IN THE CITY OF SUNDERLAND CORONER'S COURT
IN THE MATTER OF AN INQUEST INTO THE DEATH OF
MISS MELISSA DOMINIQUE LEE

RULING ON ENGAGEMENT OF ARTICLE 2 OF THE ECHR

Introduction

This Ruling addresses the issue whether or not, on the material presently available, the procedural obligation of the state under Article 2 of the ECHR is engaged in the inquest into the death of Melissa Lee ("Melissa"), in the sense considered in *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182.

Melissa died in her own home on 18 March 2016, at the age of 26. Her tragic death is understood to have been due to the toxic effects of a mixed-drug overdose. In the years before her death, she had a complex history of mental health problems and substance abuse. A coronial investigation has been commenced and there is to be an inquest into her death.

In a hearing on 22 February 2017, I heard argument on whether the Article 2 procedural obligation was engaged in this inquest. Written submissions had been filed before that hearing. The issue depended on whether there was an arguable case on the available material that the state or its agents had breached (a) the operational duty under Article 2 or (b) the general / systemic duty under Article 2. I gave an oral ruling that the substantive Article 2 procedural obligation was not engaged because, in summary, there was no basis for saying that the operational duty was engaged or for saying that the general / systemic duty was breached. I confirmed that decision after being pressed with further arguments in a hearing on 22 March 2017.

Melissa's mother then brought a judicial review claim to challenge the decision concerning Article 2 engagement. At the first stage, Mr Justice Soole refused permission for the claim to proceed on all grounds. After a permission hearing and a further rolled-up hearing, HH Judge Raeside QC found one ground of review (out of nine) to be made good, on a limited basis. Specifically, Judge Raeside found that the reasons given in the oral ruling of February 2017 were not sufficient as regards engagement of the Article 2 operational duty. He ordered that the decision be remitted back to me "to reconsider whether it is arguable on the material before [me] that state agents owed and breached the Article 2 Operational Duty, and in so doing [to] consider the indicia identified in the speech of Lord Dyson in *Rabone v Pennine Care NHS Trust* [2012] 2 AC 72 (from paragraph 22)".

The court's order stated in terms (at para. 5) that the earlier decision was not being quashed; that I was entitled to receive further written submissions from Interested Persons; and that I need not address the question whether there was any arguable breach of the Article 2 general / systemic duty of the state (since the Court had rejected the grounds challenging that aspect of the original decision). In his judgment, Judge Raeside made clear that he was not finding my decision concerning the Article 2 operational duty to be substantively wrong in law, and he said that he saw much force in the arguments in favour of the conclusion I had reached.

After the conclusion of the judicial review proceedings, I invited Interested Persons to provide any further written submissions on the question of whether there is an arguable case on the available

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material that state agents owed and breached an Article 2 operational duty in respect of Melissa. I made clear that I would consider the submissions made previously in the inquest proceedings, and would produce a written ruling after receipt of the further written submissions. In the event, further written submissions have been filed on behalf of Melissa's mother and on behalf of the NHS Trust involved in the case.

Although the written submissions filed on behalf of Melissa's mother suggest that an oral hearing be arranged, I have decided against that course. As explained above, there have now been two oral hearings and multiple rounds of written submissions in which the arguments have been canvassed. In the judicial review proceedings, I indicated that I intended to ask for written submissions and produce a revised ruling based on those submissions, and nobody suggested that an oral hearing was required as well. As already noted, the Court order reflects those indications I had made.

In preparing this Ruling, I have had regard to all the written evidence in this inquest, which has been disclosed to Interested Persons. I have also taken account of the written and oral submissions, including those made prior to my 2017 decision. I have considered the relevant issues afresh, but with a view to addressing the points raised by the Judge in the judicial review proceedings.

