Queen's Bench Division

Regina (Speck) *v* HM Coroner for the District of York

[2016] EWHC 6 (Admin)

2015 Nov 3; 2016 Jan 12 Sir Brian Leveson P, Holroyde J

Coroner — Inquest — Coroner's duties — Scope of duty to investigate death in custody — Whether duty to investigate matters which might possibly have contributed to death — Whether duty to investigate whether absence of provision of place of safety contributing to death — Mental Health Act 1983 (c 20), s 136(1) — Human Rights Act 1998 (c 42), Sch 1, Pt I, art 2 — Coroners and Justice Act 2009 (c 25), s 5, Sch 5, para 7

The police removed the deceased to a local police station, as a consequence of her erratic behaviour in a public place, pursuant to powers under section 136(1) of the Mental Health Act 1983[1], and placed her in a custody cell where she was later found dead. The coroner determined at a preliminary inquest hearing that issues as to why the local authority did not have in place a more appropriate designated health-based place of safety to which she could alternatively have been removed, and perhaps treated, fell outside the scope of the inquest as being too far removed from causation as provided by section 5 of the Coroners and Justice Act 2009[2]. The claimant, the deceased's mother, sought judicial review of the coroner's ruling, contending, inter alia, that the primary care trust had had a duty to provide a health-based place of safety and that the coroner had wrongly excluded consideration of the issue whether the absence of a place of safety had contributed to the deceased's death. It was common ground that article 2 of the Convention for the Protection of Human Rights and Fundamental Freedoms[3] was engaged, such that the state's procedural obligation to investigate the death applied. The application for permission to proceed with the claim was heard with the substantive claim to follow, if granted.

On the application for permission to proceed with the claim for judicial review—

Held, refusing permission, (1) that section 5 of and paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 plainly prescribed certain matters which it was the purpose of an inquest to investigate, and those on which the coroner or the jury had not to express an opinion; and that the effect was to divide potential issues into three categories: those which the coroner had to investigate; those which the coroner had a discretion to investigate; and those which the coroner was not permitted to investigate (post, paras 22, 49).

(2) That, having regard to established law, a coroner conducting an article 2 inquest had a discretion to investigate matters which might possibly have contributed to the death but was obliged to investigate those matters which caused, or at least arguably appeared to have caused or contributed to, the death; that, therefore, a coroner determining the scope of an inquest was entitled to conclude that a particular issue was so remote from the causes of the death that it could not arguably be said to have contributed to the death and, on that ground, to exclude it from consideration; that the coroner was entitled to distinguish between issues which at least arguably might prove to have been contributory factors in the death and those which could not even be said to have made any real contribution to the death; and that, accordingly, having drawn that distinction the coroner might decide in the exercise of his discretion to investigate the former but had no discretion to investigate the latter (post, paras 28, 47, 49).

(3) That the claimant had been unable to show, even arguably, that any body was at the material time under a duty to establish a place of safety at a time and in a place such that the deceased could have been taken to it when detained; that, therefore, the claimant had also been unable to show, even arguably, that the fact that there was no place of safety at the material time was in itself evidence of a breach of duty, causative of or contributing to the death, which the

[1] Mental Health Act 1983, s 136(1): see post, para 4.

[2] Coroners and Justice Act 2009, s 5: see post, para 20.
Sch 5, para 7: see post, para 21.

[3] Human Rights Act 1998, Sch 1, Pt I, art 2: see post, para 7.

© 2016. The Incorporated Council of Law Reporting for England & Wales

coroner was required, or had a discretion, to investigate; and that, accordingly, the coroner had been correct to decline to investigate issues as to the non-availability of a place of safety, since to have done so would have been to investigate matters which fell outside his statutory duty under section 5 of the 2009 Act (post, paras 38, 39, 47, 48, 49).

APPLICATION for permission to proceed with a claim for judicial review

By a claim form the claimant, Maureen Speck, sought judicial review of a ruling by HM Coroner for the District of York dated 8 June 2015 determining the scope of an inquest into the death of the claimant's daughter, Miss Toni Speck, at Fulford Road Police Station, York on 2 June 2011. NHS England, MEDACS Healthcare plc and the North Yorkshire Police were served as the first to third interested parties, respectively. The application for permission to proceed with the claim for judicial review was heard with the substantive claim to follow, if granted.

At the hearing on 3 November 2015 the court refused permission to proceed with the claim with reasons to be given later.

The facts are stated in the judgment of Holroyde J, post, paras 4–14.

