner for St Pancras* [2003] EWHC 2612 (Admin) at [27]). Coroners are generally encouraged to use short-form verdicts and there was every chance that a second inquest into Jodey's death would come to exactly the same conclusion as the first because there was no dispute that she took her own life. *McDonnell v HM Assistant Coroner for West London* [2016] EWHC 3078 (Admin), 154 BMLR 188 was an example of a second inquest being refused as not being in the interests of justice, partly on grounds that the issues would be overly complex to summarise neutrally in a narrative verdict.

58. The Coroner submitted that the ICE Report went to the Department's failings which lay outside the proper scope of an inquest, as the Coroner had correctly indicated. Further, Dr Turner's report merely buttressed evidence which was already before the Coroner from Jodey's family as to the causal connection between the withdrawal of benefits and her death by suicide. It had therefore been open to the Coroner to make a finding of causation and Dr Turner's evidence was not really fresh evidence at all.

Discussion

59. For the reasons set out below, I have reached the conclusion that the appeal on the first ground should be allowed and that a fresh *Jamieson* inquest into the death of Jodey should be ordered pursuant to s 13.

The evidence before the first inquest

60. The sequence of events in the weeks prior to Jodey's death is not disputed and it is summarised above at paras 20-37 above. There is clear evidence that Jodey was anxious and upset at being told that her benefits were being cut off: this is what Mrs Dove told the Coroner in her oral evidence and what Mrs Dove says in her witness statement prepared for the Divisional Court. There is also clear evidence that Jodey was worried about money in the days before her death: again, Mrs Dove said so at the inquest, she says so in her witness statement for the Divisional Court, and the notes Jodey left behind contain references to her inability to pay her bills.

61. However, there was no evidence before the Coroner, beyond the assertions of Mrs Dove and family members, to link Jodey's death in any way with the fact that the Department had stopped her benefits.

The Evidence Now Available

62. There are two pieces of fresh evidence. The first is the ICE Report. The sequence of events involving the Department is known and although those events are conveniently set out in the ICE Report, those events can be traced from other evidence. The novel information contained in the ICE Report relates to the reasons why Jodey's benefits were cut off suddenly. It is now accepted that the Department should not have stopped Jodey's benefits. It is also accepted that the Department's failings were extensive, both before and after it stopped her benefits with effect from 7 February 2017.

63. The Coroner ruled that the Department's failings were not relevant to the *Jamieson* inquest she was conducting. That conclusion is not under challenge in this appeal. It seems to me that it was well within the Coroner's discretion to conclude that the Department's failings lay outside the remit of the inquest. That conclusion is unaffected by the fact that the Department's failings have now been extensively investigated and listed in the ICE Report: they still lie outside the remit of the inquest. I do not think the *Norfolk* case on which Mr Hyam relied assists the Appellant, because in that case, the Coroner did wish to investigate the reasons why the helicopter had crashed killing all on board, considering that raised issues under Article 2 (see eg [36] and [49]) – in other words, the issue of failings was very much within the remit of that inquest.

64. Accordingly, if a second inquest were to be ordered, it would be for the coroner conducting that inquest to decide whether to admit the ICE Report to provide background evidence. It would certainly be open to the coroner to do so and there is good reason why a coroner might wish to do so: it would help to clarify the sequence of contacts between the Department and Jodey prior to her death, and it would set the backdrop to the inquest accurately by establishing that Jodey should not have had her benefits stopped with effect from 7 February 2017. But beyond acknowledging that fact, I doubt that the coroner would wish to investigate the Department's conduct

further; the specifics of individual errors and breaches of policies of the Department would appear to me to lie beyond the scope of any *Jamieson* inquest.

65. The position in relation to Dr Turner's report is different. Dr Turner provides expert evidence about the way in which the abrupt cessation of benefits is likely to have affected Jodey's state of mind. That seems to me to be an issue well within the scope of a *Jamieson* inquest. It goes to the issue of intention, which is one of the elements which has to be established at the inquest before a conclusion of suicide is entered (see para 19 above). Further, that evidence would undoubtedly assist the coroner in deciding whether to enter a narrative conclusion in addition to, or an alternative formulation of, that conclusion, to reflect the extreme anxiety and distress that Jodey might have been suffering in the moments before she took her own life (see again para 19 above). If it had been available at the first inquest, I have no doubt Jodey's family would have invited the Coroner to have had regard to it.

