Neutral Citation Number: [2021] EWHC 2511 (Admin)

Case No: CO/4764/2020

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
DIVISIONAL COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 17/09/2021

Before :

Lord Justice Warby
Mrs Justice Farbey
and
His Honour Judge Teague QC
Chief Coroner of England and Wales

- -

Between :

JOY DOVE	**Applicant**
- and –	
(1) HM ASSISTANT CORONER FOR TEESSIDE AND HARTLEPOOL	
(2) DR SHAREEN RAHMAN	**Respondents**
- and –	
SECRETARY OF STATE FOR WORK AND PENSIONS	**Interested Party**

Mr Jesse Nicholls (instructed by **Leigh Day**) for the **Applicant**
Mr Jonathan Hough QC and **Mr Anthony Jones** (instructed by **Middlesbrough Council**) for the **First Respondent**
Mr David Griffiths (instructed by **Government Legal Department**) for the **Interested Party**
Ms Claire Watson (instructed by MDU Services Limited) for the Second Respondent made no submissions

Approved Judgment

- -

Hearing dates: 22 & 23 June 2021

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Mrs Justice Farbey:

Introduction

1. On 21 February 2017, Jodey Whiting died as the result of an overdose of prescription medication. She was 42 years old. On 24 May 2017, the Assistant Coroner for Teesside and Hartlepool ("the Coroner") held an inquest into her death. The Coroner heard evidence from members of Ms Whiting's family that she had been suffering from severe stress in the period leading to her death. A recent decision by officials within the Department for Work and Pensions ("the Department") to stop paying Employment and Support Allowance ("ESA") was said to have contributed to that stress. Ms Whiting had left notes in her home which suggested that she had intended to kill herself. The Coroner concluded that Ms Whiting had died by suicide.

2. Joy Dove is Ms Whiting's mother. She applies to this court under section 13 of the Coroners Act 1988, with the *fiat* of the Attorney General, for an order quashing the Coroner's determination and directing that a new inquest take place. I offer my condolences to Mrs Dove and to the family for their tragic loss.

3. Mrs Dove accepts that Ms Whiting took her own life but submits that there ought to be a new inquest to look at the failings of the Department's staff and their contribution to Ms Whiting's mental state. She contends that there was an insufficient inquiry in the original inquest both at common law and under article 2 of the European Convention on Human Rights ("the Convention"). In addition, fresh evidence has emerged which is said to warrant another inquest. The fresh evidence comprises (i) the report of the Independent Case Examiner ("ICE") dated 14 February 2019 which followed an investigation into the Department's handling of Ms Whiting's case and which criticised the Department in a number of respects; and (ii) the report of consultant psychiatrist Dr Trevor Turner dated 19 November 2019. The conclusions of Dr Turner are said to provide fresh evidence of a link between the decision to stop Ms Whiting's ESA and her suicidal state of mind. Mrs Dove's case is that the evidence now available makes it likely that a different conclusion would be returned at a fresh inquest, namely a conclusion that identified the Department's role in the circumstances of Ms Whiting's death.

4. In response to the application, the Coroner maintains that her approach to the inquest was correct but says that she adopts a neutral and non-adversarial position to the outcome of the proceedings. Ms Whiting's GP, Dr Shareen Rahman, does not object to Mrs Dove's application.

5. By application notice dated 2 June 2021, the Secretary of State for Work and Pensions applied to be joined as an interested party. At a hearing on 11 June 2021, Morris J granted the application while criticising the Secretary of State's delay in seeking to take part in the proceedings ([2021] EWHC 1738 (Admin)). He limited the Secretary of State to written submissions at the substantive hearing but it was subsequently agreed that she should be permitted to make oral submissions.

6. We heard submissions from Mr Jesse Nicholls on behalf of Mrs Dove; from Mr Jonathan Hough QC and Mr Anthony Jones on behalf of the Coroner; and from Mr David Griffiths on behalf of the Secretary of State. We are grateful to counsel for their considerable assistance.

Welfare Reform Act 2007: provisions for ESA

7. It is convenient to start with an overview of the statutory scheme for ESA which was introduced by the Welfare Reform Act 2007 ("the 2007 Act") and which replaced Incapacity Benefit ("IB") and certain other disability benefits. By virtue of section 1 of the 2007 Act, ESA is payable on a weekly basis. A claimant is eligible for payments if he or she is assessed by the Department as having "limited capability for work" and the limitation is such that it is not reasonable to require him or her to work. The limited capability must arise from a physical or mental condition. It is fundamental to the scheme of the Act that the assessment of limited capability for work is functional: it focuses on what activity a claimant is capable of doing.

8. A claimant who is assessed as eligible for ESA will fall into one of two groups. Those in the "work-related activity group" are assessed as being functionally capable of carrying out work-related activity designed to achieve their return to work (section 8 of the 2007 Act). It is in broad terms a condition of payment of ESA that they perform such activity. Those in the "support group" have severe functional impairment. They are assessed as being functionally incapable of carrying out work-related activity and are not required to do so (section 9 of the 2007 Act).

9. Regulations made under the 2007 Act govern the assessment of whether a person falls into the work-related activity group or the support group. The relevant regulations are the ESA Regulations 2008 as amended and their Schedules. An assessment - called a "work capability assessment"- will consider the extent to which a person is capable of specific and described physical and mental activities. The less that a person is able to carry out an activity, the greater the points that he or she will receive in relation to that activity. A person who receives at least 15 points in relation to one or a combination of activities contained in Schedule 2 to the Regulations will fall into the work-related activity group. A person who satisfies the criteria in relation to a Schedule 3 activity will qualify for the support group.

10. As part of the work capability assessment, a claimant may be called by an approved health care professional ("HCP") to attend a medical examination (Regulation 23(1)). A claimant who fails to attend without "good cause" will (subject to certain exceptions which are not relevant to the present case) be treated as not having limited capability for work and will therefore be ineligible for ESA (Regulation 23(2)).

Factual background

11. The significant facts are not in dispute and may conveniently be taken from Mr Hough's skeleton argument which itself draws on the ICE report. Ms Whiting had suffered from spinal conditions from her early twenties which gave her back pain, requiring surgery and regular painkilling medication. She had a history of mental health problems, including depression, drug dependence and a diagnosed condition of emotionally unstable personality disorder. She had a history of suicidal ideation and the expression of suicidal intent. Her medical notes contain references to multiple overdoses, including nine between January 2009 and July 2015.

12. From October 2006 to September 2012, Ms Whiting received IB and Income Support. In late 2012, she was assessed for ESA which was being gradually introduced under the 2007 Act. In line with legislative procedures, she underwent a work capability

assessment which included an assessment by a HCP whose report concluded that she had severe mental health problems.

