Neutral Citation Number: [2022] EWCA Civ 1410

Case No: CA-2021-000737

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE,
ADMINISTRATIVE COURT
[2021] EWHC 1603 (Admin)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 28 October 2022

Before:

THE LORD BURNETT OF MALDON,
LORD CHIEF JUSTICE OF ENGLAND AND WALES
LADY JUSTICE NICOLA DAVIES DBE
and
LORD JUSTICE BAKER

- -

Between:

THE KING (on the application of JESSICA MORAHAN)	**Appellant**
- and -	
HIS MAJESTY'S ASSISTANT CORONER FOR WEST LONDON	**Respondent**
-and-	
(1) CENTRAL & NORTH WEST LONDON NHS FOUNDATION TRUST	
(2) THE COMMISSIONER OF POLICE OF THE METROPOLIS	**Interested Parties**

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Paul Bowen KC and Paul Clark (instructed by **Leigh Day**) for the **Appellant**
Johnathan Hough KC (instructed by **the Head of Legal Services at the London Borough of Hammersmith and Fulham**) for the **Respondent**
Frances McClenaghan (instructed by **the Directorate of Legal Services, Metropolitan Police Service**) for **The Second Interested Party**

Hearing dates: 6 and 7 July 2022

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Approved Judgment

This judgment was handed down remotely at 10.30am on 28 October 2022 by circulation to the parties or their representatives by e-mail and by release to the National Archives

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Lord Burnett of Maldon CJ:

Introduction.

1. This is the judgment of the court to which we have all contributed.

2. The issue that arises in this appeal is whether the coroner was correct to conclude that the circumstances of the death of Tanya Morahan shortly after 3 July 2018 do not call for an inquest which complies with the procedural obligation imposed by article 2 of the European Convention on Human Rights ("the Convention"). Her ruling was given on 23 September 2019. The coroner indicated that she would keep the matter under review. The consequence is that if the evidence available develops in a way which supports the contrary conclusion, she would revisit the issue. The Divisional Court (Popplewell LJ, Garnham J and HHJ Teague KC, Chief Coroner) upheld the coroner's decision: [2021] EWHC 1603 (Admin).

3. Ms Morahan died in her flat as a result of cocaine and morphine toxicity whilst under long-standing psychiatric care for schizophrenia. She was a voluntary patient in a unit operated by the Central and North West London NHS Foundation Trust ("the Trust"). She had a history of illicit drug taking but had been abstinent from drugs for many months before her death. There is no basis for suggesting that Ms Morahan took her own life.

4. The impressive and comprehensive judgment of the Divisional Court was given by Popplewell LJ. It contained a detailed analysis of both domestic and Strasbourg caselaw concerning the operational duty imposed by article 2 of the Convention and the parasitic procedural (or investigative) duty which arises when a death occurs in circumstances where "it appears that one or other of the substantive obligations has been, or may have been, violated and it appears that agents of the state are, or may be, in some way implicated". That formulation comes from the considered opinion of the House of Lords given by Lord Bingham of Cornhill in *R (Middleton) v. West Somerset Coroner* [2004] 2 AC 182 at [3].

Legal Principles

5. *Middleton* concerned a suicide in custody to which the procedural obligation applied. The question was whether the formal product of an inquest prescribed by section 11 of the Coroners Act 1988, as interpreted in *R v. HM Coroner for North Humberside and Scunthorpe, ex parte Jamieson* [1995] QB 1, satisfied the procedural obligation. Section 11(5) provided that the formal inquisition should record "(i) who the deceased was; and (ii) how, when and where the deceased came by his death." In *Jamieson* "how" had been interpreted as meaning "by what means" and not as "by what means and in what circumstances". In *Middleton* the House of Lords concluded at [16] that "where … an inquest is the instrument by which the state seeks to discharge its investigative obligation, it seems that an explicit statement, however brief, of the jury's conclusion on the central issue is required." Lord Bingham went on to explain that the only change required to the statutory scheme in such article 2 cases was to interpret "how" in section 11(5)(b)(ii) of the 1988 Act and in the Coroners Rules 1984 "in the broader sense previously rejected, namely as meaning not simply 'by what means' but 'by what means and in what circumstances'." In the context of suicide in prison Lord Bingham gave an example of what would have sufficed if the evidence supported the conclusion: "The

deceased took his own life in part because the risk of his doing so was not recognised and appropriate precautions were not taken to prevent him doing so" [45]. In all other respects the inquest remained unaffected and the statutory scheme was to be adhered to.