66. I accept Mr Hyam's twin submission that it would be open to a coroner presiding over a fresh inquest and with the benefit of Dr Turner's report (whether or not that report is contested) (i) to find as a fact that the sudden withdrawal of benefits by the Department contributed to the deterioration in Jodey's mental health state; and (ii) if that fact was found, to include reference to that fact within the conclusions part of the record of inquest (by including it at box 3 or as part of a narrative conclusion in addition to or substitution for the short-form conclusion of suicide in box 4). Mr Hyam suggested, by way of example, a narrative conclusion along the lines of: "the deceased took her own life as a result of a deterioration in her mental state exacerbated by the abrupt cessation of her ESA on 7 February 2017 by the Department"; that is a brief, neutral, factual statement which I accept would be open to a Coroner to adopt on the basis of Dr Turner's evidence, assuming his evidence was accepted.

67. I do not consider Mr Hough's submission that it was open to the Coroner to make those findings at the first inquest to be realistic. The subjective evidence of family members about why Jodey was moved to take her own life is a forensic world away from evidence of an expert psychiatrist who can speak with objectivity, drawing on long clinical experience, about the likely impact on the deceased's established mental illness of actions by third parties such as the Department. The Coroner lacked evidence of the latter type; that evidence is now available and could reasonably provide the basis for the findings Mr Hyam seeks at a fresh inquest.

The Divisional Court

68. Before turning to the central question of whether a fresh inquest should be directed in this case, I deal with Mr Hyam's two criticisms of the Divisional Court's judgment in relation to ground 3 as it was before that Court. On his first criticism, I agree with him that no sharp distinction can sensibly be drawn, in this case at least, between Jodey's mental health prior to death and her death by suicide. Her suicide was the end point to which her mental health problems brought her. I would accept that the Divisional Court were in error to the extent that they suggested that mental health deterioration could be separated from death and in appearing to dismiss Dr Turner's evidence as irrelevant because it only went to her state of mind and not to her death (see eg Farbey J at [92]).

69. On his second criticism, he points to the Divisional Court's focus on whether the Department's conduct "caused" or was "responsible for" Jodey's suicide (see Farbey J

at [93] and Warby LJ at [100]). The point made by Mr Hyam, with which I agree, is that causation is a broader concept, which encompasses acts or omissions which contribute (more than trivially) to death and that it is open to a coroner in a suicide case to consider the extent to which acts or omissions contributed to the deceased's mental health deterioration, which in turn led them to take their own life. There are two strands to this argument. The first relates to the test of causation in an inquest. In this Court, it is not disputed that causation in the context of an inquest means a material or more than trivial contribution (see the summary at para 18 above). To the extent the Divisional Court approached causation on the basis of whether the death would have occurred "but for" the particular act or omission, they were in error.

70. The second relates to whether a coroner is permitted to investigate causation of mental health deterioration at all. Mr Hough resists Mr Hyam's submission that a coroner can look at factors which contributed to mental health deterioration, suggesting that it is not or should not be open to a coroner to investigate the impact of past events on a person's mental health in a suicide case, and that to do so would represent an extension of the law which would be unwelcome and unnecessary. I am not with Mr Hough on this point for the following reasons. First, existing authority shows that it is open to a coroner to record the facts which contributed to the circumstances which may or may not in turn have led to death: the unattended open window in *Longfield*, the sexual assault in *Worthington*. These cases provide examples of the wide discretion conferred on coroners to establish the background facts, and then determine whether those facts were or were not causative of death. These are examples of coroners tailoring the scope of an inquest to the issues in the case in order to discover the 'substantial truth' (as it was put in the *Hillsborough* case). Secondly, I find no support for Mr Hough's suggestion that a distinction must be drawn between physical causes (such as the open window in *Longfield* or the fact of assault in *Worthington*) and psychiatric causes which might have exacerbated mental illness. We were shown no case to support such a distinction. I believe such a distinction lacks principle: the discretion to consider contributory factors cannot depend on the form those factors take. Thirdly, I believe it would be undesirable to restrict a coroner's discretion to conduct whatever investigations are appropriate within the ambit of a *Jamieson* inquest to establish "how" the deceased came by their death, yet such a restriction is the inevitable consequence of what Mr Hough suggests. The Court was taken to at least one example of a coroner recording that a person had taken their own life while suffering from anxiety and depression exacerbated by actions of the Department (see the narrative verdict delivered by the Senior Coroner for Inner London North in the case of Michael O'Sullivan on 7 January 2014); I see no reason to consider that was beyond the scope of that coroner's discretion in that case. Fourthly, in cases like this, where suicide is raised as a possible verdict, part of the coroner's role is to investigate whether the deceased intended to take their own life, and that will often lead to a consideration of whether the deceased acted while their mind was disturbed, with that fact being recorded if it is established, see para 19 above. An investigation of the cause or causes of disturbance of the mind may therefore be part of, or lie very close to, the matters which are already before the coroner.