John-Paul Swoboda (instructed by *Ardent Law, York*) for the claimant.
Michael O'Brien QC (instructed by *York City Council, York*) for the coroner.
Michael Rawlinson (instructed by *DAC Beachcroft LLP*) for the first interested party.
Sarah Knight (instructed by *Bevan Brittan LLP*) for the second interested party.
The third interested party, did not appear and was not represented.

The court took time for consideration.

12 January 2016. The following judgments were handed down.

HOLROYDE J

1 Miss Toni Speck died at Fulford Road Police Station, York on 2 June 2011. An inquest was opened into her death by HM Coroner for the District of York, who conducted a number of pre-inquest hearings, in the course of which he heard submissions as to the scope of issues to be considered at the inquest. The coroner gave his ruling as to the scope of the inquest on 8 June 2015. The inquest was set for hearing on 9 November 2015. On 3 November 2015 the court heard this rolled-up application for permission to apply and, if permission be granted, for judicial review of the coroner's decision as to the scope of the inquest. The application was brought by Miss Speck's mother, represented by Mr Swoboda. The defendant was the coroner, represented by Mr O'Brien QC. Two interested parties were represented before us: NHS England, represented by Mr Rawlinson; and MEDACS, represented by Ms Knight. A third Interested Party, the North Yorkshire Police, acknowledged service but had otherwise taken no part in the proceedings.

2 At the conclusion of the hearing, we refused permission, and reserved our reasons to be given in writing at a later date. These are my reasons for concluding that the application for permission must be refused.

3 It is sufficient for present purposes to summarise very briefly the circumstances in which the inquest was ordered.

4 Miss Speck was 31 years old at the date of her death. Sadly, she had a history of depression, bipolar affective disorder and drug use. She had, on a number of occasions, been admitted to Bootham Park Psychiatric Hospital in York. She had been discharged from her last such admission on 19 April 2011. At 14.50 on 2 June 2011, police officers on patrol in York were flagged down by a concerned member of the public. They found Miss Speck screaming and behaving erratically in the street. One of the officers detained her. He did so pursuant to his powers under section 136(1) of the Mental Health Act 1983, which provides:

> "If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135 above."

Section 135(6) (which has since 2011 been amended in respects which do not affect the issues in this case) defines a place of safety as:

© 2016. The Incorporated Council of Law Reporting for England & Wales

> "residential accommodation provided by a local services authority under Part 1 of the Care Act 2014 or Part III of the National Assistance Act 1948, a hospital as defined by this Act, a police station, an independent hospital or care home for mentally disordered persons or any other suitable place the occupier of which is willing temporarily to receive the patient."

5 Miss Speck was then taken to Fulford Road police station in York, where she was received into the custody suite at about 15.00. She was agitated and violent. For her own safety she was searched and dressed in a safety suit. She was placed into a cell monitored by CCTV. At 17.40, the force medical examiner observed Miss Speck through the cell hatch, but did not enter the cell. He indicated that he would call the community care team. At 17.52 it was seen that Miss Speck was perspiring profusely, and had removed some of her clothing. At 18.00 she was seen to be slumped in a corner of the cell. Staff entered the cell and found her unresponsive. Attempts were made to resuscitate her, both at the police station and at the accident and emergency department of York Hospital to which she was taken. They were unsuccessful, and at 18.48 Miss Speck was pronounced dead.

6 The medical cause of Miss Speck's death was the subject of conflicting expert evidence from two consultant pathologists, and was one of the matters to be considered at the inquest. The written reports which were provided to this court showed that the opinion of one of the consultant pathologists was that Miss Speck died as a result of excited delirium, whilst the opinion of the other was that the cause of her death was serotonin syndrome.

7 Article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms, incorporated into United Kingdom law by the Human Rights Act 1998, provides:

> "1. 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.
>
> "2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary — (a) in defence of any person from unlawful violence; (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; (c) in action lawfully taken for the purpose of quelling a riot or insurrection."

8 Given that Miss Speck died in police custody, it has throughout been common ground that article 2 is engaged, and that the inquest should be a "*Middleton*" or "article 2" inquest by which the state could discharge its procedural obligation under article 2 to investigate the death: see *R (Middleton) v West Somerset Coroner* [2004] UKHL 10; [2004] 2 AC 182, to which I refer further below.

9 Miss Speck's mother wished the inquest to consider a number of issues relating to the initial decision to take Miss Speck to a police station rather than a hospital. It would have been possible to take her directly to the accident and emergency ward of York Hospital. At the time, however, York did not have a specialist medical facility for persons detained under section 136 of the Mental Health Act 1983. A decision has subsequently been made to establish such a facility, which for convenience will be referred to as a "health-based place of safety" or "HBPoS".

