Maguire v Her Majesty's Senior Coroner for Blackpool and Flyde and ors [2020] EWCA CIV 738

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Summary

On 10 June 2020, the Court of Appeal dismissed the Appellant's appeal that Article 2 of the European Convention on Human Rights ("ECHR") was engaged in this inquest. The Court concluded that an operational duty under Article 2 ECHR was not owed for all purposes to those in a vulnerable position in care homes.

The Court concluded that this was not a case that reached the high threshold of 'very exceptional circumstances' in order to give rise to a breach of the operational duty under Article 2 and there was no systemic or structural dysfunction in medical services which resulted in Ms Maguire being denied lifesaving treatment.

The impact of this decision is that deaths that occur within residential care settings, including the death of individuals that have been subject of a deprivation of liberty authorisation, will not, ordinarily, fall within the scope of Article 2. This decision also underlines the importance of recognising the distinction between true "systemic failings" and a series of individual errors.

Facts of the Case

Jacqueline Maguire was a 52 year old woman who suffered from Down's Syndrome, had learning and behavioural difficulties, and some physical limitations. Since 1993 she had lived in a residential care home managed by United Response.

Ms Maguire's placement was paid for and supervised by Blackpool Council. Ms Maguire was subject to a Deprivation of Liberty Safeguards ("DoLS") authorisation as set out in Schedule A1 to the Mental Capacity Act 2005.

The care home provided personal care to adults with learning difficulties. It did not provide nursing care and staff at the home were not nurses and did not have medical training.

On 21 February 2017, Ms Maguire became ill. A call was placed to NHS 111 and the care home were advised to contact a GP. A telephone consult with a GP subsequently took place and due to continuing symptoms an ambulance was later called to the home.

On attending, the paramedics wanted Ms Maguire to be transferred to hospital however, she would not cooperate. An out of hours GP was telephoned and recommended that if attempts to persuade Ms Maguire to attend hospital failed, she should remain in the care home and be monitored overnight.

Ms Maguire remained in the care home overnight and the following morning on 21 February 2017, her condition was noted to have worsened. An ambulance attended and Ms Maguire was taken to hospital. It was established that she was severely dehydrated with kidney failure and metabolic acidosis. Ms Maguire died later that day following a cardiac arrest.

The Inquest

The inquest into Ms Maguire's death was held between 20-29 June 2018 in front of the Coroner for Blackpool and Fylde. DAC Beachcroft were instructing solicitors for United Response, the registered provider operating the care home in which Ms Maguire had resided prior to her death.

At the inquest, Ms Maguire's family argued that the circumstances of the death satisfied the procedural obligation under Article 2 of the ECHR.

At the conclusion of the evidence, the Coroner revisited the Article 2 obligation. He considered the case of *R (Parkinson) v. HM Senior Coroner for Inner London South [2018] 4 WLR 106,* and indicated that the evidence did not suggest that Ms Maguire's death had resulted from a violation of the positive obligation to protect life imposed by Article 2 ECHR. On this basis the procedural duty did not apply.

As a result, the jury's conclusion was limited, in accordance with Section 5(1) of the Coroners and Justice Act 2009, to '*how, when and where'* Ms Maguire came by her death. The Coroner also refused to leave the finding of neglect to the jury.

The Jury returned a conclusion of natural causes and a short narrative description of the events of 21 and 22 February 2017.

Article 2

An Article 2 inquest requires the coroner or jury to extend the '*how, when and where'* to include '*in what circumstances*' the deceased came by his or her death (section 5(2) of the 2009 Act). In accordance with the Chief Coroner's Guidance No.17, the inquest must "enable the coroner or the jury to express their conclusions on the central issue(s) canvassed at the inquest".

The No.17 Guidance confirms that an Article 2 narrative conclusion may include judgmental words such as 'inadequate', 'inappropriate', 'failure' and can include words that denote causation such as 'because' and 'contributed to'.

The Divisional Court

Following the inquest Ms Maguire's family sought to judicially review the coroner's decision that the evidence did not engage Article 2 and the fact that a finding of neglect had not been left to the jury.