For the reasons given below, I have concluded that (a) the Article 2 operational duty was not engaged in relation to Melissa (on any arguable view of the facts and evidence before me); and (b) if the duty were engaged, it was not arguably breached on the facts and evidence before me. Accordingly, I consider that the Article 2 procedural duty is not engaged in this inquest. Two points should be stressed about that conclusion. First, it will not affect the scope of inquiry at the inquest or the procedures to be adopted. The inquest will be a rigorous inquiry into all the circumstances of Melissa's death. Secondly, my conclusion is based on the material presently available and I shall keep it under review to take account of any further facts and evidence.

The Facts

As I have said, the facts on which this Ruling must be based are those in the written evidence I have received, which includes a Serious Incident Investigation Report ("the SII Report") and witness statements of all the key individuals (including Melissa's mother and the clinicians involved in the events leading up to her death). What follows is a summary of the facts based on the written materials.

Melissa was born on 18 June 1989. Her mental health problems appear to have begun in her teens but to have become worse from 2012. From that time, the records refer to a history of overdoses and other dangerous behaviour. In July 2012, she was admitted informally as a psychiatric hospital patient. From December 2012, she was under a community care regime co-ordinated by the local mental health team in Sunderland. In particular, she was referred in November 2014 to the Personality Disorder Hub ("PD Hub"), a service within Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust ("the Trust") for adults with personality disorders.

In the years preceding her death, Melissa repeatedly took overdoses of prescription and other medication. She was hospitalised for the physical effects of such overdoses and had a number of admissions to psychiatric wards. Some of those were non-compulsory, while others were

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admissions under the Mental Health Act 1983. Her condition fluctuated over time, but her history of overdosing was persistent.

The diagnosis for Melissa's condition was complex, but the primary condition diagnosed in the period preceding her death was Emotionally Unstable Personality Disorder ("EUPD"). Over time, a series of care plans were put in place for her, the latest in February 2016. Each plan was overseen by a team of health and social care services professionals. The plans and their principles are explained in detail in the evidence of Dr Mitchell, the Trust lead for Personality Disorder, who was personally involved in Melissa's care.

The rationale of the care plans was based on guidelines from the National Institute for Health and Clinical Excellence ("NICE") for treatment of those with personality disorders; guidelines which were themselves based on research. The guidelines indicated that those with EUPD should only be considered for acute psychiatric admission for management of crises which involved significant risk that could not be managed otherwise; and that the patient should be involved in the decision to the greatest extent possible. Admissions without a clearly defined clinical purpose were not recommended and could be unhelpful.

Melissa's relevant care plan included a section on the approach to hospital admissions, supported by a complex case panel review meeting. Consistent with the NICE guidelines, the plan aimed to avoid unnecessary psychiatric hospital admissions absent a significant change in risk, a significant life event or a material change in presentation. Melissa had a care co-ordinator and had access to psychological therapies.

In March 2015, a crisis management plan for Melissa was developed between the PD Hub and a psychiatric liaison team at the local general hospital. Ground rules were agreed which involved performing mental health assessments as requested and required.

Over the following months of 2015, Melissa took a number of overdoses and was treated in the A&E department of the local general hospital on a number of occasions. She was admitted to psychiatric wards briefly on some occasions during this period. There were also a number of meetings of the multi-disciplinary team responsible for the care plan. The history from the clinical notes is summarised in the SII Report.

In late November 2015, Melissa jumped or fell from a low bridge, after which she had treatment for physical injuries and received extensive consideration from therapists. She was discharged from hospital on 27 January 2016 with a full discharge plan.

On 15 February 2016, Melissa had an outpatient psychiatric appointment which referred to ongoing episodes of self-harm, but an overall improvement in her mental state. On 8 March 2016, she contacted her care co-ordinator to report increased suicidal thoughts. The care co-ordinator arranged a home visit and full assessment by the Crisis Service.

On 13 March 2016, Melissa attended at the A&E department at 2am with a mixed drug overdose. After being treated, she left the ward at 1pm and did not return. At 10pm, she called an Immediate Response Team, asking to be seen. Two crisis assessors (mental health nurses) promptly attended her at home. While there, they found that she had taken another overdose. They took her immediately to hospital and deferred their assessment until she had been treated for the overdose.