13. The Department decided to award Ms Whiting ESA from September 2012 for a period of two years. She was placed in the support group, meaning that the Department recognised that she suffered from a severe health condition. As she had been placed in the support group on mental health grounds, the Department put a flag on its system. The flag was intended to trigger a request to her GP to provide medical evidence in future ESA reassessments, which would enable the Department to decide whether a face-to-face medical assessment should be required.

14. In September 2014, Ms Whiting's entitlement to ESA was reassessed. In the questionnaire that she completed for the Department at that time, she stated: "Most days I want to kill myself, if my doctor doesn't get the pain under control asap I plan 2 kill myself." She also said: "24/7, don't want to and can't get away from all my illness." Her GP provided medical evidence that she had an emotionally unstable personality, with stress, low mood and anxiety. In these circumstances, the Department did not ask her to attend a face-to-face medical assessment. Her ESA was extended for a further two years and she remained in the support group. From 29 July 2015, she also received an award of Personal Independence Payment ("PIP"), migrating to PIP from Disability Living Allowance.

15. In September 2016, Ms Whiting began a further reassessment process. She completed another questionnaire which was received by the Department on 20 October 2016. In the questionnaire, she stated that she needed to be assessed by means of a home visit as she rarely left the house due to mobility problems and anxiety. She referred to her psychiatric care. She stated that she had suicidal thoughts "a lot of the time." The questionnaire was passed to the Centre for Health and Disability Services ("CHDA") which provides HCP reports to the Department.

16. It is not in dispute that the Department should have referred the home visit request to CHDA but did not do so. The ICE found no evidence that CHDA considered the request for itself. On 14 November 2016, CHDA asked Ms Whiting's GP to provide medical evidence which was supplied on 22 November 2016. In that evidence, the GP stated that Ms Whiting had been referred to a Crisis Team for intensive treatment but had been discharged on 25 June 2016 on the basis that she had no suicidal intent or thoughts.

17. The GP recorded having seen Ms Whiting on 3 August 2016, when she appeared to be making an effort to remain stable. The GP had last seen her on 4 October 2016. The GP was apparently unable to comment on how Ms Whiting's mental health affected her daily living.

18. On 15 December 2016, CHDA decided that Ms Whiting was required to attend a face-to-face appointment with a HCP. On the same date, CHDA wrote to her with a request to attend on 16 January 2017. Ms Whiting did not attend the appointment and did not respond to the letter. On 17 January 2017, CHDA sent a standard form to Ms Whiting seeking the reasons for her non-attendance.

19. In accordance with the Department's guidance, where a benefits claimant with mental health difficulties has failed to attend an assessment, the Department should attempt to

contact the person by telephone and should consider a "safeguard visit." There is no evidence that either of these steps was taken. The Department does not seek to maintain that they were taken.

20. Ms Whiting completed the standard form on 24 January 2017 and returned it to the Department. She said that she had not received the original letter from CHDA and that she was housebound with pneumonia. She asked the Department to write to her GP for information about her medical and personal problems. The Department did not write to the GP.

21. On 6 February 2017, the Department decided that Ms Whiting had not shown "good cause" for failure to attend the HCP appointment on the basis that the appointment letter had been correctly addressed and no medical proof of pneumonia had been supplied. The Department decided that Ms Whiting had not shown limited capability for work and stopped her ESA. By letter of the same date, the Department informed Ms Whiting of the decision. The letter referred to the usual procedures for mandatory reconsideration by the Department and to appeal rights.

22. In accordance with the Department's guidance, the decision-maker deciding whether good cause had been shown for Ms Whiting's failure to attend the HCP appointment should have determined whether her medical condition had affected her cognition. The Department was also required to give consideration to her mental health problems before making the decision to stop her ESA. The decision letter sent to Ms Whiting made no reference to her mental health condition.

23. Ms Whiting's ESA was stopped with effect from 7 February 2017. As a result of the Department's decision, Ms Whiting received letters from her local authority informing her that her housing benefit and council tax benefit (both linked to her ESA) were being terminated.

24. On 10 February 2017, she telephoned the Department and the decision letter was read to her. She said that she was ill in hospital. The Department's call-handler advised her to request reconsideration in writing with medical evidence.

25. On 13 February 2017, Ms Whiting returned the decision letter with a request for reconsideration. On 15 February 2017, a representative from Citizens Advice wrote to the Department explaining that Ms Whiting had attended the Citizens Advice office with a number of letters, including the HCP appointment letter which was unopened. Citizens Advice emphasised that, as a result of her anxiety and depression, Ms Whiting was not always able to deal with her post. The letter asked the Department to reconsider its decision.

26. On 21 February 2017, Mrs Dove found Ms Whiting lying unresponsive on a sofa in her flat. Paramedics were called and pronounced Ms Whiting dead. The medical cause of death was recorded as being the synergistic effects of morphine, amitriptyline and pregabalin together with cirrhosis. I have read copies of the notes which Ms Whiting made before her death, which Mrs Dove found and which are distressing.

Mandatory reconsideration and appeal against Department decision

27. On 25 February 2017, the Department belatedly carried out a mandatory reconsideration of Ms Whiting's case but adhered to its original decision that she had not demonstrated good cause for failing to attend the appointment with the HCP on 16 January 2017. The Department decision-maker again failed to consider Ms Whiting's mental health.

28. By notice of appeal filed on 23 March 2017, Mrs Dove appealed to the First-tier Tribunal (Social Entitlement Chamber) against the Department's decision. On 31 March 2017, the Department revised its decision on the basis of the Citizens Advice letter of 15 February 2017 and reinstated Ms Whiting's ESA from 17 January 2017. The appeal to the Tribunal consequently lapsed.

The inquest

29. The inquest into Ms Whiting's death was opened on 30 March 2017 and adjourned until 24 May 2017. The Department took no part. The Coroner told attendees that she had noted that there were ongoing discussions with the Department (as explained in correspondence before her) but that it was not her function to question any decisions made by the Department. The Coroner returned to the Department's involvement with Ms Whiting when she commented:

> "I will make a note when I do my deliberations about this, the stress factor and the ESA claim, but as I explained at the outset, unfortunately, you know, as a Coroner and the inquest, it's not our position to question any decisions made by the Department of Work and Pensions. That's just outside the remit of this court."

30. In her oral deliberations at the end of the inquest, the Coroner included the following reference to the ESA claim:

> "Jodey had her ESA claim turned down in the weeks before her death, and her mother believes, as does her sister, that this was causing her extra stress…
>
> Jodey's mum believes the extra stress Jodey was under in relation to her ESA claim was a contributing factor in her death."

The Coroner gave a short-form conclusion of suicide.