10 In relation to the scope of the inquest, Mr Swoboda, on behalf of the claimant, submitted that the inquest should consider, amongst other things, the detention of Miss Speck in police custody rather than at Bootham Hospital or another medical facility. He further submitted that the jury at the inquest should consider the following three questions in relation to Miss Speck's detention under the Mental Health Act:

> "(a) Do you consider the Fulford Road Custody Suite an appropriate or inappropriate 'place of safety'? (b) Do you consider there were suitable or unsuitable arrangements between the North Yorkshire and York Primary Care Trust [hereafter, 'NYYPCT'] and North Yorkshire Police for 'places of safety'? (c) Do you consider resources had been used appropriately or inappropriately by the North Yorkshire and York Primary Care Trust in the provision of 'places of safety'?"

11 In making those submissions, Mr Swoboda wished to persuade the coroner that the jury should consider how it had come about that, in 2011, York did not have a specialist medical facility which could be used as a place of safety for those detained under section 136 of the 1983

© 2016. The Incorporated Council of Law Reporting for England & Wales

Act, and to consider what had become of funding which he said had been designated for, but not in fact spent on, the provision of such a HBPoS.

12 In his submissions on this issue on behalf of NHS England, Mr Rawlinson submitted that the state's procedural obligation to investigate did not extend to a consideration of the policy and funding considerations relevant to the provision of places of safety. He submitted that such matters involved political issues as to policy and resource allocation, and that investigation of them would improperly take the inquest into issues as to the state's substantive article 2 obligation to protect life. Moreover, he submitted:

> "such matters are far too remote to even begin to meet the test for causation in terms of factors that more than minimally, trivially or negligibly contributed to Miss Speck's death, with the proposed exploration of them straying so far beyond proper boundaries as to be wrong in law."

13 The coroner, having considered these competing submissions, gave the following ruling on 8 June 2015:

> "I have considered the various authorities referred to in all the submissions that I have received. Having done so, I am not satisfied that the threshold as expressed in *R (Lewis) v HM Coroner for Mid and North Shropshire* [2009] EWCA Civ 1403; [2010] 1 WLR 1836 has been satisfied. Therefore the scope of the inquest will not include this issue. I adopt and accept the arguments put forward by NHS England/NYYPCT on this issue."

Later in his ruling the coroner indicated that the scope of the inquest would include Miss Speck's medical background, her arrest, her detention, the medical care provided during her detention and the cause of her death.

14 It is that ruling of 8 June 2015 which was challenged in the present application for judicial review. Mr Swoboda submitted that the decision was unlawful because it was disproportionate, perverse and procedurally improper, and because it had been improperly predetermined.

15 Mr Swoboda set out his argument in a series of propositions. In essence, he argued that the coroner applied the wrong test as to what issues should and should not be considered at the inquest; that he wrongly excluded consideration of the issue of whether the absence of a HBPoS contributed to Miss Speck's death (an issue which, he contended, would not require investigation of political issues of policy and funding); and that the coroner's decision as to the scope of the inquest therefore failed to comply with the article 2 procedural investigative duty.

16 Those submissions were resisted by the defendant and by the interested parties.

17 I have considered all the submissions, written and oral. I do not think it necessary to refer to all of them in this judgment, but all have been taken into account.

18 I have referred above to *Middleton*. That case involved consideration of the then-current statutory provisions in the Coroners Act 1988 and the Coroners Rules 1984 (SI 1984/552). Rule 36 provided:

> "(1) The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters, namely— (a) who the deceased was; (b) how, when and where the deceased came by his death; (c) the particulars for the time being required by the Registration Acts to be registered concerning the death.
>
> "(2) Neither the coroner nor the jury shall express any opinion on any other matters."

The House of Lords reviewed the relevant case law in the UK and in the European Court of Human Rights, which established that article 2 of the Convention imposed on member states not only substantive obligations not to take life without justification and to protect life, but also a procedural obligation to initiate an effective and independent investigation into a death occurring in circumstances in which it appeared that one of the substantive obligations may have been breached and that agents of the state were or may be implicated. The House concluded that in some cases the then-current regime for conducting inquests did not satisfy the requirements of the Convention. The solution, as expressed by Lord Bingham of Cornhill at para 35 of his speech, was to interpret the reference in rule 36(1)(b) to "how" the deceased met his death as meaning "not simply 'by what means' but 'by what means and in what circumstances'".