6. The conclusion in *Middleton* was given statutory force by section 5(2) of the Coroners and Justice Act 2009. The language of section 11(5)(b)(ii) of the 1988 Act was retained but section 5(2) added that where necessary to avoid a breach of Convention rights Lord Bingham's formulation should be used, namely that "how" should mean "by what means and in what circumstances". Section 10 requires the coroner or jury to determine the questions mentioned in section 5, including section 5(2) when appropriate. The way in which inquests should be conducted otherwise remains the same. In particular, the restrictions on determining civil liability, or criminal liability on the part of a named person, remain, as does the prohibition against expressing an opinion on any matter save those identified in section 5 of the 2009 Act. That is subject to the power of a coroner to make a report to identify action that might be taken to prevent a similar death.

7. 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. This has led to lengthy delays in the hearing of inquests, a substantial increase in their length with associated escalation in the cost of involvement in coronial proceedings. These features are undesirable unless necessary to comply with the statutory scheme.

8. The application (or not) of the article 2 procedural obligation will not affect the scope of the investigation carried out by a coroner or the breadth of inquiry at the inquest itself. This case is no different because the coroner plans an inquest the breadth of which nobody seeks to criticise. That breadth is unaffected by the question before us. The question whether article 2 applies, with the result that there should be a *Middleton* rather than a *Jamieson* inquest, arises frequently and may be hard fought at a series of pre-inquest reviews. They too often cause undesirable delay. Any decision may be subject to judicial review proceedings. Mr Bowen KC for the appellant was candid about the underlying reason for this phenomenon. Legal aid is not generally available for the families of the deceased at an inquest, but the relevant statutory scheme allows it to be granted, albeit not automatically, when the inquest is the vehicle for satisfying the state's procedural obligation under article 2 of the Convention.

9. *Middleton* also established for domestic purposes (reflecting the decisions of the Strasbourg Court) that the procedural obligation can arise only when it appears that there may have been a violation of a substantive obligation under article 2 (see the quotation from [3] set out above). In other words, the procedural obligation is parasitic upon the substantive obligations. There have been many cases in which the higher courts have been asked to determine whether the procedural obligation applies in given circumstances, which in turn calls for an analysis of the underlying substantive duty said, at least arguably, to have been breached. Those cases have drawn on the jurisprudence of the Strasbourg Court. They include *R (Gentle) v. Prime Minister* [2008] 1 AC 1356 (death of servicemen on active duty deployed to Iraq); *R (Smith) v. Oxfordshire Assistant Deputy Coroner* [2011] 1 AC 1 (death of a serviceman from hyperthermia in Iraq); *R (L (A Patient)) v. Secretary of State for Justice* [2009] 1 AC

588 (attempted suicide of prisoner causing severe brain damage); *R (Maguire) v. Blackpool and Fylde Senior Coroner* [2021] QB 409 (CA) (death of adult Down's Syndrome sufferer in residential care home); and *R (Tyrell) v. Senior Coroner for County Durham and Darlington* [2016] EWHC 1892 (Admin); 153 BMLR 208 (death of a prisoner from natural causes).

