Does the decision in *Maguire* mark the beginning of a shift in the application of Article 2 in healthcare inquests?

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Eleven years on from Rabone: will the Supreme Court's decision in *Maguire* mark the beginning of a shift in the application of article 2 to inquest healthcare cases, or will it reaffirm the Court of Appeal's warning in *Morahan* that an inquest is a ***"relatively summary process"***?

Bramble Badenach-Nicolson provides her views on what we might expect from the anticipated Supreme Court judgment in the matter of *R (on the application of Maguire) v His Majesty's Senior Coroner for Blackpool & Fylde and another*[1]

Lord Dyson remarked in *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2 that *"the court has been tending to expand the categories of circumstances in which the operational duty will be found to exist"* [25].[2] Whether or not that forecast has played out over the intervening decade still remains unclear and the probing questions put by the Supreme Court Justices to Counsel for the Appellant in the hearing of *R (on the application of Maguire) (Appellant) v His Majesty's Senior Coroner for Blackpool & Fylde and another (Respondents)* on 22 and 23 November 2022 would suggest that they will be reluctant to cast the proverbial net any wider.

Whilst the case of *R (Morahan) v HM Assistant Coroner for West London* [2022] EWCA Civ 1410 has not been relied upon by the Appellant in *Maguire*, what can be described as a fairly stern warning by Lord Burnett at paragraph 7 of that judgment[3] will still ring in the ears of those lawyers attempting to advance article 2 arguments and, no doubt, in those of the Supreme Court Justices when considering their decision in *Maguire*:

"An inquest remains an inquisitorial and relatively summary process. It is not a surrogate public inquiry. The range of coroners' cases that have come before the High Court and Court of Appeal in recent years indicate that those features are being lost in some instances and that the expectation of the House of Lords in Middleton of short conclusions in article 2 cases is sometimes overlooked".

Background facts

Readers will be familiar with the facts of Ms Maguire's case: she was born with Down's Syndrome in addition to learning disabilities and in 1993, she moved to live in a residential care home which was managed by a company called United Response. Her placement was paid for and supervised by Blackpool Council.

During her residency at the care home, Ms Maguire was subject to a standard authorisation granted by the Council pursuant to the Deprivation of Liberty Safeguards.

She became ill over the two days before her death. A 111 call made on 21 February 2017 resulted in advice to call an out-of-hours GP. The GP consultation took place over the phone, but continuing concerns led to an ambulance being called later in the evening.

The paramedics who attended the care home on 21 February wished to transfer Ms Maguire to hospital, but she would not co-operate. An out of hours GP was contacted who advised that attempts should be made to persuade Ms Maguire to go to hospital but that if she refused, she should stay in the care home and be monitored overnight, which is what happened.

However, the following morning, 22 February 2017, Ms Maguire's condition had worsened and she was taken to hospital with kidney failure, dehydration and metabolic acidosis. She died following a cardiac arrest later that day.

1 *The recordings from 22-23 November 2022 can be found here:* https://www.supremecourt.uk/cases/uksc-2021-0038.html
2 https://www.supremecourt.uk/cases/docs/uksc-2010-0140-judgment.pdf
3 https://www.bailii.org/ew/cases/EWCA/Civ/2022/1410.html

The inquest

The Coroner initially agreed with Ms Maguire's family that the circumstances of her death warranted an article 2 inquest. As a result, the Coroner called evidence over the course of the inquest which satisfied his procedural duty under article 2.

However, before the jury was asked to perform its section 5 Coroners and Justice Act 2009 (CJA) duty at the conclusion of the inquest, the Coroner decided that the evidence did not suggest that the death might have resulted from a violation of the positive article 2 obligation to protect life and therefore, the coronial procedural duty did not apply and the jury's conclusion was necessarily limited by section 5(1). He made this decision following the authority of *R (Parkinson) v HMSC for Inner London South* [2018] 4 WLR 106.

Of course, had the Coroner decided that the inquest should continue to satisfy the article 2 procedural obligation, the jury would have been asked to record the circumstances in which Ms Maguire came by her death (as per section 5(2)).