Fresh evidence

ICE report

31. By letter dated 13 April 2017, Citizens Advice made a formal complaint to the Department about how Ms Whiting's ESA claim had been handled. Certain aspects of the complaint relate to events after Ms Whiting's death (such as addressing correspondence to her after she had died) and would not be relevant to an inquest. It is of relevance that Citizens Advice complained about the Department's failure to consider Ms Whiting's mental health condition when deciding whether she had

demonstrated good cause for not attending the HCP appointment. The letter explained how Mrs Dove believed that the additional stress relating to the ESA claim was a factor in Ms Whiting's death.

32. By letter from an Operations Manager dated 14 June 2017, the Department responded to the complaint. On 14 July 2017, Citizens Advice sought an internal review of the Operations Manager's handling of the complaint. By letter dated 6 September 2017, a Senior Correspondence Manager from the Department's Complaints and Correspondence Review Team provided a second-tier response following which Mrs Dove sought a further review. On 7 March 2018, the ICE (who is appointed by the Department to provide a quasi-independent review of complaints) accepted Mrs Dove's complaint for investigation which led to the report of February 2019.

33. By that time, the scope of the complaint mainly concerned the Department's conduct after Ms Whiting had died which, as I have said, could not form part of an inquest. The ICE report does however deal with "Additional Matters" relating to "significant failings in the events leading up to [Ms Whiting's death]." The report makes the following findings:

    i. The Department had failed to alert CHDA to Ms Whiting's request for a home visit in relation to the ESA reassessment.

    ii. There was no evidence that the Department had attempted to telephone Ms Whiting to establish why she had not attended the HCP appointment which was in breach of departmental guidance on vulnerable claimants.

    iii. There was no evidence that the Department had considered a safeguard visit which was again in breach of departmental guidance on vulnerable claimants.

    iv. The Department had failed to contact Ms Whiting's GP for information about her illness, despite Ms Whiting's request that this should be done and despite the Department's awareness of her vulnerability.

    v. Ms Whiting was told to submit a written request for mandatory consideration in writing when this could have been done by telephone.

    vi. The Department had failed to consider Ms Whiting's mental health condition and had failed to give careful consideration to her case.

    On the evidence before this court, I see no reason to disagree with the report's conclusions.

34. I do not seek to cast doubt on the commitment to the public good which motivates large numbers of the Department's staff in their interactions with (we were told) around 20 million people each year. I am nevertheless bound to observe that the Department's failures in this case, set out in the ICE report, are shocking. ESA is not an unusual welfare benefit which might take staff away from familiar assessment tools and work methods: it is a mainstay of the social security system as administered by the Department. Ms Whiting had been in the support group since her transfer to ESA from IB in 2012. Her case was flagged on mental health grounds. Despite these indicators of her vulnerability, the Department decided to move her directly from the support

group to the complete cessation of ESA, having failed to follow its own guidance in relation to what was a single missed HCP appointment. In my judgment, the withdrawal of ESA should not have happened.

Psychiatric report

35. Dr Turner is a retired NHS consultant psychiatrist who now teaches, lectures and undertakes independent medico-legal work. His expertise is not in dispute. In preparing his psychiatric report, he was provided with a witness statement by Mrs Dove; the ICE report; the Record of Inquest; the post-mortem report; the GP's statement to the Coroner; and the notes left by Ms Whiting. His report sets out that Ms Whiting had a longstanding history of psychological health problems including repeated overdoses, misuse of morphine, depression and a presentation consistent with a Borderline Personality Disorder. Dr Turner's view is that Ms Whiting would have experienced distress and shock at the withdrawal of her welfare benefits. As a person presenting with Borderline Personality Disorder, she would be likely to have suffered a substantial depressive impact, with activation of suicidal ideas. The failures to implement measures to protect vulnerable people would have exacerbated her emotional response.

36. Dr Turner concludes that:

> "Ms Whiting's vulnerabilities would have been substantially affected by [the Department's] negative decisions…with a likely deterioration in her mental state in terms of her…suicidal ideation….
>
> [T]here was likely to have been a causal link between [the Department's] failings outlined in the…ICE report and Jodey's state of mind immediately before her death.
>
> On the balance of probabilities…it is likely that her mental state at the time of her death would have been substantially affected by the reported [the Department's] failings."

The applicant's views

37. Mrs Dove sets out her views in a witness statement dated 20 July 2019, expressing her firm belief that, had it not been for the Department's decision to stop her ESA payments, her daughter would not have ended her life when she did. She says that the impact of the Department's correspondence on her daughter was clear to see: she was very distressed and felt hopeless because she would be unable to cope without the payments.

38. Mrs Dove and the family would like the impact of the Department's decisions to be publicly and independently investigated. She says that she has never had the opportunity to put her own questions to the decision-makers or to see the relevant documents and records. A fresh inquest would ensure that the full circumstances of her daughter's death are investigated.

Legal framework

The nature of the application and the court's approach

39. Section 13(1) of the Coroners Act 1988 provides:

> "This section applies where, on an application by or under the authority of the Attorney-General, the High Court is satisfied as respects a coroner ('the coroner concerned') either –
>
> (a) that he refuses or neglects to hold an inquest or an investigation which ought to be held; or
>
> (b) where an inquest or an investigation has been held by him, that (whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise) it is necessary or desirable in the interests of justice that an investigation (or as, the case may be, another investigation) should be held."

40. On such an application, the High Court may (among other things) order a further coronial investigation and quash any determination or finding made at a previous inquest (section 13(2)).

41. In *Attorney-General v HM Coroner for South Yorkshire (West)* [2012] EWHC 3783 (Admin), para 10, the Divisional Court (Lord Judge CJ, Burnett LJ as he then was and HHJ Peter Thornton QC) gave guidance on how the court should approach a section 13 application. The single question is whether the interests of justice make a further coronial investigation necessary or desirable. The interests of justice are in this context undefined, but the emergence of fresh evidence which may reasonably lead to the conclusion that the "substantial truth" about how an individual met his or her death was not revealed at the first inquest, will normally satisfy that test.

42. The Divisional Court went on to say that section 13 is not concerned with problems with the coronial process, unless the process adopted at the original inquest has "caused justice to be diverted or for the inquiry to be insufficient." It is not a pre-condition to an order for a further inquest that the court should anticipate that a different conclusion from the one already reached will be returned. Even when significant fresh evidence may serve to confirm the correctness of the earlier conclusion, it may sometimes be desirable for the full extent of the evidence which tends to confirm the correctness of the conclusion to be publicly revealed.

The coronial jurisdiction

43. Section 5(1) of the Coroners and Justice Act 2009 provides that the purpose of a coronial investigation is to ascertain the answers to the following questions: (a) who the deceased was; (b) how, when and where the deceased came by his or her death; and (c) the particulars (if any) required by other legislation to be registered concerning the death. Section 10(1) of the 2009 Act provides that the coroner's determinations at an inquest should answer the questions identified in section 5.