10. There are categories of death which, without more, trigger the procedural obligation. The paradigm example is from *Middleton* itself, namely a violent death in custody, whether at the hands of another prisoner or by suicide. The basis for that was explained in *R (L (A Patient))* by Lord Rodger at [59] as being that it is at least possible that the prison authorities had breached their duties. But, as is clear from *Smith*, it is only where the death falls into a category which necessarily gives rise to the possibility of a substantive breach that the automatic investigative obligation arises: Lord Phillips at [70] to [72] and [84]; Lord Hope at [97] and [98]; Lord Mance at [200] and [211] to [215]. The death of a soldier on active service does not automatically suggest a possible breach of a substantive duty under article 2 and therefore the procedural obligation does not, without more, arise. The conclusion of the Supreme Court as accurately distilled in the headnote was:

> "that the investigative obligation under article 2 arose only in circumstances where there was ground for suspicion that the state might have breached a substantive obligation under article 2; that the death of a soldier on active service did not of itself raise a presumption of such a breach and accordingly did not automatically give rise to the obligation to hold an investigation which complied with the procedural duty under article 2; but that in the deceased's case, the evidence before the coroner raised the possibility of systemic failure by the military authorities to protect soldiers from the risk posed by extreme temperatures in which they had to serve; and that, accordingly, … there was an arguable breach of the substantive obligation under article 2 which was sufficient to trigger the need for an inquiry which complied with the requirements of article 2."

11. To the extent to which the judgment of Green J in R (*Letts) v. Lord Chancellor* [2015] 1 WLR 4497 suggests that there are free-standing categories not parasitic upon the possibility of a breach of a substantive obligation, we respectfully disagree.

12. The substantive duties under article 2 of the Convention fall into two categories. First, general duties which require the state to establish a framework of laws, precautions, procedures and means of enforcement that protect the lives of its citizens. This appeal is not concerned with that aspect of article 2. Secondly, an operational duty may arise that requires the state to take steps within its power to protect an individual from death. This is the so-called Osman duty identified by the Strasbourg Court in *Osman v United Kingdom* (2000) 29 EHRR 245. It concerned the question of police protection of a person under threat. At [116] the court said:

> "... not every claimed risk to life can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising. In the opinion of the Court where there is an allegation that the authorities have violated their

> positive obligation to protect the right to life in the context of their above-mentioned duty to prevent and suppress offences against the person, it must be established to its satisfaction that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk."

13. The operational duty has been recognised in a wide range of circumstances by the Strasbourg Court and domestically. For example, in *Savage v. South Essex Partnership NHS Foundation Trust* [2009] 1 AC 681 the House of Lords decided that the operational duty applied to psychiatric patients detained under the Mental Health Act 1983 in the same way as it did to prisoners because there was no difference in principle between their respective positions. In *Rabone v. Pennine Care NHS Trust* [2012] 2 AC 72 the Supreme Court concluded that the operational duty applied to a voluntary psychiatric patient who was in hospital for treatment to prevent suicide because the reality was that had she decided to leave she would have been detained: Lady Hale at [105]. That decision anticipated the judgment of the Strasbourg Court in *Fernandez de Oliveira v. Portugal* (2019) 69 EHRR 8 some years later.

14. In *Rabone* between [21] and [24] Lord Dyson identified, by reference to decisions of the Strasbourg Court, the factors potentially relevant to the existence of an operational duty. He said: "It is clear that the existence of a 'real and immediate risk' to life is a necessary but not sufficient condition for the existence of the duty." It is not sufficient because otherwise ordinary medical cases would be included but the constant jurisprudence of the Strasbourg Court is that they are not. Lord Dyson went on to consider various "indicia" which tended to support the existence of an operational duty if the necessary conditions were satisfied. The Strasbourg Court had been willing to find an operational duty where there had been an assumption of responsibility by the state for the individual's safety, including by the exercise of control. The Strasbourg Court had also emphasised the vulnerability of a deceased as a factor and whether the risk in question was an "ordinary" one of the sort that persons in the category in question should run or whether it was exceptional. He gave as an example of an ordinary, rather than exceptional, risk the case of *Stoyanovi v. Bulgaria* (App.No. 42980/04) where a soldier died in a parachute exercise.