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On 14 March 2016, after Melissa had been treated, the Crisis Team was told that she was fit to be assessed. Two members of the team carried out the assessment from 4pm, for a period of over an hour. Melissa told them that she was experiencing suicidal thoughts and was using medication bought on the street. She acknowledged the support of her care co-ordinator, and spoke about the stresses she was facing. She requested a short (72 hour) admission to hospital, but the assessors concluded that it was not justified by the guidance in the care plan. They considered that she had good insight, capacity to make decisions, and no sign of psychotic or mood disorder. Arrangements were made for her to see a support worker on 16 March and her care co-ordinator on 18 March. On 15 March 2016, the assessment carried out by the nurses was reviewed by a consultant psychiatrist, Dr Brown, who approved it as clinically sound.

On 17 March 2016, Melissa was admitted to hospital in the early hours after a further overdose of medication (with alcohol). She received treatment. In the evening, she asked to be discharged from hospital and was discharged. Later that evening, she sent some text messages to family and friends which provoked some concern about her state of mind. In response, her father visited her at home in the early hours of 18 March 2016. He spoke to her and felt reassured, apparently because she was discussing plans for the weekend ahead. He therefore went home, leaving Melissa at her home.

Later in the morning of 18 March 2016, a social care worker attended Melissa's home for a planned appointment. There was no response at the door, so her parents were called. Her father entered the flat and found Melissa unresponsive. An ambulance was called. On their arrival, the ambulance staff assessed her as dead.

Legal Principles

The principal statutory purpose of an inquest is to ascertain the answers to four factual questions: who the deceased was; and how, when and where he/she came by his/her death. The determinations made at the end of an inquest should answer these four questions. See sections 5 and 10 of the Coroners and Justice Act 2009. Before the incorporation of the ECHR into UK law by the Human Rights Act 1998, the question "how" the deceased came by his/her death was always understood as meaning "by what means" the death came about. This question was usually answered by the coroner or jury choosing between short-form verdicts (e.g. accidental death), although a short narrative conclusion could be given instead. See *R v North Humberside Coroner, Ex Parte Jamieson* [1995] QB 1 at 23-26.

Article 2 of the ECHR enshrines the right to life. It imposes substantive obligations on the state not to take life and to take steps to safeguard life. In addition, it entails procedural obligations. These include a requirement that in some circumstances, the state must establish an independent investigation into a specific death which satisfies standards laid down in the Strasbourg case law. See *R (Amin) v SSHD* [2004] 1 AC 653 at para. 20.

There are some categories of case where the courts have said that the obligation to establish an investigation of this kind is automatically engaged. These include cases where a person in prison commits suicide and cases where the deceased person was deliberately killed by police officers or soldiers. There has been no suggestion that the present case falls into any category of that kind. Otherwise, the obligation to establish an investigation which complies with Article 2 case law is

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engaged only where, on the evidence, the state or its agents arguably committed a breach of a substantive Article 2 duty in relation to the particular death. *See R (Humberstone) v LSC* [2011] 1 WLR 1460 at paras. 52-68; *R (Letts) v Lord Chancellor* [2015] 1 WLR 4497 at paragraphs 71-91.

In the *Middleton* case, the House of Lords considered what would be the effect on an inquest of a conclusion that the state's procedural obligation to establish an independent investigation was engaged in relation to the death. The answer was that the expression "how" the deceased came by his/her death should be read down (using the interpretive provisions of the Human Rights Act) to mean "by what means and in what circumstances" the death came about. This may result in the inquest determination addressing a wider range of surrounding circumstances and contributory factors. It may lead to an expanded form of narrative verdict being delivered.

Since the *Middleton* case, it has been confirmed that the approach adopted in that case only applies where the Article 2 procedural obligation is engaged in the way described above: see *R (Hurst) v London North District Coroner* [2007] 2 AC 189 at paras. 48-53. The courts have also made clear that a decision on Article 2 engagement will have little, if any, effect on the scope and procedures of an inquest. This is because any properly conducted inquest will consider the broad circumstances of death in any event. See: *R (Sreedharan) v Manchester City Coroner* [2013] EWCA Civ 181 at para. 18(vii).