71. It may be that the passages from the Divisional Court's judgments which Mr Hyam criticises reflect the different way the case was argued before that Court. But I am with Mr Hyam on the basis of his arguments before this Court and I conclude that in two

respects the Divisional Court was in error in its approach to the fresh evidence, particularly that of Dr Turner.

Necessary or desirable in the interests of justice

72. I come then to the statutory test: is it necessary or desirable in the interests of justice that a further inquest into Jodey's death should be held? The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires (*Sutovic*), it is to establish the 'substantial truth' (*Hillsborough*). I think it is in the interests of justice that Mrs Dove and her family should have the opportunity to invite a coroner, at a fresh inquest, to make a finding of fact that the Department's actions contributed to Jodey's deteriorating mental health and, if that finding is made, to invite the coroner to include reference to that finding in the conclusion on how Jodey came by her death (in box 3 or 4 of the record of inquest). I do not consider that to be necessary, but I do consider it to be desirable. I reach that conclusion for the following reasons. First, the extent to which the Department's actions contributed to Jodey's mental health is a matter of real significance to Mrs Dove and her family. It is reasonable for them to press for that matter to be investigated as part of the inquest into Jodey's death. The coroner may or may not make the findings which Jodey's family seeks, but either way, this is part of determining the 'substantial truth'. Secondly, there is a public interest in a coroner considering the wider issue of causation raised on this appeal. If Jodey's death was connected with the abrupt cessation of benefits by the Department, the public has a legitimate interest in knowing that. After all, the Department deals with very many people who are vulnerable and dependent on benefits to survive, and the consequences of terminating benefit payments to such people should be examined in public, where it can be followed and reported on by others who might be interested in it. Thirdly, if the findings the family seeks are made, it is at least possible that the coroner will wish to submit a PFD report to the Department. It is in the public interest that the coroner at least be given the opportunity to consider whether a PFD report is warranted, in light of the fact that Jodey's benefits were cut off abruptly, in error, as we now know. If the coroner concluded that the error had contributed in any way, direct or indirect to Jodey's death, that would be a serious matter to which the Department should be alerted, in order that remedial steps can be taken. Indeed, it may be that the coroner will wish to hear from the Department at the second inquest about any remedial steps which have already been taken in light of the ICE Report and as part of the coroner's consideration of whether to make a PFD report. Overall, I agree with Mr Hyam that this case bears similarities with *Davison*, where the fresh evidence raised issues of potentially wider significance and the public interest favours directing a fresh inquest.

73. I accept that the verdict at any future inquest may not be different but this is not a reason not to direct a second inquest, as the *Hillsborough case* makes clear. The passage in *Mulholland* on which Mr Hough relies is, in my judgment, overtaken by the wider statement of principle contained at [10] of *Hillsborough* (see para 9 above). *McDonnell* was a very different case on its facts, and the refusal of the court in that case to direct a second inquest has no bearing on the decision in this Court.

74. For those reasons, based on the fresh evidence provided by Dr Turner, I conclude that a fresh inquest is desirable in the interests of justice.

Ground 2: Article 2

75. For the reasons set out below, I have reached the conclusion that the appeal on ground 2 should be dismissed. This is because the Department owed Jodey no Article 2 operational duty. The evidence in this case does not meet the criteria necessary to establish that such a duty exists. In the absence of any operational duty, it is not necessary to consider questions of arguable breach.

Article 2 Operational Duty

76. Article 2 of the Convention provides that everyone's right to life shall be protected by law. It prohibits the taking of life by a state without justification and requires the state to take positive steps to protect life including in some circumstances to prevent a real and immediate risk to life (including a risk of suicide): this is called the operational duty.