19 Lord Bingham went on to say, at para 36, that where it was necessary under article 2 to investigate in what circumstances the deceased met his or her death:

© 2016. The Incorporated Council of Law Reporting for England & Wales

> "it must be for the coroner, in the exercise of his discretion, to decide how best, in the particular case, to elicit the jury's conclusion on the central issue or issues … It would be open to parties appearing or represented at the inquest to make submissions to the coroner on the means of eliciting the jury's factual conclusions and on any questions to be put, but the choice must be that of the coroner and his decision should not be disturbed by the courts unless strong grounds are shown."

20 The effect of the decision in *Middleton* was subsequently incorporated into section 5 of the Coroners and Justice Act 2009, which is the starting-point for consideration of the issues in this case:

> "(1) The purpose of an investigation under this Part into a person's death is to ascertain— (a) who the deceased was; (b) how, when and where the deceased came by his or her death; (c) the particulars (if any) required by the 1953 Act to be registered concerning the death.
>
> "(2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998 (c 42)), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.
>
> "(3) Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than— (a) the questions mentioned in subsection (1)(a) and (b) (read with subsection (2) where applicable); (b) the particulars mentioned in subsection (1)(c). This is subject to paragraph 7 of Schedule 5."

21 Paragraph 7 of Schedule 5 to the Act requires the coroner to make a report to an appropriate person where:

> "(a) a senior coroner has been conducting an investigation under this Part into a person's death; (b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and (c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances."

22 Those statutory provisions plainly prescribe not only that there are certain matters which it is the purpose of an inquest to investigate, but also that there are certain other matters on which the coroner or the jury must not express an opinion. I accept the submission on behalf of the defendant and the interested parties that the effect is to divide potential issues into three categories: those which the coroner must investigate; those which the coroner has a discretion to investigate; and those which the coroner is not permitted to investigate.

23 As to the first and second of those categories, the Court of Appeal in *R (Allen) v HM Coroner for Inner North London* [2009] EWCA Civ 623; [2009] Inquest LR 187 took up the reference in *Middleton* to "the central issue or issues". Quoting that phrase at para 33 of the judgment, the court said:

> "it was not incumbent on the coroner to investigate, still less to state his conclusion in relation to, every issue raised by the claimant, however peripheral to the main questions to be determined … The coroner was … required to do no more than focus the investigation and the inquisition on the central issue or issues in the case."

Later, at para 40, the court added: "the coroner was only obliged to investigate those issues which were, or at least appeared arguably to be, central to the cause of the death."

24 After *Middleton* had been decided, but before the 2009 Act came into force, the Court of Appeal in *R (Lewis) v HM Coroner for Mid and North Shropshire* [2010] 1 WLR 1836 had to consider the extent of the coroner's duty to leave matters to the jury. That was a case in which the deceased had been found hanging in his cell at a young offender institution. The coroner left a number of questions to the jury, all of which related to matters arising before the deceased was found hanging. The coroner then made a report to the Prisons Minister and others, in which again he referred only to action which should have been taken before the deceased was found.

© 2016. The Incorporated Council of Law Reporting for England & Wales

Judicial review was sought on the ground that the judge should have enabled the jury to make findings as to what had happened after that time. There was however no evidence that the deceased had still been alive when he was found. The claim was dismissed on the ground that the jury's role was limited to considering factual questions which directly related to, or had contributed to, the death, and it could not be shown that any act or omission after the deceased was found had caused or contributed to his death. On appeal, the Court of Appeal held that in an article 2 inquest the coroner had a power, but was not under a duty, to leave to the jury matters which were possibly, but not probably, causative of the death. Sedley LJ acknowledged that the submissions on behalf of the appellant provided powerful reasons why there was a power to elicit the jury's views on matters which were only possibly causative of death, but concluded that he was "unable to find a reason of principle for making it a duty". Etherton LJ agreed, and added that the language of section 11(5) of the 1988 Act "is more naturally confined to actual, that is to say, probable causes of death than all possible causes, even if less than probable". Mr Swoboda in the course of his submissions to us argued that Etherton LJ dissented from what Sedley LJ said, but I could not accept that submission: it was in my view clear that Etherton LJ agreed with Sedley LJ, and added a further reason for reaching the same conclusion.