In this case, as in many others, it is necessary for the coroner holding an inquest to consider whether the Article 2 procedural obligation is engaged in the sense considered in the *Middleton* case. Given that, as I have said, there is in this case no suggestion that the procedural obligation is automatically engaged, the question turns on whether it is arguable that the state or its agents breached substantive Article 2 duties. It is therefore necessary to consider the legal principles applying to such duties.

Article 2 imposes a general or systemic duty on the state to establish a system of laws, precautions, procedures and means of enforcement to protect the lives of citizens. In addition, it imposes operational duties in certain situations upon state agents and agencies to protect identifiable individuals or groups (or indeed to protect society at large from identifiable threats). See *Savage v South Essex NHS Foundation Trust* [2009] 1 AC 681 at para. 19; *R (AP) v HM Coroner for Worcestershire* [2011] EWHC 1453 (Admin). As explained above, this Ruling does not need to address the Article 2 general duty.

The Article 2 operational duty was first recognised clearly in *Osman v UK* (2000) 29 EHRR 245, which concerned the duty the police may owe to protect individuals against threats to their lives. At para. 116, the Court said that a breach of the duty could only be established if "the authorities knew or ought to have known at the [relevant] time of the existence of a real and immediate risk to the life of the 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, judge reasonably, might have been expected to avoid that risk." In that formula, the concept of a "real" risk is one which is substantial and significant, rather than remote. The concept of an "immediate" risk is one which is present and continuing. See *Rabone* at paras. 38-39.

The Article 2 duty recognised in *Osman* to take reasonable action to avert an appreciable "real and immediate risk to life" has been extended to various situations outside the context of police protection against crime. In *Keenan v UK* (2001) 33 EHRR 38, the Court found that the duty was

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owed to by prison authorities to those at risk in state custody. The duty has also been found to be owed where the state has created a risk, for example by its security operations: see *Makratzis v Greece* (2005) 41 EHRR 49; *Mammadov v Azerbaijan* (2014) 58 EHRR 18.

However, the Strasbourg institutions have consistently held that the Article 2 duty does not apply in most situations of clinical care. Clinical negligence will not ordinarily give rise to a breach of the Article 2 duty, even though the patient may be at a real and immediate risk of death (because of his/her condition) and even though the negligence may amount to a failure to take reasonable steps to save the patient. This principle has been established by the Strasbourg courts in the cases of *Powell v UK* (2000) 30 EHRR CD 362; *Calvelli v Italy* (App. No. 32967/96); and *Dodov v Bulgaria* (2008) 47 EHRR 932.

This approach was endorsed by the Grand Chamber in *Lopes de Sousa Fernandes v Portugal* (2018) 66 EHRR 28. In that case, at para. 187, the court reaffirmed that, provided that a state has made provision for high professional standards among clinicians (a matter covered by the general duty), "matters such as an error of judgment on the part of a health professional or negligent co-ordination among health professionals in the treatment of a particular patient cannot be considered sufficient to call a Contracting State to account". The Court acknowledged (at paras. 191 to 192) that an operational duty might nonetheless be owed in "exceptional circumstances" where a patient's life was knowingly put in danger by denial of life-saving treatment or where a systemic dysfunction in hospital services resulted in denial of access to life-saving treatment.

The English courts have had to consider on several occasions in recent years whether the Article 2 operational duty applies to a type of case. In *Savage* (cited above), the House of Lords held that it was owed to protect a detained mental patient who presented a suicide risk. The reason for this conclusion was that such a patient was in a position analogous to that of a prisoner or army conscript (to whom the duty had been found to apply). At paras. 49-50, Lord Rodger gave his reasons, which included that a detained patient is under the control of hospital authorities, as well as being peculiarly vulnerable.