44. Section 5(3) prohibits a coroner from expressing any opinion on matters other than the section 5 questions subject only to the coroner's ability to report any matter to an appropriate person for the purpose of preventing future death (see para 7 of Schedule 5 to the 2009 Act). An inquest determination must not appear to determine any question of criminal liability of a named person or any question of civil liability (section 10(2) of the 2009 Act).

45. The scope of an inquest's conclusion will depend upon whether or not article 2 of the Convention is engaged. The scope in cases that do not raise article 2 is set out in *R v HM Coroner for North Humberside, Ex Parte Jamieson* [1995] QB 1. The court (Sir Thomas Bingham MR, McCowan and Hirst LJJ) considered earlier but similar provisions to those now contained in section 5 of the 2009 Act. It held that an inquest is an inquiry to establish answers to four important but limited factual questions: the identity of the deceased, the place of his or her death, the time of his or her death and how the deceased came by his or her death. The "how" question is directed only to the means by which the deceased came by his or her death: it does not encompass the wider circumstances of death. Subsequent case law has confirmed that the "how" question under *Jamieson* is directed to the immediate physical means of death (*R (Cairns) v HM Deputy Coroner for Inner West London* [2011] EWHC 2890 (Admin), para 26).

46. The "how" question in this limited form must be asked and answered in all inquests that do not raise rights under the European Convention on Human Rights. In *R (Middleton) v West Somerset Coroner* [2004] UKHL 10, [2004] 2 AC 182, para 20, the House of Lords held that the requirements of article 2 of the Convention mean that an inquest "ought ordinarily to culminate in an expression, however brief, of the jury's conclusion on the disputed factual issues at the heart of the case." Consequently, where the obligation under article 2 to establish an independent investigation is engaged and is not discharged by any other means, a change to the scope of the *Jamieson* questions is needed: the "how" question is expanded to mean not simply "by what means" but "by what means and in what circumstances" a person came by his or her death (*Middleton*, para 35). Acts or omissions of third parties may be recorded. However, findings - or suggestions of - criminal and civil liability must be avoided (*Middleton*, para 37).

47. The approach in *Middleton* was given statutory effect by section 5(2) of the 2009 Act which states:

> "Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998 (c. 42)), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death."

State responsibility under article 2 of the Convention

48. Article 2 of the Convention provides that everyone's right to life shall be protected by law. It lays down a negative duty on states not to take life without justification and, in limited circumstances, positive obligations to protect life. These latter obligations comprise an operational duty to take reasonable steps to prevent real and immediate risk to life (including the risk of suicide) as well as a systems duty to establish a framework of laws, procedures and means of enforcement that will protect life.

Operational duty

49. The operational duty was first recognised by the European Court of Human Rights (ECtHR) in *Osman v United Kingdom* (2000) 29 EHRR 245. The ECtHR held, at para 116 of its judgment, that in order to demonstrate a breach of the duty, it must be established by way of a fact-sensitive enquiry 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."

50. The ECtHR in *Osman* referred to the operational duty as arising in the context of a real and immediate risk to life. In order to meet this threshold, it is not necessary for the risk to be apparent just before death (*Rabone v Pennine Care NHS Trust* [2012] UKSC 2, [2012] 2 AC 72, para 40) but the risk must be present at the time of the alleged breach of duty (*Rabone*, para 39).

51. The subsequent caselaw of the ECtHR has expanded the operational duty beyond the enforcement of the criminal law to certain other circumstances in which individuals are imprisoned, detained or otherwise under the control of the state. There is a duty to protect military conscripts – who are under the control of the state albeit not detained (*Kilinç v Turkey* (App No 40145/98) (unreported) 7 June 2005). The duty to protect prisoners from suicide was established in *Keenan v United Kingdom* (2001) 33 EHRR 913. Immigration detention may engage article 2 (*Slimani v France* (2004) 43 EHRR 1068) as may the detention of psychiatric patients in hospital (*Savage v South East Essex NHS Foundation Trust (MIND and others intervening*) [2008] UKHL 74, [2009] 1 AC 681).

52. In *Rabone*, the Supreme Court extended the operational duty to protect psychiatric patients admitted voluntarily to hospital in circumstances where the degree of control exercised by the hospital was in substance no different as between detained and voluntary patients. Lord Dyson JSC at paras 22-24 set out three indicia of the existence of the operational duty: (i) the assumption of responsibility by the state for the individual's welfare and safety (including by the exercise of control); (ii) the vulnerability of the victim (for example, children to whom local authorities owe duties); and (iii) the nature of the risk. This last factor encapsulates the case law of the ECtHR (such as *Stoyanovi v Bulgaria* (Application No 42980/04) (unreported) 9 November 2010) to the effect that the ordinary risks that inhere in everyday activities or professional obligations do not give rise to an operational duty, as opposed to dangerous and threatening situations that give rise to exceptional risk caused by man-made or natural hazards. Lord Dyson observed that these three indicia are relevant but not necessarily a sure guide to whether an operational duty will be found by the ECtHR to exist in circumstances which have not yet been considered by it (*Rabone*, para 25).

53. That the operational duty involves an assumption of responsibility by the state for an individual's safety had previously been expressed by Lord Rodger in *Mitchell v Glasgow City Council* [2009] UKHL 11, [2009] AC 874, para 66 (cited in *Rabone*, para 22):

> "In particular, where a state assumes responsibility for an individual, whether by taking him into custody, by imprisoning him, detaining him under mental health legislation, conscripting him into the armed forces, the state assumes responsibility for that individual's safety. So in these circumstances police authorities, prison authorities, health authorities and the armed forces are all subject to positive obligations to protect the lives of those in their care".

54. More recently, in *R (Maguire) v Blackpool and Fylde Senior Coroner* [2020] EWCA Civ 738, [2021] QB 409, Lord Burnett of Maldon CJ (giving the judgment of the court) held that state responsibility is "the unifying feature" of the application of the operational duty (see para 72). In those cases in which the operational duty does not apply, the various mechanisms provided by law (civil, disciplinary, criminal) may take their course (*Maguire*, para 78). The court in *Maguire* held that the operational duty did not apply to failures by individual personnel involved with the care of a vulnerable resident of a care home.