77. A number of domestic cases have recently examined the Article 2 operational duty. The key ones to which we were referred are: *R (Maguire) v Blackpool and Fylde Senior Coroner* [2020] EWCA Civ 738, [2021] QB 409 (Court of Appeal, Lord Burnett CJ, Sir Ernest Ryder and Nicola Davies LJ), *R (on the application of Gardner) v Secretary of State for Health and Social Care* [2022] EWHC 967 (Admin), [2022] 4 All ER 896 (Divisional Court, Bean LJ and Garnham J) and *R (Morahan) v HM Assistant Coroner for West London* [2022] EWCA Civ 1410, [2023] 2 WLR 497 (Court of Appeal, Lord Burnett CJ, Nicola Davies LJ and Baker LJ). In those cases, the Court considered the line of authority starting with *Osman v United Kingdom* (2000) 29 EHRR 245 at [115], which case was considered by the Supreme Court in *Rabone v Pennine Care NHS Trust* [2012] 2 AC 72. *Rabone* established the criteria which define the existence of an Article 2 operational duty; see the judgment of Lord Dyson JSC at [21] to [24].

78. For present purposes, it is sufficient simply to refer to the summary of the *Rabone* criteria which appears in *Gardner*, to which Mr Hyam referred:

> "250. We draw the following from the domestic and Strasbourg cases which we have cited:
>
> (i) A real and immediate risk to life is a necessary but not sufficient factor for the existence of an art 2 operational duty;
>
> (ii) Generally, the other necessary factor is the assumption by the State of responsibility for the welfare and safety of particular individuals, of whom prisoners, detainees under mental health legislation, immigration detainees and conscripts are paradigm examples since they are under State control;
>
> (iii) However, the duty may exist even in the absence of an assumption by the State of responsibility, where State or municipal authorities have become aware of dangerous situations involving a specific threat to life which arise exceptionally from risks posed by the violent or unlawful

> acts of others (*Osman*) or man-made hazards (*Oneryildiz, Kolyadenko*) or natural hazards (*Budayeva*), or from appalling conditions in residential care facilities of which the authorities had become aware (*Nencheva, Campeanu*);
>
> (iv) *Watts* suggests that, in appropriate circumstances (which remain so far undefined), the operational duty may also arise where State or municipal authorities engage in activities which they know or should know pose a real and immediate risk (according to *Maguire*, an exceptional risk) to the life of a vulnerable individual or group of individuals."

79. This Court must abide by the *Ullah* principle (*R (Ullah) v Special Adjudicator* [2004] UKHL 26, [2004] 3 All ER 785) that courts should, absent some special circumstances, follow any clear and consistent jurisprudence of the Strasbourg court, to keep pace with the developing jurisprudence of that Court, but do no more than that (see *Gardner* at [251]). The issue for this Court is therefore whether there is a clear and consistent line of Strasbourg authority which shows that the operational duty exists on facts such as those involved in this case.

Submissions

80. The Appellant says that the Department was under an operational duty to protect Jodey's life, which duty was arguably breached by the abrupt termination of benefits. Core to this submission is the history of failings by the Department which are highlighted in the ICE Report. Mr Hyam says that there should be a fresh inquest under Article 2, to consider not just how Jodey came by her death but also in what circumstances she came by her death, as required by s 5(2) of the 2009 Act. This would permit the coroner to consider the impact that the Department's "shockingly bad treatment" had on Jodey.

81. Mr Hyam accepts that Jodey was not in state detention, which is the paradigm situation where the state owes an operational duty to protect life, but nonetheless he argues that the *Rabone* criteria are met on the facts of this case because Jodey was vulnerable, as the Department knew and there was an obvious risk to her life in consequence of her long-term mental health difficulties including self-harm. From *Rabone*, he noted passages from Lord Dyson and Lady Hale's judgments which make the point that detention or custody is not a pre-requisite for the operational duty to exist. He took us to a number of cases outside the detention setting and argued that by analogy with the facts of those cases, Jodey was owed an operational duty by the Department to protect her against the risk that she would take her own life, and that the Department breached that duty when it withdrew her benefits peremptorily.

82. Mr Hyam further submitted that serious suffering caused by preventing access to benefits can be a breach of Article 3, citing *R (Limbuela) v SSHD* [2006] 1 AC 396 and other cases. He said there was no proper basis for distinguishing between Articles 2 and 3 in this context.

83. Mr Hough suggests that there is no clear and consistent line of Strasbourg case law which suggests that the operational duty arises on facts like those present in this case. The state does not generally owe an Article 2 operational duty to prevent a person who

lives independently from taking their own life, citing *Rabone* at [100]. None of the cases on which the Appellant relies are truly analogous with this case. Article 3 cases are not relevant because they concern the state's responsibility to provide food and shelter (and to avoid destitution); they are not concerned with protection from the different harm of suicide.