15. The operational duty is to protect against particular risks to life, not all risks. That is clear from *Osman* itself. The only risk in question was the risk of criminal attack by a third party. It is also clear from *Rabone.* In that case the operational duty existed to protect Miss Rabone from the risk of suicide. As Lord Dyson explained at [30]:

> "In the case of the suicide of a psychiatric patient, the likelihood is that, given the patient's mental disorder, her capacity to make a rational decision to end her life will be to some degree impaired. She needs to be protected from the risk of death by those means."

The Facts

16. Tanya Morahan was 34 when she died. Her first contact with mental health services was in June 2008 when she was 24. The diagnosis was of a drug-induced psychosis following a reported history of heavy use of cocaine and ecstasy. In April 2013 she was admitted to hospital following psychotic symptoms. A further admission for two weeks occurred in February and March 2014 during which a diagnosis of schizophrenia was made. In September 2014 Ms Morahan was readmitted to hospital having presented with distressing auditory hallucinations. In August 2015, following three occasions upon which she presented at Accident & Emergency reporting hearing voices, Ms Morahan was admitted and detained in hospital under section 2 of the Mental Health Act 1983 ("the 1983 Act"). That allows compulsory detention for assessment. In September 2015, then eight months pregnant, she was referred to perinatal services. She was detained under section 3 of the 1983 Act for treatment. Ms Morahan gave birth to a son on 24 November 2015. In July 2016 her son was taken into foster care and a placement order was subsequently made with a view to his adoption.

17. In May 2017, following a disturbance which caused concern to her neighbours, Ms Morahan was again detained under section 2 of the 1983 Act and discharged on 27 June 2017. In July 2017 she was detained under section 2 and admitted to Crane Ward, a secure unit at Riverside, Hillingdon. On 3 July 2017, a diagnosis of paranoid schizophrenia was made. She was released but again detained under section 2 in August and October 2017.

18. On 3 December 2017, following a call to emergency services by concerned neighbours, Ms Morahan was admitted to Accident & Emergency where she tested positive for cocaine and opioids. Having been reviewed by the mental health team she was discharged from hospital but two days later was detained under section 2. On 11 December she was moved to Crane Ward. On 30 December 2017 the section 2 detention was replaced by a section 3 detention following a full assessment. That allows a patient to be detained for treatment. The assessment recorded Ms Morahan as being "a risk to herself as she is unwell and thought disordered and suffering from a severe psychotic episode…. Tanya does not have a history of self-harm or suicide." The assessment of the two doctors included the opinion that Ms Morahan misused illicit substances which affected her cognitive ability, that her mental state was confounded by her misuse of illicit substances and that she was vulnerable.

19. Ms Morahan responded well to treatment. By April 2018 she was allowed periods of unescorted leave from the unit. The doctors used the power provided by section 17 of the 1983 Act (leave of absence subject to conditions for a detained patient). By May 2018 she was allowed unescorted 30-minute leave four times a day in the local area and escorted leave for six hours for occupational therapy or hospital appointments. Unescorted leave was also permitted to enable Ms Morahan to see her solicitor and to visit her general practitioner.

20. Ms Morahan's progress is set out in the statement of Dr Rahim, her consultant psychiatrist and responsible clinician. By May 2018 she was doing well with no signs of mood disorder or psychosis and was attending occupational therapy groups. Her detention under section 3 of the 1983 Act was due to expire on 28 June 2018 and it was considered unlikely that she would satisfy the criteria for extending it. The clinicians decided that a referral should be made to an open rehabilitation unit. From mid-May

Ms Morahan began to sleep at such a unit whilst remaining a patient at Crane Ward. That was pending an assessment for admission to the rehabilitation unit. A urine drug screen on 16 May was negative for drugs. Dr Rahim states that Ms Morahan presented as well in her mental state with no psychotic or affective symptoms and continued to use her unescorted leave well.