55. The court's focus in *Maguire* on state responsibility is consistent with there being no general duty on the state to protect an individual from taking his or her own life even if the authorities know or ought to know of a real and immediate risk (*Rabone*, para 100, per Baroness Hale of Richmond JSC). It is also consistent with the judgment in *Fernandes De Oliveira v Portugal* (2019) 69 EHRR 8, para 108, in which the Grand Chamber of the ECtHR observed that the operational duty applies "in certain well-defined circumstances." The scope of the operational duty has been extended only on an incremental basis and only in ways that "flow naturally" from existing jurisprudence of the ECtHR (*Maguire*, para 99). This incremental approach recognises that the scope of the operational duty must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities (*Osman*, para 116). In determining whether the state has breached the duty, the courts will take into consideration the many competing demands on state resources and the proportionality of any particular state intervention.

56. In considering the scope of the operational duty, the state's duty to respect the rights of others is relevant (*Rabone*, para 104, per Baroness Hale). I would add that, in the context of the provision of social security benefits, the state has a duty to respect the rights of all those who claim benefits and to direct its resources to that objective. That duty has been imposed by Parliament in comprehensive statutory provisions for the allocation of welfare benefits and for rights of appeal to an independent Tribunal against the Department's decisions. In my judgment, any consideration of article 2 obligations in the context of social security must recognise the core demand on the Department to operate a system that takes account of the statutory rights of the very many people whose physical or mental health may raise a pressing need for benefits such as ESA.

Systems duty

57. The systems duty is not concerned with errors of individual state actors or with the failure of co-ordination among individual state actors (*Lopes de Sousa Fernandes v Portugal* (2018) 66 EHRR 28, para 187). A breach of the systems duty will involve "an arguable failure of a systematic nature, i.e. a failure to provide an effective system of rules, guidance and control within which individuals are to operate in a particular context" (*R Long) v Secretary of State for Defence* [2015] EWCA Civ 770, [2015] 1 WLR 5006, para 25, per Lord Dyson MR). A series of distinct but separate operational

mistakes does not of itself demonstrates a failure of the system (*R (Scarfe) v Governor of HMP Woodhill* [2017] EWHC 1194, para 58). In the medical context, where the state has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, matters such as error of judgment on the part of an individual health professional or negligent co-ordination among professionals in the treatment of a particular patient are not sufficient of themselves to call the state to account under article 2 (*R (Parkinson) v Kent Senior Coroner* [2018] EWHC 1501 (Admin), [2018] 4 WLR 106, para 87).

Procedural duty

58. As an adjunct to these substantive aspects of article 2, there is a procedural obligation to investigate deaths for which the state might bear responsibility. The investigation must be independent of those responsible for the death and involve the family or representatives of the deceased (*Maguire*, para 11). A lawfully conducted *Middleton* inquest will ensure that the state meets the procedural obligation.

59. It is now well-established that there are some categories of case, such as suicides in prison and deliberate killings by state agents, where the procedural obligation is automatically engaged. Mr Nicholls did not suggest that the present case falls into such a category. In all other cases, the adjunctive nature of the procedural obligation means (as Mr Nicholls accepted) that it is engaged only if there is an arguable case that the state has breached one or more substantive article 2 duties in relation to a person's death (*R (Humberstone) v Legal Services Commission* [2010] EWCA Civ 1479, [2011] 1 WLR 1460, paras 52-68; *R (Letts) v Lord Chancellor* [2015] EWHC 402 (Admin), [2015] 1 WLR 4497, paras 71-75). If there is no basis for believing that a person's death was the result of a breach of a substantive article 2 duty, the procedural obligation on the state does not arise (*Maguire*, para 100). There must be a "credible suggestion" that the state has breached its article 2 obligations (*Maguire*, para 75) which must be advanced on a "real evidential basis" (*R (Morahan) v HM Assistant Coroner for West London* [2021] EWHC 1603, para 75).

Other inquests

60. Mr Nicholls drew attention to the inquest into the death of Philippa Day in which the Assistant Coroner for Nottinghamshire ruled that both the article 2 operational duty and the systems duty were engaged. The Assistant Coroner was willing to consider the role of the Department and the evidence of multiple and serious errors in administering Ms Day's claim for Personal Independence Payment. The Assistant Coroner's conclusions of law (set out in his ruling dated 17 November 2020) are not binding on this court. Although the ruling itself is lengthy, I would regard the legal analysis of the critical points (which is what is important) as less than comprehensive. That is no criticism of the Coroner who was not writing his decision for the purposes of citation in other cases; but I do not regard his legal analysis as advancing Mr Nicholls' submissions.

61. The same applies to the documents we have seen which contain the conclusions in a number of other inquests touching on the suicide of a number of individuals where evidence pointed to problems with the Department's handling or processing of their benefit claims. These documents make distressing reading. However, they are not binding and cannot be deployed to persuade this court to tread a new path rather than to follow established (and binding) case law on article 2.

62. Mr Nicholls relied on the First Ruling on Case Management and Directions given on 5 June 2020 by HHJ Lucraft QC (then Chief Coroner) in the inquest into the Fishmongers' Hall and London Bridge terror attacks which killed two people on 29 November 2019. Judge Lucraft reached no final decisions on article 2 in that Ruling which in any event would not bind us.

ESA Regulations 29 and 35

63. The ESA Regulations recognise that a functional assessment may in some circumstances not fully measure the incapacitating effect of certain conditions which may render someone incapable of work. Regulation 29(1) makes additional provision for this type of claimant:

> "(1) A claimant who does not have limited capability for work **as determined in accordance with the limited capability for work assessment** is to be treated as having limited capability for work if…
>
> (2) (a) …
>
> (b) the claimant suffers from some specific disease or bodily or mental disablement and, by reason of such disease or disablement, there would be a substantial risk to the mental or physical health of any person if the claimant were found not to have limited capability for work." (Emphasis added.)

64. It is plain on the face of Regulation 29 that this provision arises if and only if a person has been found in the work capability assessment not to have limited capability for work. In my judgment, the duty to treat a person as having limited capability for work in the circumstances of Regulation 29 does not arise for consideration unless and until a claimant fails to score the requisite 15 points under Schedule 2.

65. Mr Nicholls invited the court to read Regulation 29 far more widely, as a provision ensuring the state's compliance with article 2. He cited no authority for that proposition and was not able to explain why a provision relating to whether a person has limited capability for work should imply article 2 obligations on the Department. Not least, as I raised in discussion, Mr Nicholls' argument truncates the ESA decision-making process which is not limited to Regulation 29 but includes Schedule 2 itself, Schedule 3 and Regulation 35 (which makes provision comparable to Regulation 29 for entry into the support group). I regard the resort to Regulation 29 as a red herring.

Grounds for seeking a fresh inquest

66. Mr Nicholls advanced four grounds for a fresh inquest:

i. There has been an insufficiency of inquiry by the Coroner at common law;

ii. There has been an insufficiency of inquiry by the Coroner under article 2;

iii. Fresh evidence is now available which may reasonably lead to the conclusion that the substantial truth about how Ms Whiting died was not revealed at the first inquest; and

iv. A different conclusion would be likely at a fresh inquest.