84. Mr Dixey supports the submissions advanced for the Coroner. He says that no operational duty existed in this case, and that the Appellant's case on Article 2 amounts to a suggested significant extension of the existing case law.

Discussion

85. Despite Mr Hyam's engaging submissions on the law, in my judgment this ground falls to be determined first and foremost on the facts. There is no other case which comes close to this one on its facts. The issue for this Court is therefore whether the basic ingredients of an Article 2 operational duty, as they are outlined in *Rabone,* are present. If they are present, even arguably, it might then be necessary to decide whether this case represented the sort of incremental development of the law that Lord Dyson referred to in *Rabone;* but not otherwise.

Real and Immediate Risk to Life / Actual or Constructive Knowledge of that risk

86. The first two *Rabone* criteria, as they are summarised in *Gardner* (see para 78 above) relate to the existence of a real and immediate risk to life, of which the State has actual or constructive knowledge. As is clear from the policy documents attached to Ms Varney's witness statement (see para 38 above), the Department had arrangements in place for dealing with vulnerable benefit claimants. The Department defined vulnerable persons as those who had complex needs or required additional support to enable them to access benefits and services. The procedure was for cases involving vulnerable persons to be flagged. Further, a person with mental health needs affecting their capability for work was granted an additional amount of benefit, known as the support group component. Jodey was flagged and received the support group component from 2014 onwards. But this fact alone would not be sufficient to show that there was any real or immediate risk to that person's life arising from suicide. More would be required.

87. The exchanges between Jodey and the Department are summarised at paras 21-37 above. In 2014, Jodey completed and returned to the Department a form in which she wrote that most days she wanted kill herself and if the doctors did not get her pain under control, she planned to kill herself. Her GP confirmed on 8 September 2014 that she had an emotionally unstable personality and constant stress, low mood and anxiety. When her benefits were due for review in 2016, she wrote "I have suicidal thoughts a lot of the time and could not cope with work or looking for work". Her GP told the Department that she went to a crisis team for mental health difficulties in June 2016 due to her mental health issues but had been discharged 10 days later demonstrating nil suicide intent or thoughts. The GP confirmed in August 2016 that Jodey appeared to be making an effort to be stable and in October 2016 was appropriately dressed and was walking with only one stick. After the missed work capability assessment appointment on 16 January 2017, Jodey wrote to the Department saying that she had not received the appointment letter and had been housebound with pneumonia and had a cyst on the brain. She telephoned the Department on 10 February 2017 and said she was ill in

hospital. On 13 February 2017, she requested a reconsideration of the decision to withdraw benefits and asked for a new appointment.

88. There is no suggestion that in any of these contacts the Department were put on notice that Jodey was at real and immediate risk. To the contrary, although suicide was mentioned in some of the exchanges in 2014 and 2016, the exchanges which immediately preceded her death in 2017 were not, so far as this Court is aware, centred on her ideas of suicide. There was no indication in any of her dealings with the Department in the weeks and days prior to her death that her mental state was acutely deteriorating or that she had become exceptionally vulnerable in the days before her death.

89. On the evidence before this Court, there is no proper basis for concluding that the Department, at the material time, knew or ought to have known that Jodey was at real and immediate risk of her life.

90. Indeed, it appears that no one around Jodey was aware that she was at real and immediate risk immediately before she took her own life. According to Mrs Dove's statement, Jodey's daughter Emma had offered to let Jodey stay at her house overnight on 20 February 2017 but Jodey had declined that offer. Mrs Dove had spoken to her daughter that same evening and recognised that she needed some extra support. But it came as a terrible shock to Mrs Dove and her family when Jodey was found dead in her own home on 21 February 2017. The evidence suggests that the real and immediate risk that she would take her own life was unknown to anyone.

Sufficient Connection / Assumption of Responsibility

91. The third *Rabone* criterion relates to the state's assumption of responsibility for the individual (noted in *Maguire* to be the unifying feature of the operational duty: see [72]). The policy documents before us demonstrate the Department's arrangements for dealing with vulnerable persons as defined in the policies described above. But none of those policies, even assuming they were correctly implemented, indicates that the Department assumed responsibility for Jodey, or indeed for any vulnerable person who is in receipt of benefits. The fact that the Department is the agency responsible for administering the welfare benefits system does not of itself involve any assumption of responsibility to safeguard against the risks of suicide or self-harm by any of the many millions of persons with whom the Department has dealings.