By contrast, in *Mitchell v Glasgow City Council* [2009] 1 AC 874, the Supreme Court held that the duty is not owed by a local authority to prevent an attack on a tenant (even if it ought to have foreseen a real and immediate risk of death and could have taken preventive action). The reasoning, in brief summary, was that the authority had no relevant degree of control and had not undertaken a special responsibility to prevent criminal assaults. See paras. 65-66.

In the *Rabone* case, the Supreme Court had to decide whether an Article 2 operational duty was owed to a mental patient posing a suicide risk who was hospitalised and under close supervision, but who was not sectioned under the Mental Health Act. The Court concluded that the distinction between such a patient and a detained patient was more formal than real. The patient was still in practice subject to the same level of control and supervision as a detained patient. Accordingly, the duty was owed.

In his judgment, Lord Dyson JSC explained that an Article 2 operational duty would not normally be owed in a situation of medical care and treatment (para. 19). From para. 21, he identified three "indicia" or clues which might assist in deciding whether the duty applied in a new situation not previously considered by the Courts. These were: (i) assumption of responsibility and exercise of control (with state detention as the paradigm example); (ii) the vulnerability of the person

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concerned (e.g. the particular vulnerability of a child); and (iii) the nature and degree of the risk involved. See paras. 22 to 24. At para. 25, Lord Dyson recognised that these indicia did not necessarily provide a sure guide as to whether an operational duty would apply to a given set of circumstances. This must be right. A person undergoing critical surgery may be vulnerable, at an acute risk of death and entirely within the power of the surgical team, yet the Article 2 operational duty will not apply. The three "indicia" are guiding principles rather than a battery of fixed tests, and it is also necessary to consider whether the case before the court is analogous with any of those categories of case where the duty has already been found to exist.

Since *Rabone*, another important case has been decided which bears on these issues. In *R (Parkinson) v HM Senior Coroner for Kent* [2018] 4 WLR 106, the Court was concerned with a person who lacked mental capacity and was subject to emergency diagnosis and treatment in an A&E department. One of the claimant's arguments was that such a person was particularly vulnerable and under the control of clinicians, such that an Article 2 operational duty applied. The Court rejected that argument, pointing out in the first place that the case did not involve a patient who was detained or under a degree of control equivalent to detention: see para. 94.

Overview of Issues concerning Engagement of the Article 2 Procedural Obligation

It is first of all necessary for me to consider whether or not state agents owed an Article 2 operational duty to Melissa. Secondly, I must consider whether, if such a duty was owed, there is an arguable case on the available material that the duty was breached. If the duty was not owed or was not arguably breached on the available material, then the procedural obligation under Article 2, ECHR, is not engaged as matters stand.

For Melissa's mother, it is argued that the duty was owed and was arguably breached. For the Trust, it is argued that the duty was not owed and that it was not arguably breached. Sunderland City Council, which was responsible for Melissa's social care in the community, has broadly supported the position of the Trust.

Article 2 Operational Duty: Engagement

The issue to be decided under this heading is whether or not state agents, and in particular the clinicians involved in Melissa's care, owed an Article 2 operational duty to take action to prevent fatal self-harm. Since no decision which has been drawn to my attention deals with a case such as Melissa's directly, I shall consider the three "indicia" identified by Lord Dyson in the *Rabone* case before standing back and considering whether this is a case in which the duty applies, having regard to its similarities to and differences from decided cases.

The first of the three "indicia" is assumption of responsibility. Melissa was a young woman who at the relevant time apparently had mental capacity to make decisions as to her own care. She was living independently in the community, in her own home. She was receiving social care assistance and clinical care for personality disorder in the community. The Trust had produced a care plan in conjunction with Melissa herself, and the objective of that plan was to promote her personal autonomy. Its guiding principles and provisions were intended to underpin her care and support her in living independently, rather than to place her under supervision. Accordingly, and as explained by Dr Mitchell, the plan sought to avoid unjustified hospital admissions in the best clinical interests of the patient.