25 The decisions in *Allen* and *Lewis* were cited and followed, after the 2009 Act came into effect, by the Divisional Court in *R (LePage) v HM Assistant Deputy Coroner for Inner South London* [2012] EWHC 1485 (Admin). Judicial review was sought in that case on the ground that the coroner had wrongly failed to call a forensic pathologist (Dr James) who could have given some evidence as to the cause of the death which went beyond the evidence of other pathologists who were called. The Chief Coroner (Judge Thornton QC), with whom Owen J agreed, noted that Dr James would however only have been able to say that the cause of death (which was cocaine toxicity) may have been exacerbated by the physical and mental consequences of arrest and restraint, but that was no more than a possibility requiring "significant speculation". The judge said that the evidence of Dr James: "did not therefore pass the threshold of positive assistance to the inquiry. The possibility he raised was no more than speculative, and speculation is no firm foundation for calling evidence." The judge went on to reject a submission that in an article 2 inquest, there is "a separate free-standing duty on the part of the coroner to inquire into all possible issues".

26 Similarly, in the recent case of *R (Wiggins) v HM Assistant Coroner for Nottinghamshire* [2015] EWHC 2841 (Admin) the Divisional Court again affirmed that a coroner in an article 2 inquest is only obliged to investigate the issues which are, or at least appear arguably to be, central to the cause of the death. Counsel in that case had sought to rely (as Mr Swoboda has sought to rely in this case) on a passage in the speech of Lord Bingham in *R (Amin) v Home Secretary* [2003] UKHL 51; [2004] 1 AC 653 in which his Lordship identified the purposes of an article 2 inquest. Ouseley J, with whom Davis LJ agreed, said of that argument, at para 107:

> "It is true that there is no reference to causation in that passage, but it does not follow that Lord Bingham considered that causation was irrelevant. The investigation is directed to seeing whether there has been at least an arguable breach of article 2. It is implicit in such an investigation that what is being investigated caused or may have caused or contributed to the death. Otherwise the link between the investigation and article 2 is severed."

27 In the face of those authorities, Mr Swoboda none the less submitted that the coroner was under a duty to investigate issues which possibly, but not probably, caused or contributed to Miss Speck's death. He submitted first that the coroner made his decision at a stage before he had heard any evidence, and was therefore under a duty to investigate possible as well as probable causes. He submitted secondly that where an issue falls within the scope of the article 2 procedural investigative obligation, there is a duty to investigate matters which could have had a real prospect of avoiding the death or altering the outcome. In support of this second submission Mr Swoboda cited a number of cases, including most recently *R (Long) v Secretary of State for Defence* [2015] EWCA Civ 770; [2015] 1 WLR 5006.

28 I am unable to accept these submissions. It is in my judgment clear, from the line of decisions beginning with *Lewis* and *Allen*, that a coroner conducting an article 2 inquest has a discretion to investigate matters which may possibly have contributed to the death, but his only duty is to investigate those matters which caused, or at least arguably appear to have caused or contributed to, the death. A coroner determining the scope of an inquest is therefore entitled to conclude that a particular issue is so remote from the causes of the death that it cannot even arguably be said to have contributed to the death, and on that ground to exclude it

© 2016. The Incorporated Council of Law Reporting for England & Wales

from consideration. The coroner is entitled to distinguish between issues which at least arguably might prove to have been contributory factors in the death, and those which cannot even arguably be said to have made any real contribution to the death. Having drawn that distinction, the coroner may decide in the exercise of his discretion to investigate the former; but he has no discretion to investigate the latter. It cannot be a valid criticism to say that the coroner has made such a decision before hearing the evidence: if that argument were correct, every coroner would have to hear all the evidence which any person interested in an inquest suggested could be relevant, however tenuous its connection with the cause of death appeared to be, before any decision could be made as to the proper scope of the inquest.

29 The Strasbourg authorities relied on by Mr Swoboda did not in my view assist his argument. The earliest in time, *E v United Kingdom* (2002) 36 EHRR 519 related to the state's obligations under article 3, which raises different considerations. *Öneryildiz v Turkey* (2004) 41 EHRR 325, and *Opuz v Turkey* (2009) 50 EHRR 695 were both cases in which the court was considering the ambit of the substantive obligation of the state to take all appropriate steps to safeguard life, and that was the context in which the courts made the references (on which Mr Swoboda relied) to a failure to take steps which "could have had a real prospect of altering the outcome". Similarly, in *Long* [2015] 1 WLR 5006 the issue was whether there was an arguable breach of the substantive duty under article 2, such as to trigger the procedural investigative duty. It was in that context that the court, at para 32, said that it was sufficient to show "a failure to take reasonable measures which could have had a real prospect of avoiding the deaths". It does not seem to me that the passages from the judgments in those cases, on which Mr Swoboda relied, contradict or qualify the test in *Lewis* and subsequent cases.