The family initially claimed for judicial review of the Coroner's decision in 2019, however that was dismissed on the basis that there was no *"systemic dysfunction arising from a regulatory failure"*, nor was there a *"relevant assumption of responsibility"*.

Court of Appeal 2020 decision

The family advanced three grounds of appeal in 2020:

(i) The Divisional Court erred in concluding that the article 2 obligation did not apply, following *Rabone v Pennine Care NHS Trust* [2012] 2 AC 72;

(ii) If *Parkinson* applied, the Divisional Court was wrong to conclude that the failure to have in place a system for admitting Ms Maguire to hospital did not amount to a systemic failure; and

(iii) The Divisional Court erred in failing to take account of the wider context of premature deaths of people with learning disabilities.

The Court of Appeal held that Ms Maguire's death was related to her seeking *"ordinary medical treatment"* and that therefore the operational article 2 duty of the state to protect life was not engaged in the first place. Accordingly, no further investigation by way of an article 2 inquest was required. The Court also held that the *"very exceptional circumstances"* which would lead to an article 2 inquest in a medical case such as this did not come into place because there was no systemic regulatory failing.

Maguire Supreme Court hearing on 22 and 23 November 2022

An application for permission to appeal to the Supreme Court was lodged in February 2021 and the hearing took place in November 2022. The key question was whether there is a credible suggestion there was a breach of either a systemic or operational duty[4], and therefore whether the Coroner's procedural duty to order an article 2 inquest arose.

It was made clear at the outset of the hearing that the Appellant was not seeking to argue that this was a case where the coronial article 2 procedure automatically arose. Jenni Richards KC, acting for the Appellant, further clarified her position that there had been a breach of either or both systemic or operational duties on the part of the State. Moreover, she argued that there was not necessarily a dividing line between the two obligations (systemic and operational), referring to the Strasbourg case of *Fernandes de Oliveira v Portugal* [2019] ECHR 106.[5]

This case underpinned much of the appeal, paragraph 107 in particular:

"The question whether there has been a failure by the State to comply with its above-mentioned regulatory duties calls for a **concrete rather than an abstract assessment of any alleged deficiency.** *The Court's task is not normally to review the relevant law and practice in abstracto, but to determine whether the manner in which they were applied to, or affected, the applicant or the deceased gave rise to a violation of the Convention (see Lopes de Sousa Fernandes, cited above, § 188). Therefore, the mere fact that the regulatory framework may be deficient in some respects is not sufficient in itself to raise an issue under Article 2 of the Convention.* **It must be shown to have operated to the patient's detriment**" *[emphasis added].*

In *Lopes de Sousa Fernandes v Portugal* (2018) 66 EHRR 28, quoted above, the applicant complained that the respondent state had been responsible for breaches of article 2 in relation to the death of her husband. It was reaffirmed in the judgment that within the context of alleged medical negligence, a state's substantive positive obligations relating to medical treatment were limited to

4 *The* 'credible suggestion' *test was established in* R (Skelton) v Senior Coroner for West Sussex and Chief Constable of Sussex Police *[2020] EWHC 2813*

5 **https://www.bailii.org/eu/cases/ECHR/2019/106.html#_ftn90**

a duty to regulate; in other words a duty to put in place an effective regulatory framework compelling hospitals to adopt appropriate measures for the protection of patients' lives.

Where a contracting state had made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, matters such as an error of judgment on the part of a health professional or a negligent coordination among health professionals in the treatment of a particular person could not be considered sufficient to call a contracting state to account in relation to its positive article 2 obligations. The fact that the regulatory framework might be deficient in some respect would not be sufficient in and of itself to engage article 2 concerns; it had to be shown to have operated to the patient's detriment.

Alleged systemic breaches

Ms Richards argued that there were a number of different systemic breaches, the primary concern being that there should have been in place a system which would have produced in advance a care plan ensuring that there was a pre-identified means of getting an incapacitated patient to hospital, when they were known to be unable to consent and had a fear of going to hospital.

As expected, there was considerable judicial intervention on this point. Lord Reed queried whether there was any point in the ambulance being sent for on the evening of 21 February 2017, if the crew were unable to administer sedatives. This gave rise to a series of questions as to whether there was in fact a systemic failing, or whether there was a series of poor judgment calls over the course of the evening which did not amount to a failing on the part of the State.