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In my view, the situation in Melissa's case did not involve assumption of the level of responsibility by the state which has been found in the cases where the Article 2 duty is owed. The state did not exercise close supervision or control, as in the cases involving detention or a situation closely comparable to that of detention. It did not take responsibility for overseeing Melissa's daily life. It did not assume responsibility by creating a danger for her, as has been the case in some of the authorities.

It is argued on behalf of Melissa's mother that the state did assume significant responsibility for her, since (a) she was a long-term patient of the Trust; (b) she received social care services from the local authority; and (c) she raised with clinicians suggestions that she be admitted to hospital, both on 12 March 2016 and on 14 March 2016. I have taken these matters into account, but remain of the view that the state did not assume responsibility for Melissa's welfare to the degree which has been found in the cases where the operational duty applies.

The second of the three "indicia" is vulnerability. It is true that, in one sense, Melissa was more vulnerable than most people in the community, in that she had mental health problems which presented an established propensity for self-harm (with the risk of serious harm). However, she did not demonstrate the kind of helpless or acute vulnerability which Lord Dyson instances at para. 23 of the *Rabone* case (there, a child known to be at risk of abuse). Melissa had mental capacity at the relevant times, and was involved in the care plans which were made for her. She exercised self-will and had the means and ability to request help. To the extent that she was vulnerable, it was an inherent vulnerability to her own condition.

It is argued on behalf of Melissa's mother that she was vulnerable in that she was unable to live independently without a degree of clinical oversight and a level of social care, and in that her life was punctuated with hospital admissions. She was open to exploitation and a user of illicit substances. Again, I have taken these points into account. However, it must be acknowledged that many people living in the community are substance abusers and require mental health services. These characteristics are not of themselves sufficient to engage the operational duty.

The third of the three "indicia" is the nature and degree of risk. Again, it is true that Melissa presented a particular kind of risk. However, it was a long-term, chronic risk of self-harming which fluctuated and at over a long period entailed the possibility of inadvertent, serious harm. This nature and degree of risk can be seen from her previous episodes of self-harm and from the sequence of events in the months and weeks leading up to her death which I have summarised above. Although there were signs of dangerous behaviour in the period leading up to Melissa's death, the records indicate that similar signs could have been identified at many times in the past. In *Rabone* at para. 24, when referring to this feature, Lord Dyson suggested that the question was whether or not the risk was "ordinary" for individuals of the kind in question (his example being that of soldiers in a combat zone). The risk of self-harm and suicide in Melissa's case was chronic and was sadly consistent with her condition. The best available guidance, and the advice of clinicians, supported her living independently despite that chronic risk.

On behalf of Melissa's mother, it is pointed out that Melissa gave particular signs of propensity for self-harming behaviour in the weeks preceding her death. Attention is especially drawn to her communication with the care co-ordinator on 8 March 2016; the request for help on 13 March 2016; her discussions with clinicians on 14 March 2016; and the admission to hospital on 17

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March 2016. It is true that there were signs of risk over this period, but the sequence of events was apparently consistent with the fluctuating pattern of her condition which can be seen in earlier periods as well.

Having considered the three "indicia", it is now appropriate to stand back as the courts have done in other cases and consider how this case compares to other decided cases. In my judgment, it is significant that the Strasbourg and domestic courts have been consistently careful to limit the application of the operational duty in the context of clinical care. A finding that the duty applies to prevent fatal self-harming by capacitous individuals living independently in the community would be a very significant extension. In both the *Savage* and *Rabone* cases, the courts were prepared to recognise the duty because the patients were living under a regime of supervision and control which clearly differentiated their cases from those of ordinary clinical care. Melissa's case lacks those features.

For all the reasons given above, and having regard to all the indicia, I consider that no relevant Article 2 operational duty was owed by state agents or agencies in relation to Melissa.

Finally, as a coda, I should point out that I have reached my conclusion without relying upon the decision of the Divisional Court *in R (Maguire) v HM Senior Coroner for Blackpool* [2019] EWHC 1232 (Admin). I am aware that that decision is under appeal, and it addresses a case which is more difficult than the present one.