The parties addressed each of these grounds in turn, and I shall do likewise.

Ground 1: inquiry at common law

67. Mr Nicholls dealt first with the inquest on the basis that it was a *Jamieson* inquest that does not raise article 2 issues. He accepted that, in the absence of article 2 issues, the question of how a person came by his or her death is answered by reaching a conclusion as to the immediate cause of death: see *Cairns*, above. He submitted however that, as a matter of common law, it is often necessary and in the public interest to inquire beyond that cause. The function of an inquest is to "seek out and record as many of the facts concerning the death as [the] public interest requires" (*R v South London Coroner, Ex parte Thompson* (1982) 126 S.J. 625 cited in *Jamieson*, p.17). The relevant facts must be fully, fairly and fearlessly investigated (*Jamieson*, p.26). The scope of a *Jamieson* inquest is not especially narrow: the question of how the deceased came by his or her death is clearly wider than merely finding the medical cause of death and may include acts and omissions that are directly responsible for the death (*R (Worthington) v HM Senior Coroner for the County of Cumbria* [2018] EWHC 3386 (Admin) DC, para 49, Hickinbottom LJ, myself and HHJ Lucraft QC).

68. Mr Nicholls submitted that a coronial inquiry may range wider than is strictly required for its determination. The inquiry is not restricted to the last link in the chain of causation (*R v Inner West London Coroner, Ex parte Dallaglio* [1994] 4 All ER 139, p.64; cited in *R (Hurst) v London North District Coroner* [2007] UKHL 13, [2007] 2 AC para 21). Coronial practice shows that coroners are willing to adopt a broad investigative scope. He took us to the "Decision following pre-inquest hearing" of Hallett LJ sitting as a coroner in the inquests into the London Bombings of 7 July 2005 as an example of an inquest with a broad scope.

69. Mr Nicholls submitted that the inquest in relation to Ms Whiting should have had a broader scope and should not have focused solely on the immediate cause of her death. There was no investigation of the Department's flawed handling and determination of her ESA claim and its causative impact. The public interest and the interests of Ms Whiting's family demanded that a new inquest should investigate the Department's conduct. The failings which were subsequently identified by the ICE report require public exposure to ensure accountability and to prevent future deaths.

70. Mr Nicholls submitted that, on a section 13 application, this court may exercise more than the conventional supervisory function that would be appropriate in judicial review proceedings. He submitted that we have the power to substitute our own view on the scope of the inquiry, particularly as there is fresh evidence available to us that was not available to the Coroner. The critical test is the public interest. Mr Hough submitted that the *Wednesbury* principle should apply. I would prefer Mr Hough's submission as more consistent with authority that it is not the function of a section 13 review to revisit matters lawfully determined by a coroner (*McDonnell v HM Assistant Coroner for West London* [2016] EWHC 3078 (Admin), paras 28-29). The question of the effect of fresh evidence is a different one calling for discrete consideration. However, the test for the grant of relief is not critical in the present case because, in my judgment, the Coroner's inquiry was on either test sufficient.

71. The Coroner's function at Ms Whiting's inquest was to conduct an inquest in accordance with the 2009 Act. It is plain from reading the transcript of proceedings that she had that task in mind. Her decision on the scope of the inquest represented her view about what was necessary and proportionate to discharge that function. She considered Ms Whiting's medical background, the medical cause of her death, the circumstances in which she was found dead and (to the extent that it could arise from the evidence before her) the apparent reasons for her suicidal mental state. She took what evidence she could from Ms Whiting's family on the effect on Ms Whiting of the decision to stop ESA. In my judgment, her inquiry was sufficient.

72. I do not agree that the Divisional Court in *Worthington* changed the scope of *Jamieson* inquests. The court in that case was considering whether a coronial determination was too wide on conventional judicial review principles such that certain words should be excised from the "how" conclusion. The court held that the words should not be excised: they fell within the Coroner's discretion in recording the answer to the "how" question. Nothing in the judgment of the court suggests it intended to depart from *Jamieson* by which it was bound. Nor does the judgment imply that the "how" question in a *Jamieson* inquest is capable of covering the general conduct and procedures of the Department in deciding to withdraw benefits from claimants, which would suggest a significantly wider inquiry than was under consideration in *Worthington*. In my judgment, the Coroner in the present case directed herself properly in law. I discern no *Wednesbury* or other public law error in the Coroner's approach or conclusions.

73. Nor do I accept that the Coroner was required by the public interest to undertake a broader inquiry, whether for the purpose of calling the Department to account or for the purpose of enabling questions of the Department's conduct to be publicly ventilated. The Department's policies, practices and conduct in decisions to withdraw benefits raise multi-factorial questions which are matters for ministers and for Parliament. The primary purpose of an inquest is to determine by what means someone has died. There is an ancillary power – now contained in para 7 of Schedule 5 to the 2009 Act – to make a Prevention of Future Deaths ("PFD") report. However, that power does not dictate the scope of an inquest (*R (Butler) v HM Coroner for the Black Country District* [2010] EWHC 43 (Admin), para 74). In my judgment, an ancillary power to make a PFD report does not imply that a coroner becomes the guardian of the public interest in matters relating to social security. The Coroner has no specialism in these matters and is not well-equipped to undertake such an inquiry.

74. Other forms of scrutiny exist. At the administrative level, the Department has a structured, three-tier complaints procedure. The third tier (the ICE) makes autonomous decisions following investigations as happened in the present case. Any legal defect in the ICE's approach or any legal error falling outside the ICE's powers would be amenable to judicial review in the High Court. It is the constitutional function of that court, not the Coroner, to hold the executive to account.

75. Substantive decisions relating to ESA are appealable to the Tribunal. The wide jurisdiction which Parliament has bestowed on the First-tier Tribunal (which is not limited to public law error but includes consideration of matters of fact and law afresh) ensures the just and fair application of social security law in a specialist forum. There are onward appeal rights (with permission) to the Upper Tribunal on points of law. There is a considerable and well-established body of case law from the Upper Tribunal relating to the statutory provisions relating to ESA and their practical application.

Tribunal judges of both Chambers are best placed to carry out the difficult balance between protecting the rights of vulnerable social security claimants and ensuring that precious public resources are allocated in accordance with fair but proportionate procedures. I would regard it as contrary to the administration of justice for coroners to stand in the shoes of specialist tribunal judges.

76. I have considered the cumulative effect of these avenues (administrative review by way of the complaints process, judicial review in the High Court and appeal rights in the Tribunal). In my judgment, they do not readily suggest a lack of accountability or a lack of public scrutiny which a coroner ought to remedy. I gratefully adopt the observation of Singh J (as he then was) that "there is no public interest in having unnecessary duplication of investigations or inquiries" (*R (Secretary of State for Transport) v HM Senior Coroner for Norfolk* [2016] EWHC 2279 (Admin), para 49, with which Lord Thomas of Cwmgiedd CJ agreed).