Ms Richards referred to Mr Maguire's own written case (as he was another Interested Party) where he provided the Court with references of instances where a different course of action may have made a difference to Ms Maguire's case and would ultimately have prevented her death. One such instance was sending a different ambulance crew: one of the key alleged failings was that a crew was sent, none of the members of which were qualified to administer sedatives. Ms Richards suggested that there should have been a policy in place where the crew are duty bound to radio back to ambulance control, asking for an advanced paramedic to attend. However, that point was tested again: the ambulance crew could have taken such action in any event, regardless of whether there was a policy in place. That much was *"obvious"*. Lord Stephens queried whether any systemic or operational breach had taken place on the part of the State in a situation where the ambulance crew and the GP had the authority to request sedation as a matter of urgency but no such action was taken.

Ms Richards emphasised that the key consideration was that no exercise of judgment was carried out on the evening of 21 February 2017, either by the attending paramedic who gave evidence to that effect at the inquest or by the out of hours GP, who had accepted that her own triage of Ms Maguire had been poor and she could have sent a doctor to the care home equipped with sedatives.

To illustrate this point further, Ms Richards referred to the fact that the next morning, ambulance staff attended and they were able to extract Ms Maguire from the home by way of a carry chair with her limbs tied to the legs of the chair. Therefore, whilst the Mental Capacity Act 2005 gave the home the power to sedate or manhandle Ms Maguire, it was an act of broad terms and did not deal with specificities which may have made a difference in this case. Assessing the Act on a regulatory level, it was submitted by Ms Richards that there was no process which compelled the production of a protocol which might have applied here, and that could be characterised as a systemic failure.

Lady Rose asked Ms Richards to clarify whether her case was either that a) a protocol should have been prepared in advance to deal with a case such as Ms Maguire's or b) whether a regulation should exist which would have compelled the production of a protocol in advance. Lady Rose observed that had there been a protocol in place and everyone had just ignored it, there would not have been a regulatory breach. Ms Richards confirmed that she was running both arguments.

Again, the discussion turned to the question of whether it would have been *"obvious"* to the ambulance crew that they should consider sedation and Lord Sales queried whether a plan or protocol would have been ignored on the night of 21 February by this specific group of practitioners and that in itself would not have constituted a systemic or operational breach. Ms Richards' argument was that whilst such a consideration was indeed *"obvious"*, there should be plans in place to enable practitioners to deal with situations such as Ms Maguire's. However, again, Lord Sales made the point that if the practitioners in question should have been thinking about sedation and other means of conveying Ms Maguire to hospital by means of basic common sense, that detracted from the need to have a protocol in the first place.

Alleged operational breach

This part of the hearing was shaped by the definition of an operational breach by the Court in *Osman v UK* [1998] 10 WLUK 513[6]: a duty by the State to take reasonable measures would arise where there was a real and immediate risk to life.

A number of Strasbourg cases were examined in detail, such as *Traskunova v Russia* [2022] ECHR 631[7], where the deceased participated in a clinical trial and it was held that there was deficient implementation of a regulatory framework, and UK prison death cases such as *Keenan v UK* [2001] 33 EHRR 38[8] and *Edwards v UK* [2002] ECHR 303[9]. In all three cases it was held that there was a range of healthcare shortcomings and those failures amounted to a breach of the States' operational obligations.

The Justices considered whether *Traskunova* was an *'outlier'* in the body of cases explored as the judgment appeared to draw a fairly rigid line between systemic and operational duties. This question was examined within the context of the principles set out in *R (Humberstone) v Legal Services Commission* [2010] EWCA Civ 1479: namely that article 2 would be engaged in hospital settings in limited circumstances where allegations were systemic in nature. They did not include cases where the only allegations were of *'simple'* medical negligence.

After some lengthy consideration of the above issue, Lady Rose re-centred the discussion on paragraph 107 of *Fernandes de Olivera v Portugal*: the Applicant must show that a deficiency, whether systemic or operational, had some quantitative effect on the death. As Lady Rose put it, one has to descend from the abstract consideration of the regulatory framework to show it made some difference in the instant case. It was on this basis that the Justices had trouble in squaring *Traskunova* with the general principles discussed: in *Traskunova* the systemic regime was held to be satisfactory but there was a failure in implementation. Ms Richards' proposed solution to this mis-fit between the authorities was to decide that there was an overlap between the systemic and operational duties owed by the State.