21. Formal assessment for admission to the rehabilitation unit was carried out on 21 May 2018 by Dr Rahim and other members of the multidisciplinary team. The risk assessment completed on 21 May 2018 included the following:

> "… 7. Deliberate harm to self? None known; 8. Harm to self through neglect? Yes; 9. High risk posed to this person through substance misuse? Yes; 10. Risk to physical health? None known….. 26. Tanya struggles to complete her [activities of daily living] when she is unwell. She takes illicit substances in the community which contributed to a deterioration in mental state…. 30. Tanya has a history of substance misuse (cannabis, cocaine and alcohol) which has a detrimental effect on her mental health and poses a potential risk to her physical health."

22. Ms Morahan was admitted to the rehabilitation unit on the same day. She had capacity to consent to admission to the rehabilitation unit as well as capacity to consent to treatment. In her statement Dr Rahim records that Ms Morahan said that she intended to stay off illicit drugs to "win back her son". She continued to make good use of unescorted leave. On 29 May 2018 breathalyser and urine drug screening were negative of all substances.

23. On 13 June 2018 Ms Morahan visited her flat with the occupational therapist. It was agreed that they should start clearing up at the flat over the coming weeks. The results of a breathalyser test and urine drug screening on 14 June again were negative. Unescorted leave continued successfully.

24. On 25 June 2018 a team meeting was held to discuss Ms Morahan as her detained status was due to expire on 28 June. The nursing record of progress states that:

> "Tanya tends to play down her mental illness and other associated problems such as her past alcohol and drug abuse. I did ask her what would happen if she came off Section at the end of June would she still stay and receive treatment in Hospital. Tanya informed me that it depended on where she is in her Recovery as to whether she would stay as an informal patient…. There has not been any psychotic symptoms of her mental illness that staff have observed and have always been appropriate in behaviour. No issue of any drugs or alcohol. Tests taken for both have been negative (14/06/2018)…"

25. When interviewed by the team Ms Morahan stated that she would be "really low" if the section was renewed, she was looking forward to coming off the section. The notes record:

> "Tanya denies any mental health symptoms apart from sometimes feeling down due to her life situation, asked for an increase in Citalopram [an anti-depressant] to 30mg as prev did well on this dose. Agrees to remain at [the rehabilitation unit] to take meds, stay off drugs and alcohol, work with ARCH [a community support organisation for drink and drug abuse] psychology OT and to ensure there is a good support/activity package in place prior to discharge."

26. The discussion of the multi-disciplinary team records that she tended to minimise her risks and symptoms. The community care coordinator advised that Ms Morahan rarely managed long in the community. She noted that substance misuse was always a factor in readmission, but that she appeared better now than prior to previous discharges.

27. The record of the assessment notes:

> "Actions to be taken if AWOL: Leave suspended"

That is a reference to the power given by section 17 of the 1983 Act to allow leave to a patient liable to be detained. It would have no relevance once Ms Morahan was no longer detained. Thereafter, the clinicians would have to consider using the coercive powers under sections 2 or 3 of the 1983 Act if they wished to force her to reside in the rehabilitation unit. Once she was no longer subject to restrictions under the 1983 Act, when Ms Morahan left the rehabilitation unit she was not on statutory leave of absence.

28. Dr Rahim says that the team considered the chronology of the illness, the good progress and compliance with the treatment plan. Ms Morahan did not fulfil the criteria for detention under the 1983 Act as she was asymptomatic, with good insight and had the capacity to continue with her admission treatment plan on a voluntary basis. Therefore, her section 3 detention was rescinded on 25 June following the meeting. She agreed to remain at the rehabilitation unit as a voluntary patient.

29. As Popplewell LJ noted at [16], there is no reason to doubt the correctness of the assessment that Ms Morahan no longer met the criteria for detention under the 1983 Act. Dr Rahim may be cross-examined on this point, along with all others, at the inquest but it has not been suggested otherwise before us.