77. For these reasons, there was no requirement in public law for the Coroner to make further inquiry in relation to the Department and it would not have been in the interests of justice. I would dismiss Ground 1.

Ground 2: article 2 of the Convention

Operational duty

78. Mr Nicholls submitted that the evidence now available concerning Ms Whiting's death discloses an arguable breach of the article 2 operational duty. Focusing on Lord Dyson's three indicia in *Rabone*, he submitted that (i) the Department had assumed responsibility for Ms Whiting's welfare and safety by providing her with the income necessary to survive and had done so in order to prevent an identified risk to her mental health if her benefits were withdrawn; (ii) Ms Whiting was particularly vulnerable; and (iii) the risk to her which the withdrawal of her benefits had posed was exceptional.

Assumption of responsibility

79. Mr Nicholls cited no authority to support the proposition that a department charged with allocating public funds by way of welfare benefits has assumed responsibility for preventing the suicide of those who receive those funds. He cited no authority which suggests that an extension of the operational duty to cover Ms Whiting's situation would flow from the case law of the ECtHR or from domestic authority.

80. The Department is bound to apply the law as set down by Parliament. It is bound to allocate funds to those meeting the statutory criteria for ESA. Conversely, it is bound not to allocate funds to those who do not meet them. The reason the Department allocated ESA to Ms Whiting in the years before her death was that she satisfied the statutory eligibility criteria; the decisions had nothing to do with article 2. I have kept the shocking nature of what happened at the front of my mind. It is nevertheless in my judgment something of a leap from a flawed – even badly flawed – work capability assessment to the engagement of article 2 rights.

81. Mr Nicholls pointed to the Department's internal guidance on procedures to be adopted when a claimant does not attend an HCP appointment. The guidance uses the language of safeguarding in stipulating when staff should undertake a home visit to a claimant

prior to disallowing his or her benefit for failure to attend an appointment. The guidance refers to "Safeguard Visits for non-attendance at mandatory interviews" and "failing in your duty on behalf of DWP to safeguard vulnerable claimants by not checking the Mental Health flag." It does not follow, however, that the use of the word "safeguarding" imports the assumption of responsibility. Guidance is not the same as law. It should not be read with the precision of law. It is intended to communicate to decision-makers what they should do in everyday, practical language. In my judgment, the language of safeguarding conveys in a practical way the actions that the Department's officials should take. It is not a reason for this court to adopt an approach to state responsibility that would (as Mr Hough and Mr Griffiths emphasised) amount to a significant extension of domestic and ECtHR jurisprudence.

82. As I have set out above, Mr Nicholls relied on Regulation 29 of the Regulations as ensuring the article 2 rights of ESA claimants. However, Ms Whiting was refused ESA because she did not attend a medical assessment under Regulation 23(2). That decision did not bring Regulation 29 into play. Mr Nicholls made no submissions on why, as a matter of principle, a filtering mechanism such as Regulation 23(2) would engage article 2; nor is it obvious that it would do so.

Vulnerability

83. Ms Whiting undoubtedly had significant physical and mental health problems which made her particularly vulnerable. However, I agree with Mr Hough and Mr Griffiths that it is not sufficient for the purposes of establishing an operational duty that an individual is sufficiently vulnerable by reason of physical or mental ill-health. The case of *Maguire* concerned a vulnerable adult living in residential care and unable to care for herself. The court considered in detail the effect of *Rabone* and of Lord Dyson's three indicia, including vulnerability, but found that the operational duty was not engaged. The court concluded, as I have set out above, that the unifying feature of the application of the operational duty is state responsibility.

84. There is no indication in *Maguire* that the court intended to depart from *Rabone*. It would not have been free to do so. Ms Whiting was not under the control of the state as in the prisoner cases; nor was she a vulnerable person under the care of the state; nor was she a child to whom responsibility may in certain circumstances arise because of inherent or automatic vulnerability. The question is whether the Department had a duty to protect Ms Whiting from taking her own life. In my judgment, the question falls to be answered by the touchstone of state responsibility: there is no general obligation to prevent suicide in the absence of the assumption of responsibility.

Nature of the risk

85. Mr Hough and Mr Griffiths relied on evidence that the risk posed by Ms Whiting's mental state and her tendencies to self-harm or suicide had sadly been a constant in her life for many years. The risk posed to Ms Whiting by the withdrawal of benefits did not arise from an inherently dangerous situation of specific threat to life such as risks posed by hazards which a person would not ordinarily assume. I agree with Mr Hough and Mr Griffiths and would not classify the risk to Ms Whiting as exceptional in the sense deployed by Lord Dyson.

Standing back

86. It follows that I do not accept that Ms Whiting's case would arguably meet Lord Dyson's indicia. I have nevertheless taken into consideration that Lord Dyson did not regard those indicia as a sure guide in all cases. I have therefore stood back and considered whether it is arguable (which is the low threshold that the applicant must meet) that an operational duty arose on any other grounds and, in particular, on any accumulation of the various factors that Mr Nicholls has emphasised. In the absence of (i) an arguable assumption of state responsibility; and (ii) any ECtHR or domestic authority from which an article 2 duty would flow on the facts of the present case, I do not regard it as being open to this court to hold that such a duty exists, even arguably.

Systems duty

87. It is not in dispute that the Department had policies and procedures in place which were intended to support vulnerable benefits claimants within the ESA scheme. Mr Nicholls' principal submission relied on the broader elements of the systems duty which require states to ensure that systems function effectively by way of measures that ensure implementation, supervision and enforcement of standards (*Lopes de Sousa Fernandes v Portugal* (2018) 66 EHRR 28, para 189). By way of evidence that the Department's systems arguably do not meet the systems duty, Mr Nicholls relied on a National Audit Office report entitled "Information held by the Department for Work & Pensions on deaths by suicide of benefit claimants" (5 February 2020). The report states that the Department had received four PFD reports from coroners since 2013, of which two were related to suicide. It had investigated 69 suicides of benefit claimants since 2014-15. Mr Nicholls submitted that, when considered with the concerns of Parliamentarians about the numbers of those who have died through suicide after being refused benefits and the evidence recorded by coroners in other inquests (such as Ms Day's), it can be inferred that the system did not function adequately.

