June 2019

briefing

Inquests following a death in custody or detention

Introduction

Many prison healthcare facilities and services are routinely contracted out to NHS or independent healthcare providers. When a person dies in custody there will always be an inquest. Consequently it is inevitable that these providers, their medical and nursing staff as well as their respective indemnity providers or insurers will become involved in not only the internal investigations that follow such deaths, but also the Coronial inquiries or inquests that occur. Prison staff, the police and others may well be involved.

Such inquiries can take time, especially those heard with a jury. They can also cost a lot of money both in staff time involved in the process and legal fees for representation.

It is open to a Coroner to hold what I will describe as a straightforward hearing, relying on written testimony, where the evidence supports this. If a Coroner decided to hold such a hearing in the face of evidence that suggested an unnatural or violent cause of death or a failing in the provision of care to the deceased that might have a bearing on the death then he might expect that decision to be challenged by way of Judicial Review.

Of the 250 deaths that occur in the prisons in England and Wales each year, over two thirds are from natural causes. A very small number result from violence, or are otherwise unnatural, and between a quarter and a third are from suicide.

Background

In the case of *Tyrrell v HM Senior Coroner County Durham and Darlington* [2016], the issue was a question of what Article 2 of the European Convention on Human Rights (ECHR) requires of a Coroner when a prisoner dies of natural causes. The answer to this question is of interest to all those involved in the provision of healthcare services to the prison population and their insurers.

The claimant argued that the Coroner was required to conduct what is described as a “Middleton inquest”, a reference to the decision of the then *House of Lords in R (Middleton) v West Somerset Coroner* [2004]. The argument was based on the fact of the death having occurred in custody, there was a sufficient trigger for an obligation to conduct an Article 2 compliant inquest as described in the Middleton case.

Michael Tyrrell, the claimant’s father, died of pneumonia secondary to cancer on 30 May 2013. He was in hospital at the time but in custody and under guard. An investigation that looked at the quality of care provided to the deceased concluded the death was a natural one. Having regard to that report the Coroner obtained evidence from treating doctors which supported a conclusion of death from natural causes and determined that Article 2 ECHR was “not engaged”.

Consequently the inquest was relatively straightforward, with evidence from statements of the treating doctors. The Coroner recorded a conclusion of death by natural causes. It is the decision that Article 2 was not engaged that lies at the heart of the challenge (by way of Judicial Review) by the claimant in this case.

It was accepted that there was nothing in the circumstances of this case which suggested any systemic failing on the part of the prison authority to provide appropriate medical care to the deceased. It was also accepted that there was no support for any suggestion that the care provided by the National Health Service was sub-standard or that there was negligence on the part of treating doctors. It was also accepted that if the deceased had not been in custody but had received precisely the same care and treatment from the NHS as a patient at liberty, then there would have been no obligation under Article 2 for the Coroner even to hold an inquest.

As the judge found, “Mr Stanbury” [counsel for the claimant] “was unable to identify any practical difference between the investigation in fact conducted by the Coroner into this sad death, including the short inquest, and one which would have followed had the Coroner decided that “Article 2 was engaged” in the sense that the procedural obligation was triggered by the death”.

Human Rights

A “Middleton” type inquest is not concerned with the scope of the inquiry at an inquest but with the outcome, and in particular whether Article 2 ECHR required an expansion of the conclusions with which the inquest should culminate. In the Middleton case, the House of Lords concluded that the only change required to the coronial regime was that such 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” which would be achieved by interpreting the words “how the deceased came by his death”, which was and is the relevant statutory formulation, to mean not simply “by what means” but “by what means and in what circumstances.”

As to the means and circumstances, Mr Tyrrell was 65-years-old when he died having been sentenced to 26 years’ imprisonment in 2002 for drugs importation. He moved to HMP Frankland in June 2005. In May 2012 he complained of a sore throat and was diagnosed with a dental infection which resulted in the removal of some teeth in June. With persisting pain, a specialist ear, nose and throat investigation found nothing abnormal. A maxillofacial specialist was next involved with Mr Tyrrell referred for an MRI scan in February 2013. None of those who had seen Mr Tyrrell had suspected that he might be suffering from cancer. Before the scan was carried out, Mr Tyrrell’s condition deteriorated and so he was admitted to hospital. On 4 March 2013 an exploration under anaesthetic was performed which revealed a malignant tumour under the tongue. A CT scan followed which confirmed that the mass was four centimetres across. The lymph nodes were involved, as was confirmed on post-mortem. Chemotherapy and radiotherapy were undertaken but Mr Tyrrell developed bilateral pneumonia which was the immediate cause of death.

His death was notified to the Coroner, and an inquest was opened and adjourned. The death was also notified to the PPO. The PPO is a non-statutory body which operates to investigate any death of a person in custody. A clinical review was commissioned by the PPO, which concluded that the diagnosis of the terminal illness was made appropriately and that the post-diagnosis treatment was conducted to an appropriate standard.

The report, including the clinical review, was provided to the Coroner. The post-mortem examination report established the cause of death, which was uncontroversial. The Coroner commissioned additional medical evidence with a view to exploring further the question whether the diagnosis of Mr Tyrrell’s cancer had been timely. Two pre-inquest reviews were held. In May 2014 the claimant instructed Professor Christopher Nutting, Clinical Director and Head of Neck and Lung Cancer Units at the Royal Marsden Hospital, to conduct a complete review of the treatment received by Mr Tyrrell. He reported on 5 August 2014. He described the tumour as relatively rare and notoriously difficult to diagnose. Although the original throat pain was likely to have been caused by the early development of a tumour, Professor Nutting was not critical of the various medical staff who dealt with Mr Tyrrell. It was not until mid-

February 2013 that the symptoms were such that a diagnosis became feasible, although it was not suspected by the clinicians.