30 In the present case, Mr Swoboda argued that there was a duty to provide a HBPoS. From that starting point he argued that there was evidence, which the coroner wrongly excluded from the scope of the investigation, that there was a two-fold breach of that duty: both a failure to provide a HBPoS, and a misuse of funds which had been allocated for the creation of a HBPoS. He accepted that he would have to show at least an arguable case that one or both breaches occurred before Miss Speck's death and that the proven breach or breaches contributed to her death. I shall consider these points in turn.

31 First, as to the suggested duty to provide a HBPoS, Mr Swoboda asserted that there could be no genuine dispute but that there should have been a HBPoS in York at the material time. That was, in my view, a bold assertion. In support of it, Mr Swoboda first pointed to the definition of a place of safety in section 135(6) of the Mental Health Act 1983 (quoted in para 4 above) which includes "residential accommodation provided by a local services authority under … Part III of the National Assistance Act 1948". He referred to provisions in section 21 of the 1948 Act permitting local authorities to make arrangements for providing residential accommodation for adults who, by reason of illness or disability, are in need of care and attention. But those provisions cannot in my view help him in relation to the temporary removal to a place of safety to a person found in a state of apparent mental disorder.

32 Next, Mr Swoboda referred to a code of practice issued by the Department of Health in 2008 (and in force in 2011) pursuant to section 118 of the Mental Health Act 1983, which with reference to places of safety said, at para 10.21:

> "A police station should be used as a place of safety only on an exceptional basis. It may be necessary to do so because the person's behaviour would pose an unmanageably high risk to other patients, staff or users of a healthcare setting. It is preferable for a person thought to be suffering from a mental disorder to be detained in a hospital or other healthcare setting where mental health services are provided (subject, of course, to any urgent physical healthcare needs they may have)."

33 Mr Swoboda argued that in the light of that guidance, it was axiomatic that a HBPoS should be available, since otherwise the article 2 duty on the state could not be fulfilled. But in my view, that does not follow at all. The desirability of there being a HBPoS available in circumstances such as those in which Miss Speck was detained is clear; but it does not follow that the local NHS Primary Care Trust, or any other body, was under a duty to provide one in York prior to June 2011. There was other provision which could be said to fulfil the state's article 2 obligation. Mr Swoboda did not and could not argue that the police were forbidden to use a police station as a place of safety: on the contrary, the evidence here showed that Fulford Road Police Station was designated by the North Yorkshire Police as a place of safety. Nor did he argue that the accident and emergency department at York Hospital could not have been used as a place of safety. In those circumstances, it was a fact that the police, in deciding where to detain

© 2016. The Incorporated Council of Law Reporting for England & Wales

Miss Speck, did not have the option of taking her to a HBPoS, but did have the options of taking her to the police station or hospital.

34 Mr Swoboda also relied in this context on a report obtained by the claimant from Dr Burdett-Smith, a consultant in emergency medicine, who considered the sequence and timing of events at the police station and concluded that if Miss Speck had been taken directly to the accident and emergency department when first detained, or had been taken to hospital after her arrival at the custody suite, it was more likely than not that she would have survived. Mr Swoboda relied on that report as evidence that Miss Speck would probably have survived if a proper medical assessment had been made of her by 16.30 on the afternoon of her detention. Had she been taken to a HBPoS, he argued, it could be expected that she would have received a full medical assessment within a short time of her arrival there. But again, whilst that may be said to underline the desirability of a HBPoS being available, it does not provide any basis for saying that any body was at the material time under a duty to provide one. Moreover, it was a striking feature of Dr Burdett-Smith's report that it contained no reference at all to a HBPoS: it referred throughout to a hospital or to the accident and emergency department of a hospital. As I have indicated, it would have been possible for Miss Speck to have been taken straight to York Hospital, and it was within the scope of the inquest to investigate the issue of whether the decision to take her instead to the police station had contributed to her death.

35 Mr Swoboda next referred to various records which he relied on as showing that, "the local emanations of the state were acutely aware of their duty to provide a HBPoS". He had made an application to be permitted to rely on additional evidence in the form of a statement by a senior officer of the North Yorkshire Police, Deputy Chief Constable Madgwick, together with a number of exhibits showing correspondence beginning in 2009 between the North Yorkshire Police and NHS North Yorkshire and York, on the subject of the provision of places of safety. We were prepared to consider this evidence de bene esse. It was apparent that police forces nationally had understandably become concerned that police stations were not the most suitable environments for some mentally disordered persons, and DCC Madgwick's force in particular was concerned that there was very little provision for the temporary accommodation of such persons in medical establishments as places of safety. DCC Madgwick's statement did not however identify any statutory or other legal basis for his assertion that at the material time it was "the duty of the local social services authority to provide a Health Based Place of Safety". No doubt his statement reflected his understanding and his belief, and one can well understand the concerns which prompted the correspondence; but the foundation of that understanding was not made clear. Thus the admission of this evidence could not have assisted the claimant's case.