88. The taking of life is a tragedy. The court must nevertheless consider the state's legal obligations in the context of the United Kingdom's advanced social security system which is built on multiple foundations. The system for administering ESA derives from statute, regulations, guidance and case law which together cover substantive decision-making, practice and procedures. They contribute to a comprehensive framework for decision-making. Mr Nicholls made no concrete suggestion as to how, in the circumstances of this case, the scope of the Department's duties or their implementation might be deficient. We were asked to infer that the number of failings identified in the ICE report gives rise to an arguable breach of at least some part of the systems duty. However, in my judgment, on the evidence before the court, the Department's errors amounted to individual failings attributable to mistakes or bad judgment. I would not regard them as systemic or structural in nature. The applicant has not established an arguable breach of the systems duty.

Procedural duty

89. In the absence of an arguable breach of the operational or systems duty, the article 2 procedural duty does not arise. The Coroner was not required to undertake an inquiry into the role of the Department in Ms Whiting's death and it would not be open to, or in the interests of justice for, a fresh inquest to do so. Ground 2 does not succeed.

Ground 3: fresh evidence

90. Mr Nicholls submitted that, even if the Coroner's approach was not flawed on the evidence before her, fresh evidence is available which may reasonably lead to the conclusion that the substantial truth about how Ms Whiting died was not revealed at the first inquest. The court does not need to be satisfied that the conclusions at a fresh inquest are likely to be different. The statutory requirement is to demonstrate the existence of "new facts or evidence" which render a fresh inquest necessary or desirable in the interests of justice (*Frost v HM Coroner for West Yorkshire (Eastern District)* [2019] EWHC 1100 (Admin), para 41).

91. The ICE investigated and reported on non-compliance by the Department with proper procedures in dealing with Ms Whiting's entitlement to benefits. As I have held above, it is not necessary and would not be in the public interest for a coroner to engage in an extensive inquiry into the Department's decision- making. The fact that the ICE found numerous significant failings does not mean that an inquest should adduce substantial evidence about them.

92. It is important to analyse what Dr Turner's report says. His conclusion is that there was likely to have been a causal link between the Department's failings outlined in the ICE report and Ms Whiting's state of mind immediately before her death. As Mr Hough submitted, the causal link which Dr Turner draws relates to Ms Whiting's state of mind and not to her death. Dr Turner does not go as far as to say that the Department's decision to stop Ms Whiting's ESA caused her to take her own life. He did not rule out other stressors as causative of her suicidal state or her suicide.

93. While my sympathies go out to Mrs Dove and the family, I have to take into consideration the evidence before the court. I agree with Mr Hough that it is likely to remain a matter of speculation as to whether or not the Department's decision caused Ms Whiting's suicide. In my judgment, it would be extremely difficult for a new inquest to conclude that the Department caused Ms Whiting's death.

94. For these reasons, I am not persuaded that the interests of justice incline towards a new inquest in light of the fresh evidence. I would dismiss Ground 3.

Ground 4: potential for a different conclusion by a coroner

95. I can deal with Ground 4 shortly. Mr Nicholls submitted that the fresh evidence makes it more likely that a different conclusion would be returned at a fresh inquest, namely a narrative conclusion alongside the short-form which would be able to identify the role of the Department in the circumstances of Ms Whiting's death and make findings on whether the Department's acts and omissions contributed to the death. In my judgment, this Ground adds nothing of substance to Mr Nicholls' preceding grounds. The inquest conducted by the Coroner was short but fair. It covered the legal ground and dealt with the evidence before the Coroner including the views of Ms Whiting's family. It complied with the requirements of *Jamieson*. It was not bound to do anything else and I am not persuaded that the interests of justice called for anything else.

Conclusion

96. Accordingly, despite Mr Nicholls' intelligent submissions, I am not persuaded that the interests of justice make a further coronial investigation necessary or desirable. I would therefore dismiss this application.

Lord Justice Warby:

97. I agree that this claim should be dismissed, for the reasons given by Farbey J. The question for us is whether it is necessary or desirable in the interests of justice that another coronial investigation should be held, either because there was an insufficiency of inquiry, or because of fresh evidence. I do not consider that there was any insufficiency of inquiry, nor that the fresh evidence means another investigation is necessary or desirable.

98. As is common ground, the formal determination that Ms Whiting died by suicide was the only one open to the Coroner. She added, as part of her public oral deliberations, that Ms Whiting's mother and sister believed that extra stress caused by the refusal of her ESA claim was a contributing factor in her death. But the Coroner did not seek to question decisions made by the Department.

99. She treated this as a *Jamieson* investigation. The authorities indicate that when addressing the "how" question in such a case a coroner may, as a matter of discretion, go beyond a bare determination of the mechanism of death. But the scope of this discretion is limited by statute. The coroner may not trespass into the territory of appearing to determine criminal or civil liability or expressing opinions on matters other than those specifically encompassed by s 5(1). That territory is forbidden by ss 5(3) and 10(2) of the 2009 Act. Where the discretion is available, its exercise is governed by the public interest. The Coroner took the view that the public interest did not require her to investigate the role of the Department. For the reasons given by Farbey J at [73-76] the Coroner was not wrong. What this coroner did was, on the evidence she had, sufficient to satisfy the requirements of a coronial investigation of the *Jamieson* variety.

100. The fresh evidence does not alter the position in that respect. Indeed, rather the contrary. There has been an investigation by the ICE, leading to a detailed report which is not a private or confidential document. This shows, starkly, that there were multiple failings by staff at the Department before (as well as after) Ms Whiting's death. The nature of the errors is clearly set out in the ICE report, and in the judgment of Farbey J, and is not in dispute. The Department does not seek to defend them. I see no reason to believe that the ICE's findings are incomplete or inadequate, or that a further coronial investigation is necessary or desirable to supplement them, or to provide further publicity, or for any other reason. Dr Turner's report links the Department's errors with the stress that Ms Whiting was clearly suffering when she took the decision to end her life; but it would not support a finding that the Department was responsible for that decision, assuming such a finding would be open to a coroner as a matter of law.

101. For the claimant, it is said that the errors in this case are not isolated. But the ICE did not identify any systemic flaws. And the evidence and argument relied on in support of the claim that there were such flaws is wanting in detail and precision. The evidence before us is incapable of showing that the errors made in relation to Ms Whiting stemmed from any systemic or structural failure that would represent a breach of the

state's "systems duty" under Article 2 of the Convention. The only available conclusion is that a series of individual errors was made. We have no grounds for supposing that a further coronial investigation might find otherwise.

102. Nobody has sought to disagree with the ICE's conclusion that these were "significant failings". The Department accepts that assessment. But that is not the same thing as a breach of the state's operational duty to safeguard life. For the reasons given by Farbey J, it is not arguable that the facts of this case engaged the state's operational duty. Accordingly, despite the deep sympathy one must feel for Ms Whiting's family, I agree that there is no ground on which to order a new investigation.

HHJ Teague QC :

103. I agree with both judgments.