Professor Nutting's report provides no foundation for any suggestion of negligence on the part of the many medical practitioners who examined or treated Mr Tyrrell in the year before his death, still less of any systemic failings in the medical care provided by or through the prison medical services or the NHS.

The Coroner

The functions and duties of Coroners are now set out in the Coroners and Justice Act 2009 (the 2009 Act). By section 1(2) the Coroner is under a duty to investigate three categories of death:

- Those where the deceased died a violent or unnatural death
- Those where the cause of death is unknown
- Those where the deceased died whilst in custody or otherwise in state detention

Section 4 requires the Coroner to discontinue the investigation if a post-mortem examination reveals the cause of death and the Coroner considers that it is unnecessary to continue the investigation. However, that requirement does not apply to deaths which were violent or unnatural or when the deceased died in custody or otherwise in state detention.

Thus the effect of section 4 is that there must always be an inquest into the death of someone who has died in custody or otherwise is state detention.

Europe

The Strasbourg Court has considered the positive obligation to protect life under Article 2 in the context of deaths in custody attributable to poor medical facilities or treatment. The positive obligations require states to make regulations compelling hospitals and care providers, including those providing care to prisoners, whether private/independent or public, to adopt appropriate measures for the protection of patients' lives. They also require an effective independent judicial system to be set up so that the cause of death of patients in the care of the medical profession, whether in the public or the private sector, is investigated, and those responsible made accountable. Furthermore, where a hospital is a public institution, the acts and omissions of its medical staff are capable of engaging the responsibility of the respondent state under the Convention.

The positive obligations under Article 2 encompass a duty to account for the cause of any death which occurs in custody. The procedural obligation arises only in circumstances where the responsibility of the state is engaged in the sense that there is reason to believe that the substantive positive obligations (identified by Lord Bingham in the Middleton case) have been breached by the state. In the case of deaths in custody the procedural obligation will be triggered in the case of all suspicious deaths, including apparent suicides. The essence was captured by Lord Bingham in para 6 of the Middleton case:

> "*The death of any person involuntarily in the custody of the state, otherwise than from natural causes, can never be other than a ground for concern*."

Conclusions

It follows that the Coroner was correct to decline to conclude that the procedural obligation under Article 2 was engaged. The evidence was unequivocal that the death of Mr Tyrrell was from natural causes. There was no reason to

suppose that the state, in the guise of the prison authority, had failed to protect his health and wellbeing. On the contrary, the indications were that he had received appropriate treatment both within the prison and from the NHS.

There is nothing in domestic authority which requires a different conclusion from that suggested by the Strasbourg jurisprudence so the Coroner was correct to rule that the procedural obligation under Article 2 ECHR did not arise in this case. It would not arise in any case where it is established that the death arose from natural causes and there is no reason to believe that the state failed to protect the life of the prisoner in question.

On 5 January 2015, the Chief Coroner published advice to Coroners relating to the deaths in prison and the need for a post-mortem examination. He indicated that where "a death may be unnatural or suspicious, the Coroner should request a forensic post-mortem examination." He continued: "On the other hand where a patently natural death has occurred there may be no need to request a forensic examination. For example, where a member of the increasingly elderly prison population dies expectedly after a long illness, there may be no need for a forensic post-mortem examination. There may be no need for a post-mortem at all."

There is no guidance directly on the question whether all deaths in custody attract the procedural duty under Article 2 ECHR but the Chief Coroner has issued guidance (Guidance No. 16) for those who die subject to Deprivation of Liberty Safeguards (DoLS):

> "*The mere fact that the inquest will be concerned with a death 'in state detention' does not mean that it will necessarily be an Article 2 inquest. In some cases it may be. But in many cases, particularly those where the death is from natural causes, there will be no arguable breach of the state's general duty to protect life."*

Please note that new guidance has been issued for those who die subject to DoLS after 3 April 2017 (Guidance No. 16a) which concludes that with a death occurring on or after 3 April 2017 any person subject to a DoL is no longer 'in state detention' for the purposes of the 2009 Act. This means that an inquest does not automatically need to be held.

Useful links

Tyrrell v HM Senior Coroner County Durham and Darlington
House of Lords in R (Middleton) v West Somerset Coroner
Coroners and Justice Act 2009
Article 2 ECHR
Chief Coroner Guidance No. 16
Chief Coroner Guidance No. 16a

Mills & Reeve on-line inquest support

You will find this guidance and a lot more information and guidance documents on our free on-line support page.

There is also a set of videos with top tips on what to do and others tell their stories of who they got through the process. All designed to make it a little bit easier for you.

Follow the link or type in:
https://www.mills-reeve.com/foresight/inquests/information-on-inquests

Recent Feedback

"I'm most grateful for your support during the Inquest. It was outstanding."
Executive Director Forensic Services, NHS Client

"I feel genuinely privileged to know that you are on our team and offer my heartfelt thanks"
Dr Stephen Merron, Consultant Anaesthetist, University Hospital North Midlands NHS Trust

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