On 15 May 2019 the Divisional Court dismissed the case. The court acknowledged that where the state assumes a degree of responsibility (for which it should be called into account) for the welfare of an individual who is subject to DoLs, who is not imprisoned or placed in detention, the line between state responsibility and individual actions can be a fine one. The court stated it was the coroner's function to consider this line and it was open for the coroner to reach the conclusion that he did. On the matter of neglect, the court agreed with the coroner's analysis that the evidence did not support a finding of neglect.

The Court of Appeal

Ms Maguire's family subsequently appealed to the Court of Appeal. DAC Beachcroft were instructed by the First Interested Party, United Response.

The family appealed on three grounds:

1. The Divisional Court erred in concluding that the procedural obligation under article 2 ECHR did not apply. By parity of reasoning with *Rabone v. Pennine Care NHS Trust (Inquest and others intervening)* [2012] 2 AC 72, the circumstances of Ms Maguire's care dictated that the procedural obligation applied. It was not a medical case of the sort considered in *Parkinson*.
2. 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 on the evening of 21 February 2017 did not amount to a systemic failure.
3. The Divisional Court erred in failing to take account of the wider context of premature deaths of people with learning disabilities as being relevant to the application of article 2.

On 10 June 2019, the Court of Appeal dismissed the appeal. The Court of Appeal considered the following in its judgment:

Decision on grounds 1 & 3

1. The approach highlighted in cases considered during the hearing did not support a conclusion that for all purposes an operational duty is owed to those in a vulnerable position in care homes, which then spawns the distinct procedural obligation (with all its components) in the event of a death which follows either alleged failures or inadequate interventions by medical professionals. The case of *Dumpe v. Latvia* (App. No. 71506/13) most clearly demonstrated that it is necessary to consider the scope of any operational duty.
2. The coroner was right to conclude that, on the evidence adduced at the inquest, there was no basis for believing that Ms Maguire's death was the result of a breach of the operational duty of the state to protect life.
3. It was unnecessary to decide whether on the evening of 21 February the evidence suggested that the medical professionals knew or ought to have known that Ms Maguire faced a real and immediate risk of death and did all that they reasonably should have done to prevent the risk from materialising. Collectively they did not think that the situation was dangerous.
4. Ground 3 - the learning disability mortality review and confidential inquiry into premature deaths of people with learning disabilities are said to support the contention that the operational duty was owed to Ms Maguire, in connection with the medical attention she received leading up to her death. The Court of Appeal considered that they do not provide additional weight to the argument that a relevant operational duty was owed to Ms Maguire.

Decision on ground 2

1. The court considered whether there was reason to believe that the "very exceptional circumstances" that can give rise to a breach of the operational duty under article 2 in a medical case defined in *Lopes de Sousa* might be in play. They found that that the criticisms of the paramedics or out of hours GP did not come close to satisfying the first exception identified by the Strasbourg Court, namely that the patient's life was knowingly put in danger by a denial of access to life-saving emergency treatment.
2. The court reiterated that the collective judgement of the professionals was that Ms Maguire was not in danger on the evening of 21 February 2017 and could be kept under observation at the home, even though it was preferable that she went to hospital.
3. The court did not accept that this was a case which raised "systemic or structural dysfunction in [medical] services"

which resulted in Ms Maguire being denied life-saving treatment.

4. The criticism of the care home, the paramedics and the out of hours GP is that between them they failed to get Jackie to hospital on the evening of 21 February; and that a plan, protocol or guidance should have been in place that would have achieved that end. The court considered that this was remote from the sort of systemic regulatory failing which the Strasbourg Court had in mind as underpinning the very exceptional circumstances in which a breach of the operational duty to protect life might be found in a medical case.

The decision in this case re-affirms the high threshold that must be met in order to trigger an article 2 inquiry and maintains the distinction in the scope of Article 2 between patients cared for in mental health hospitals and those who may be vulnerable but live in a community setting.