However, the Justices again voiced their concerns that *Traskunova* did appear to cast the net very wide. Another suggestion by the Appellant was that the errors of judgment in that case could be characterised as a series of failures which amounted to a systemic breach. This prompted a reassessment of *Lopes de Sousa Fernandes v Portugal* [186]:

"The Court reaffirms that in the context of alleged medical negligence, the States' substantive positive obligations relating to medical treatment are limited to a duty to regulate, that is to say, a duty to put in place an effective regulatory framework compelling hospitals, whether private or public, to adopt appropriate measures for the protection of patients' lives".

Paragraph 186 above was further elaborated upon in paragraph 191 of *Lopes de Sousa* where it was clarified that the State's responsibility under article 2 would only really be engaged in exceptional circumstances. The first type of exceptional circumstance

"concerns a specific situation where an individual's life is knowingly put in danger by denial of access to life-saving emergency treatment [...] it does not extend to circumstances where a patient is considered to have received deficient, incorrect or delayed treatment".

The second type of exceptional circumstances illustrated by the Court in *Lopes de Sousa* arises where:

"a systemic or structural dysfunction in hospital services results in a patient being deprived of access to life-saving emergency treatment and the authorities knew about or ought to have known about that risk and failed to undertake the necessary measures to prevent that risk from materialising, thus putting the patients' lives, including the life of the particular patient concerned, in danger".

It was emphasised at paragraph 195 of *Lopes de Sousa* that:

"the dysfunction at issue must be objectively and genuinely identifiable as systemic or structural in order to be attributable to the State authorities, and must not merely comprise individual instances where something may have been dysfunctional in the sense of going wrong or functioning badly".

Comment

Returning to the two Portuguese cases: the obstacle the Appellant faces in this case is that even if there had been a policy in place to cater for situations such as the one in which Ms Maguire found herself on the evening of 21 February 2017, it seems the outcome would most likely (and very sadly) not have been any different. To quote the above Strasbourg authorities: the mere fact

6 https://www.bailii.org/eu/cases/ECHR/1998/101.html

7 https://hudoc.echr.coe.int/fre#{%22tabview%22:[%22document%22]

8 https://hudoc.echr.coe.int/fre#{%22itemid%22:[%22001-59365%22]}

9 https://hudoc.echr.coe.int/fre#{%22itemid%22:[%22002-5416%22]}

that the regulatory framework (systemic or operational) may well have been deficient in some respect will not be sufficient to raise an issue under article 2. Moreover, the regulatory deficiency must be shown to have operated to Ms Maguire's detriment.

An important feature of the oral evidence at the inquest was that neither the out of hours GP nor the paramedic attending the home considered the potential issue of extracting Ms Maguire from the home, either by sedation or manhandling. On the face of this evidence, it is not only most unfortunate but also deeply concerning that two different practitioners failed to carry out the same judgment exercise. That in itself will most likely be considered to be symptomatic of a serious regulatory failing.

Nevertheless, the fact that the care home staff, with the help of a different ambulance crew, were able to safely convey Ms Maguire to hospital with physical restraint on the morning of 22 February 2017 does not sit easily with the argument that Ms Maguire suffered detriment as a result of deficiencies in the regulatory framework. On the contrary, that Ms Maguire was safely take to hospital on the morning of 22 February 2017 indicates that the ambulance crew and out of hours GP involved in her care (or lack thereof) on the evening of 21 February 2017 were negligent and would most likely not have followed protocol in any event.

Of course, one of the main motivations for families making article 2 arguments is that it gets them one step closer to the possibility of legal aid funding and until that position changes, the article 2 inquest scene will continue to develop and those family members unable to afford legal representation will be overwhelmed by the sea of authorities through which Ms Richards waded in this appeal. It seems unlikely that the judgment will mark a dramatic change in the way courts determine article 2 healthcare cases. However, it will hopefully break new ground in providing relative clarity to families and practitioners alike in otherwise murky waters.