Article 2 Operational Duty: Breach

If, contrary to my views set out above, a relevant Article 2 operational duty was owed, the next question would be whether it was arguably breached on the evidence before me. Based on the submissions which have been made to me, I understand Melissa's mother to say that a duty was arguably breached because (a) clinicians should have identified a real and immediate risk of death in the days leading up to 18 March 2016; (b) they failed to take reasonable action within their powers in that they did not arrange an emergency admission to a psychiatric ward; and (c) Melissa thereby lost a substantial chance of survival (the test of causation in Article 2 cases articulated by Lord Brown in *Van Colle v Chief Constable of Hertfordshire Police* [2009] 1 AC 225 at para. 138).

In my judgment, on the evidence before me, there is not an arguable case that state agents breached an Article 2 operational duty (assuming, against my previous conclusions, that such a duty applied). I say that for the following reasons.

In the period leading up to her death, Melissa exhibited signs of self-harming behaviour which were consistent with her chronic clinical presentation. Although her symptoms and behaviour varied, this was itself a feature of her condition. Furthermore, Melissa was under a regime of care whereby she was only to be admitted to hospital where that was necessary to deal with immediate management of a crisis and for clear and specific therapeutic purposes. The nature of appreciable risk and the conduct of the clinicians have to be judged in that context.

Against that background, it is very difficult to identify a time when Melissa presented a real and immediate risk of death which the clinicians ought to have appreciated and taken specific action to avert. On 14 March 2016, a clinical assessment which was undertaken found her to present a

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moderate risk of self-harm. However, there is no apparent basis for saying that the clinicians should have had Melissa immediately admitted to a psychiatric ward at this point, since to do so would have been contrary to the care plan. That was the judgment of the mental health clinicians at the time, and it was approved by a consultant psychiatrist the next day. Furthermore, even if Melissa had been admitted to hospital on 14 March 2016, the admission would very probably have been very short (no more than 72 hours).

There was no further indication of specific risk until 17 March 2016. Melissa's overdose on that day was, once again, consistent with her chronic history of self-harming. It was brought to the attention of the psychiatric liaison team and the care co-ordinator. Based on the care plan and the NICE guidance which informed it, there was no apparent case for an admission to a psychiatric ward, still less a compulsory admission (which would probably have been required as Melissa chose to leave hospital on the evening of 17 March).

Finally, the last person to see Melissa before her death was her father, in the early hours of 18 March 2016. He, who knew her well, felt reassured by her presentation. Like the clinicians, he saw no sign that a crisis was imminent or that Melissa's self-harming was escalating to a degree requiring immediate hospitalisation.

Considering all those facts, I cannot on the present evidence identify a point in time when there is an arguable case that clinicians ought to have (a) appreciated that Melissa presented a real and immediate risk of death and (b) taken action which would have given her a substantial chance of survival (i.e. admitting her to hospital in a manner and for a period which would have prevented any fatal overdose). Therefore, if an Article 2 operational duty applied on the facts, in my judgment there is not a case that it was arguably breached.

It is important for me to stress that the conclusions I have reached under this heading are based on the presently available (written) evidence. I shall keep a completely open mind in considering the full evidence given at the inquest in due course.

Conclusion

In my judgment, the Article 2 procedural obligation of the state is not engaged in this case in the sense considered in the *Middleton* case. I shall keep this Ruling under review to accommodate any developments in the evidence. I hope that the inquest can now proceed, as I am aware that years have passed since Melissa's death and I am keen to avoid unnecessary delay. However, I shall not take any further step in the inquest proceedings until either (a) I am informed by the legal representatives of Melissa's mother that she does not intend challenging this Ruling or (b) three months have passed from the date of this Ruling without a judicial review claim having been brought (that being the ordinary time limit for bringing such a claim).

Karin Welsh
HM Senior Assistant Coroner
for the City of Sunderland
Dated this 4th day of December 2019

HM Senior Assistant Coroner for the City of Sunderland