30. On 27 June 2018 Ms Morahan and her occupational therapist visited her flat. Some progress was made towards cleaning up the accommodation. On 1 July 2018 she failed to return to the rehabilitation unit at the time expected and did not answer her mobile phone. The police were informed that she was missing. At 07.00 the following morning Ms Morahan rang to say that she had been drunk and had travelled to Munich. She said she would return to the unit by that evening. She did so. Ms Morahan said that she had acted impulsively after meeting others and having a few beers. She denied illicit drug use. The results of a urine drug screening and a breathalyser reading were negative.

31. A risk assessment completed on 2 July 2018 records:

> "7. Deliberate harm to self? … None known; 8. Harm to self through neglect? Yes; 9. High risk posed to this person through

> substance misuse? Yes; 10. Risk to physical health? None Known."

The risk history includes the following:

> "Recently been discharged from Sec 3 (25/6/2018) and has a vulnerability to taking illicit substances and misusing alcohol which leads to deterioration in her mental health….
>
> Tanya struggles to complete her [activities of daily living] when she is unwell. She takes illicit substances in the community which contributed to a deterioration in mental state."

32. The medical assessment found no symptoms of mood disorder, no deterioration in Ms Morahan's mental state or physical health. She agreed to work more closely with staff around her leave. The team noted that this was the first time during Tanya's rehabilitation admission that she had failed to comply with her treatment plan. She had remained stable in her mental state and appeared remorseful regarding absconding and was willing to continue her treatment. There were no grounds to detain her under the 1983 Act. It was agreed to continue Ms Morahan's informal status on the rehabilitation unit and to continue to work with her towards recovery and rehabilitation.

33. On 3 July 2018 Ms Morahan left the unit stating that she was going to tidy up her flat. She did not return when expected and in the evening phoned to say she was in Essex. When reminded about her evening medication she replied, "I have a life". She failed to respond to subsequent phone calls. The matter was reported and circulated to the police for a welfare check. The police called at her flat in the early hours of 4 July but got no response.

34. Over the next few days, attempts were made by staff to contact Ms Morahan on her phone but there was no response. Dr Rahim was on annual leave from 6 July. On 5 July she emailed her specialist registrar to request that on Ms Morahan's return she should be assessed for detention under the 1983 Act as this was the second time she had not returned since becoming an informal patient.

35. On 6 July 2018 the Trust says their staff again contacted police for help in finding Ms Morahan. Further attempts by the rehabilitation unit team to make contact were unsuccessful.

36. On 13 July 2018 the Trust was informed by the coroner's office that Tanya Morahan had been found dead in her flat following a visit on 9 July 2018 by her landlord and the police.

37. The findings at post-mortem and further evidence from the Home Office pathologist are set out at [28] of the judgment as follows:

> "The post-mortem was carried out by the Home Office pathologist Dr Chapman on 12 July 2018. The body was heavily decomposed. The post-mortem report recorded the quantities of drugs in her blood, which included a substantial amount of cocaine, a lesser amount of morphine and small quantities of

> prescription drugs. Dr Chapman gave as the probable cause of death cocaine and morphine toxicity. He was subsequently asked two questions by the Claimant's solicitors for the purposes of the inquest and gave a written response. The first asked about the time of death. He said that the extent of decomposition of the body at the time of the post-mortem made it more likely that she had died closer to the last time she was known to be alive (3 July) than the time when her body was discovered (9 July). He was also asked whether, if she had been abstinent from drugs for some time whilst at the rehabilitation unit, that would affect her tolerance. His response was:
>
> > 'Tolerance to opiate drugs can be lost rapidly during abstinence so a period in hospital could make taking the drugs more dangerous once drug abuse is restarted. Tolerance to cocaine is less significant.'"