36 Mr Swoboda also relied on minutes of a meeting in November 2012 of the NHS North Yorkshire and York Cluster at which concern was expressed that it was "the only place in England" without a HBPoS; and minutes of a meeting in April 2013 of the NHS Vale of York Clinical Commissioning Group which spoke of a "requirement for designated PCTs to provide a place of safety". Again, these documents no doubt reflected the concerns and understanding of the members of the bodies concerned at the time of those meetings; but again, they provided no basis for saying that either they or any other body was under a duty to establish a HBPoS in York prior to June 2011.

37 These, and other documents to which Mr Swoboda took us, show that there was understandable concern about the provision of a HBPoS in the York area, and that there was guidance and discussion as to what could and should be done. But in my view, they fell far short of identifying any duty to establish a HBPoS at a time prior to June 2011, such as would found an argument that a HBPoS should have been available in or near York when Miss Speck was detained. Mr Swoboda's submissions were not able to make good that deficiency. Indeed, it was noticeable that they did not identify specifically which body it was asserted should have established a HBPoS, or when it should have done so.

38 Reliance was placed on the decision of the House of Lords in *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74; [2009] 1 AC 681, in which the House considered the extent of a health authority's article 2 positive substantive duty to protect life. But that case was concerned with the duty owed to an in patient, known to be suffering from mental illness, who absconded from hospital and committed suicide, and it was concerned with the authority's knowledge of a real and immediate risk to life. It does not in my opinion assist the claimant here to establish the existence, at the material time, of a duty to set up a HBPoS to which persons apparently suffering from mental disorder might be admitted. I am unable to accept Mr Swoboda's submission that *Savage* supports the proposition that the discharge of the article 2 obligation required the establishment, prior to June 2011, of a HBPoS.

© 2016. The Incorporated Council of Law Reporting for England & Wales

39 For those reasons, the claimant was in my judgment unable to show that any body was, even arguably, under a duty to establish a HBPoS at a time, and in a place, such that Miss Speck could have been taken to it when detained in June 2011. It follows that the claimant was also unable to show, even arguably, that the fact that there was no HBPoS at the material time was in itself evidence of a breach of duty, causative of or contributing to the death of Miss Speck, which the coroner was required, or had a discretion, to investigate.

40 I must none the less address the alternative basis on which Mr Swoboda sought to show a breach of duty, namely his submissions as to the alleged misapplication of funds.

41 The foundation of those submissions was a statement by Mrs Julia Mulligan, the Police and Crime Commissioner for North Yorkshire Police. Having been elected to that post in November 2012, she took an active interest in the provision of places of safety, and in the circumstances of Miss Speck's death. Her statement indicates that she identified the former NYYPCT as the body responsible for the provision of places of safety in the area, and that she found reference in the minutes of the meetings of the board of that NHS Trust to, "the receipt of Department of Health funding for the section 136 facility". But, she said, she could find no record of how that funding had been spent: clearly it had not been spent on a HBPoS, because none existed in York or North Yorkshire at the time. She therefore attended the penultimate meeting of the Board on 27 November 2012 but received no satisfactory explanation. The minutes of that meeting record that Mrs Mulligan referred to a report to a board meeting in April 2012 regarding "establishment of a Designated Place of Safety at a cost of £55k", and record a response that work was ongoing but that there could be no commitment as to any timescales and that "the actual cost was more than £55k".

42 The first difficulty which Mr Swoboda faced in developing this line of argument was that he was not able to provide the court with the minutes of any earlier meeting of the board at which reference was made to the receipt of "funding for the section 136 facility". He was driven to rely simply on Mrs Mulligan's reference to it as evidence that there was some funding prior to June 2011 which, by inference, must have been spent on something else. He sought to rely on a passage at paras 49–50 of the judgment of the court in *R (Takoushis) v Inner North London Coroner* [2005] EWCA Civ 1440; [2006] 1 WLR 461, paras 49–51 in which the court held that a coroner had reached a contentious conclusion before the inquest began. But that case was factually far removed from this: the court there found that the coroner had correctly identified the need to investigate certain events, but had then failed to carry out that investigation in sufficient detail. That decision cannot in my view assist this claimant in seeking to challenge the decision of the coroner here that certain matters were outside the proper scope of the inquest.