Conclusion on Ground 2

92. On the evidence, the requisite ingredients for the existence of an Article 2 operational duty are not present. She was vulnerable, but not known by the Department or anyone else to be especially vulnerable at the time, no one appreciated that she might have been at immediate and real risk to her life, and she was not under the responsibility of the state at or prior to her death. There was no operational duty in existence. This is in essence to confirm the view reached by the Divisional Court at [79]-[86].

93. That is not to ignore the multiple failings on the part of the Department. The Department accepts that individuals within the Department failed to follow the relevant systems and policies at crucial points. But that does not render the Department responsible for Jodey under the Convention.

Disposal

94. I would allow this appeal on ground 1 only and direct a fresh *Jamieson* inquest to be conducted by a different coroner to consider how Jodey came by her death. I would dismiss this appeal on ground 2.

LORD JUSTICE WILLIAM DAVIS

95. I agree with the judgments of Whipple LJ and Lewis LJ.

LORD JUSTICE LEWIS

96. I agree that the appeal should be allowed on ground 1 for the reasons given by Whipple LJ. The appeal arises out of the tragic death of Jodey Whiting on 21 February 2017 in Stockton-on-Tees. There was an inquest. The coroner decided, and it is accepted, that the medical cause of death was the effects of an overdose of morphine, amitriptyline and pregabalin. The conclusion of the coroner was that the death was suicide. The issue that arises now concerns Jodey's mental state at the time that she took the overdose of drugs. Jodey had an underlying mental health condition and also suffered chronic pain from a back condition. She also had other problems in her life. In addition, in February 2017, the Department determined that Jodey was no longer eligible for ESA and withdrew that benefit. The question which arises on this appeal is whether it is necessary or desirable for there to be a new inquest in the light of fresh evidence so that the coroner, if he or she considers it appropriate to do so, can consider whether there was any factual connection or link between the withdrawal of benefits and the deterioration in Jodey's mental health in the period immediately before her death.

97. The case put on behalf of the Appellant in this Court is different from, and narrower than, that put forward in the Divisional Court. In particular, it is not now asserted that the coroner needs carry out an inquiry into the Department's systems and policies. It is not said that the coroner should investigate the failings on the part of the Department which led to Jodey's benefits being withdrawn. Those matters have been the subject of an investigation by an independent case examiner. That investigation concluded that there were multiple failings on the part of the Department in the way it dealt with the withdrawal of benefits including, but not limited to, failing to telephone Jodey, or to consider a home visit, when Jodey did not attend a face to face work capability assessment. The Divisional Court held that the Coroner had concluded that she was not required to investigate the role of the Department, and the new evidence, comprising in particular, the report of the independent case examiner and the evidence of Dr Turner, a consultant psychiatrist, did not alter that position: see [100] in the judgment of Warby LJ, with whom HHJ Teague KC, the Chief Coroner, agreed.

98. The arguments in this appeal are narrower. The relevant new evidence is that of Dr Turner. That evidence is that Jodey was suffering an underlying mental health condition, namely borderline personality disorder, and chronic pain from physical conditions. She had other difficulties in her life at that stage. Dr Turner's evidence is that Jodey would have experienced shock and distress at the withdrawal of her welfare benefits and that the effect would have been heightened by her current difficulties, her isolation and pain, and her emotional instability resulting from her underlying mental health condition. Jodey's vulnerabilities would in his opinion have been substantially affected by the withdrawal of benefits with a likely deterioration in her mental state.

99. On balance, I am satisfied that it is desirable for there to be a new inquest given this fresh evidence. Although not necessary to have a fresh inquest, it is desirable because it is appropriate for an opportunity to be given for a coroner to consider whether or not he or she accepts the evidence of Dr Turner and, if so, whether he or she considers that it is appropriate to make findings of fact about Jodey's mental state, and any link or connection between the withdrawal of the welfare benefits and her mental state in the period leading up to Jodey's death. Those will be matters for the coroner to consider at a fresh inquest. The coroner will need to observe the limitations imposed on coroners by sections 5(3) and 10 of the Coroners and Justice Act 2009, and those recognised in the case law to the effect that any such findings will be short, factual statements expressing no judgment or opinion (see *R v North Humberside Coroner ex p. Jamieson)* [1995] Q.B. 1 at page 24F-G).

100. In relation to ground 2, I agree that there is no arguable duty owed by the Department under the Convention on the facts of this particular case.