The Coroner's Decision

38. The coroner considered Lord Dyson's discussion of the relevant factors indicating whether a substantive duty was owed to Ms Morahan. She noted that Ms Morahan was not a suicide risk and that it was speculation that she could have been detained after failing to return when expected. The coroner accepted that Ms Morahan was vulnerable. She concluded that neither the Trust nor the police knew or ought to have known of a real and immediate risk of death. The reference to the police flowed from a submission then advanced, but no longer advanced, that they failed in their duty towards Ms Morahan.

The Divisional Court

39. The Divisional Court concluded that Ms Morahan's death did not occur in circumstances that gave rise to an automatic duty to hold an inquest that complied with the procedural obligation under article 2 of the Convention. It rejected the argument advanced on behalf of the appellant that the procedural duty was triggered by the fact of her being a voluntary patient without more; and that the cause of her death was irrelevant. Moreover, the court concluded ([124] et seq) that "no operational duty was owed to Tanya to protect her against the risk of accidental death by the recreational taking of illicit drugs." There was no real and immediate risk of death from such a cause of which the Trust was or ought to have been aware. Finally, it concluded that even if such a duty existed, there was no arguable breach to give rise to the parasitic article 2 procedural duty.

The Appeal

40. Mr Bowen advances the following three grounds of appeal.

    - First, the Divisional Court erred in its conclusion that Ms Morahan's death did not occur in circumstances in which the article 2 operational duty was arguably owed by the Trust.

- Secondly, the Divisional Court erred in not concluding that an automatic duty to hold an article 2 compliant inquest (a *Middleton* inquest) arose on the facts.

- Thirdly, the Divisional Court erred in concluding that there was no arguable breach of any article 2 substantive duty.

Ground 1

41. Popplewell LJ considered whether an operational duty under article 2 was owed to Ms Morahan between [124] to [134], summarising his conclusions in this way:

> "I would conclude that no operational duty was owed to Tanya to protect her against the risk of accidental death by the recreational taking of illicit drugs. None of the factors identified in *Rabone* are fulfilled. First there was no real and immediate risk of death from such cause of which the Trust was or ought to have been aware. There was no history to suggest suicide risk. There was no history of accidental overdose. There had been drug abstinence, evidenced by urine drug tests, throughout her s. 3 detention whenever she had had periods of unescorted leave. She had described her illicit drug taking prior to her admission as of limited intensity. Mr Bowen placed a great deal of reliance in his submissions on the opioid test result in December 2017 and Dr Chapman's response letter stating that a period of abstinence could result in a reduced tolerance to opioids in particular. Those aspects of the evidence cannot, in my view, bear the weight he sought to put upon them. They rest upon a single opioid test result and a statement that abstinence is capable of reducing tolerance, without providing any foundation for there having been a foreseeable real and immediate risk of overdose by opiate abuse. It must be kept in mind that the risk must be real, avoiding the benefit of hindsight, and be a risk of death, not merely of harm even serious harm. There was nothing to suggest that permitting Tanya to continue her rehabilitation into the community after her absence on 30 June/1 July gave rise to a real and immediate risk of death by overdose." [124]

42. We consider that conclusion to be unassailable for the reasons summarised by Popplewell LJ. Mr Bowen submits that the question whether there is a real and immediate risk of death should be considered when an assessment is made of whether there has been a breach of the operational duty, rather than as an ingredient in whether the duty exists. That submission is inconsistent with *Rabone* and the Strasbourg caselaw referred to by Lord Dyson (see [14] above). As Lord Dyson explained, it is a necessary but not sufficient condition for the existence of the duty.

Fresh evidence

43. Mr Bowen sought to rely upon fresh evidence from Dr Langford, a consultant in clinical pharmacology and therapeutics. He was asked to consider the risk to a person who had abstained from using cocaine and opioids of returning to their use. This was a topic covered in the evidence of Dr Chapman. Dr Langford concludes that Ms Morahan

would have lost tolerance to drugs during her period of abstinence. In his conclusion he suggests that she was generally at "high risk of having a drug related death". That, no doubt, flowed from her longstanding abuse of drugs and the history of admission to hospital in December 2017 for a drug related incident. It echoed the observation in the clinical notes of 2 July that Ms Morahan was at "high risk through substance misuse" (see [31] above).