43 Although Mr Swoboda did his best, he was in my judgment quite unable to overcome this first difficulty. In order to show, even arguably, that a breach of a duty to establish a HBPoS contributed to Miss Speck's death, he had to start with evidence that a HBPoS should and could have been established at a time such that it would have been available to receive Miss Speck in June 2011. There was simply no evidence which could enable him to do so. I am afraid it seemed to me that the assertion made on behalf of the claimant was in reality based on what may well have been a misunderstanding as to when any relevant funding had become available, and in ignorance as to whether any such funding was ring-fenced or otherwise designated specifically for the establishment of a HBPoS at a time and in a location which would have been of assistance to Miss Speck in June 2011. I could see no basis or justification for Mr Swoboda's submission that these were circumstances which should be investigated at the inquest "in order to ensure that culpable and discreditable conduct was exposed".

44 There was also a second difficulty. As is immediately apparent even from the brief quotation in para 41 above in relation to the ongoing work at that time to establish a HBPoS, and the cost thereof, any investigation of why there was no HBPoS would inevitably have involved consideration of the funding available to the NYYPCT, and the decisions which it took as to when and how that funding should be and was expended. I could not accept Mr Swoboda's submission that no such questions arose, and that there was simply a question of fact: was funding misapplied or was it not? It was to my mind entirely clear that any such investigation would therefore have to go into issues of policy and resources with which an inquest should not be concerned. That would not only be wrong in principle (compare, eg, *R (Smith) v Oxfordshire Assistant Deputy Coroner* [2010] UKSC 29; [2011] 1 AC 1, para 81): it would require investigation into the workings of a Trust which ceased to exist several years ago, and would add very substantially to the length and complexity of the inquest.

45 Mr Swoboda advanced an alternative argument. Even if the coroner was not under a duty to investigate such matters, he submitted, the coroner could and should have done so in

© 2016. The Incorporated Council of Law Reporting for England & Wales

the exercise of his discretion. Understandably emphasising the importance of the matter to Miss Speck's family, of which I am very conscious, he submitted that the effect of the coroner's decision was that the inquest would fail to bring the true facts to light. He criticised the coroner's decision not to investigate the matters which Mr Swoboda had asked to be investigated, submitting that the decision was perverse and had been made without consideration of the evidence.

46 I have already indicated that it was in my view impossible to argue that the coroner should have heard all the evidence which Mr Swoboda wanted to put forward before he could legitimately decide on the proper scope of the inquest. I would add that the exercise which Mr Swoboda wished the coroner to undertake would in any event have required speculation upon speculation, because it was submitted that it was necessary and appropriate to consider what action the police officers who detained Miss Speck would have taken if a HBPoS had been available. But that would not only have required an assumption that a hypothetical HBPoS existed at the material time: it would also have required speculation as to where the hypothetical HBPoS was located, what resources it hypothetically held, what facilities it hypothetically provided, and whether taking Miss Speck there would have involved any, and if so what, risk to the other persons hypothetically present at the HBPoS. It was in my judgment impossible to argue that the coroner could only properly have exercised his discretion by permitting that line of investigation to be pursued. The claimant's submissions fell far short of establishing the "strong grounds" which *Middleton* requires if the coroner's judgment in such matters is to be overturned.

47 Drawing these strands together, my conclusions were as follows. First, that the duty of the coroner was limited to a duty to investigate those matters which caused, or at least arguably appeared to him to have caused or contributed to, the death. Secondly, that the claimant was unable to show even an arguable case that any body was at the material time under a duty, statutory or otherwise, to establish a HBPoS at a time, and in a location, such that Miss Speck could have been taken to such a facility in June 2011. Thirdly, that the claimant was therefore unable to show even an arguable case that Miss Speck's death was caused or contributed to by a breach of such a duty. Fourthly, that the coroner was therefore correct to decline to investigate issues as to the non-availability of a HBPoS: to have done so would have been to investigate matters which fell outside his statutory duty under section 5 of the Coroners and Justice Act 2009. Lastly, that even if I had been persuaded that it was within the coroner's discretion to investigate such matters, I would have found there was no basis on which it could be said that his decision not to do so was a perverse or otherwise unlawful exercise of that discretion.

48 For those reasons I concluded that the permission should be refused. In view of an agreement reached between the parties, it was not necessary for the court to make any order as to costs.

SIR BRIAN LEVESON P

49 I agree and have nothing to add.

Permission to proceed with claim for judicial review refused.

THOMAS BARNES, Solicitor

© 2016. The Incorporated Council of Law Reporting for England & Wales