44. We have been willing to consider the evidence without prejudice to its admissibility even though we are satisfied that it should not formally be admitted in these appeal proceedings. It does not satisfy any of the tests for admissibility. But in any event, it does not support the proposition that at the time Ms Morahan failed to return to hospital she was at a real and immediate risk of death for the purposes of article 2. The sad reality was that, as a long-term drug user, she was at risk, even high risk, of serious harm and accidental death at some stage if she reverted to using drugs. "Real and immediate risk" as a Strasbourg term of art is much more specific.

Ground 2

45. In his oral submissions Mr Bowen placed emphasis on the second ground of appeal. He reminds us that if this ground is established there would be no need to consider any of the evidence which was relevant to a fact-sensitive determination of whether an operational duty was owed under article 2 of the Convention. He submits that the death of a voluntary psychiatric patient whether in or away from the hospital and whatever the cause of death requires an article 2 compliant inquest. For example, such an inquest would be required even if a voluntary patient were involved in a road traffic accident. He submits that it is not necessary to show that there was a real and immediate risk of death from a drugs overdose of which the Trust was, or ought to have been, aware.

46. There is no authority which decides that an article 2 operational duty is owed to voluntary psychiatric patients to protect them from all risks of death. The risk of death in this sad case is accidental death from the recreational use of drugs of a voluntary patient who was genuinely at liberty to come and go. It is far removed from the circumstances in *Rabone* where the very purpose of being in hospital was to protect against the risk of suicide.

47. *R (Ullah) v. Special Adjudicator* [2004] 2 AC 323 established the principle that a domestic court should follow the "clear and constant" jurisprudence of the Strasbourg court. That duty "is to keep pace with Strasbourg jurisprudence as it evolves over time: no more, but certainly no less": Lord Bingham of Cornhill at [20]. In *R (Al-Skeini) v. Secretary of State for Defence* [2008] AC 153 at [106] Lord Brown of Eaton-under-Heywood explained that a national court should not get ahead of Strasbourg: "I would respectfully suggest that last sentence could as well have ended: 'no less, but certainly no more'". One reason for that self-denying ordinance is that an aggrieved person can go to Strasbourg and try to persuade the court to expand the reach of a Convention right. By contrast, a state party to the Convention cannot take a case from its national courts to Strasbourg to complain that the national courts went too far. Lord Reed approved that approach in *R (AB) v. Secretary of State for Justice* [2022] AC 487 between [54] and [59].

48. The appellant's case entails an invitation to march ahead of Strasbourg in this area, an invitation which, on authority, we are bound to decline. This is not one of those cases,

envisaged by Lord Reed in *R(AB)*, where the application of well-established Strasbourg jurisprudence leads compellingly to a particular development.

49. That is sufficient to determine this ground of appeal but there is a further impediment to the argument. *R (L (A Patient))* and *Smith* make clear that it is only where the death falls into a category which necessarily gives rise to the possibility of a substantive breach that the automatic investigative obligation arises. That is self-evidently not the case with a voluntary patient at liberty to leave hospital and in respect of all causes of death. That contrasts with the range of cases discussed in those authorities and identified by the Strasbourg Court as falling within the automatic category, including voluntary psychiatric patients being treated to manage suicide risk, like Ms Rabone, who would be detained were they not to remain in hospital.

Ground 3

50. This ground of appeal does not arise given our conclusions on the existence of an article 2 operational duty.

Conclusion

51. The coroner was right to conclude that Ms Morahan's circumstances did not give rise to an operational duty under article 2 of the Convention upon the Trust to protect her from the risk of accidental death from the use of recreational drugs. She was therefore right to conclude that the parasitic procedural duty to hold a *Middleton* inquest did not arise. There is no error in the Divisional Court upholding that decision. In the result the appeal must be dismissed.