Neutral Citation Number: [2022] EWHC 1377 (Admin)

Case No: CO/3451/2021

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISRATIVE COURT IN WALES

Cardiff Civil and Family Justice Centre
2 Park Street, Cardiff, CF10 1ET

Date: 07/06/2022

Before:

MRS JUSTICE HILL

- -

Between:

R (JOANNE PATTON)	**Claimant**
-and-	
HER MAJESTY'S ASSISTANT CORONER FOR CARMARTHENSHIRE AND PEMBROKESHIRE	**Defendant**
-and-	
PEMBROKESHIRE COUNTY COUNCIL **HYWEL DDA UNIVERSITY LOCAL HEALTH BOARD** **THE CHIEF CONSTABLE OF DYFED POWYS POLICE**	**Interested Parties**

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Christian Howells (instructed by Watkins and Gunn solicitors) for Ms Patton
Sebastian Naughton (instructed by Pembrokeshire County Council Legal and Democratic Services) for the Defendant
Malcolm Duthie (instructed by Dolmans Solicitors) for Pembrokeshire County Council
James Berry (instructed by Hywel Dda University Health Board Legal Services) for Hywel Dda University Health Board

Hearing date: 4 May 2022

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.
Covid-19 Protocol: this judgment was handed down by the judge remotely by circulation to the parties' representatives by email and release to The National Archives. The date and time of hand-down is 10.30am on 7 June 2022

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MRS JUSTICE HILL

Mrs Justice Hill:

Introduction

1. This is a claim for judicial review brought by Ms Joanne Patton, the mother of Kianna Patton who died on or around 23 October 2019 when she was 16 years old. Her body was found hanging in an abandoned hotel on that date.

2. At the time of her death Kianna was under the care of Specialist-Child and Adolescent Mental Health Services ("S-CAMHS"). She was living with a friend, whose mother had let her use cannabis. This caused Ms Patton significant anxiety given Kianna's mental health issues. She sought assistance in relation to Kianna from social workers and Police officers before her death. She believes there were serious failings in the way they responded and in the care S-CAMHS provided to Kianna.

3. An inquest was duly opened into her death. Pembrokeshire County Council ("the Council"), Hywel Dda University Local Health Board ("the Health Board") (which is responsible for S-CAMHS) and the Chief Constable of Dyfed Powys Police ("the Police") were granted Interested Person status in the inquest proceedings and are thus Interested Parties in this claim.

4. By this claim Ms Patton challenges the Coroner's ruling dated 8 August 2021 to the effect that the inquest into Kianna's death will not investigate in what circumstances she came by her death, pursuant to section 5(2) of the Coroners and Justice Act 2009, because the procedural investigative duty contained in Article 2 of the European Convention on Human Rights ("the Convention") did not arise. On 24 November 2021 she was granted permission on all her three grounds by Upper Tribunal Judge Grubb, sitting as a judge of the High Court.

5. The Council played an active role in the proceedings, defending the Coroner's decision. The Health Board remained neutral on the first two of the Claimant's grounds but made some limited submissions on the third. The Coroner took a neutral stance in responding to the claim but provided written and oral submissions intended to assist the court, particularly in understanding the approach he had taken in reaching his decision. I was greatly assisted by the submissions from all counsel. The Chief Constable remained neutral on the claim and placed no submissions before the court.

6. I reiterate my condolences to Ms Patton and her family for their tragic loss. As in any case of this nature it has been necessary to make difficult decisions based on a complex and nuanced

legal framework, but at the heart of the case remains the death of a vulnerable child and a grieving family.

The facts

7. Kianna was born on 22 June 2003. She was one of three children. Ms Patton's evidence is that she generally performed well at school as a young child. Difficulties appear to have emerged in 2017. Kianna went missing on more than one occasion. It appears that in June 2017 she took an overdose but did not tell anyone about it.

8. At around the beginning of 2018, Ms Patton noticed that Kianna's behaviour had started to change, particularly after she started using drugs, having become friends with other children who did so. Kianna started missing school and her grades began to fall.

9. On 26 January 2018 Kianna was referred to S-CAMHS by her GP as she had disclosed self-harm with a razor blade and was experiencing panic attacks and low mood. She was duly assessed by a S-CAMHS clinical psychologist and placed on a waiting list.

10. On 15 May 2018, while she was waiting for treatment from S-CAMHS, Kianna attended the Accident and Emergency Department following an overdose of Tramadol. She told medical practitioners that she had intended to end her life. A referral was made to S-CAMHS and the local safeguarding board. The Council was also notified of her overdose. Consideration was given to Kianna being referred to the Child Care Assessment Team ("CCAT").

11. On 17 May 2018 a meeting was held at Kianna's school. It was noted that she had been offered therapy with S-CAMHS and had access to the school counsellor and nurse. Ms Patton's evidence is that a social worker made an urgent referral for a Family Intervention Team ("FIT") worker to be assigned to support Kianna, but that they were told the FIT did not have capacity to help them.

12. On 10 July 2018 a social worker assessed Kianna's needs but decided that the criteria for a care and support plan were not satisfied, because other services and her mother could meet her needs.

13. On 21 July 2018 Kianna was arrested for assaulting Ms Patton and taken to Haverfordwest Police Station. She refused to come home. A strategy discussion was held between the Council and the Police. It was eventually agreed that she would stay with a family friend until the relationship settled down.

14. Between 23 and 30 August 2018 a social worker assessed Kianna's needs, again concluding that she did not meet the criteria for a care and support plan as support from other agencies was available and was being provided through S-CAMHS.

15. Ms Patton and Kianna were offered 'preventative' support from the Team Around the Family ("TAF") but they declined this. Ms Patton's evidence is that she had not found support from this team effective.

16. On 10 September 2018 a "contract" was signed by Kianna and her mother aimed at "setting boundaries and enhancing understanding of each other's wishes". No child protection concerns were identified. On 14 September 2018 the CCAT "closed" Kianna's case, with her

consent and that of her mother. On 1 October 2018 these steps were approved by a TAF manager.

17. On 14 June 2019 S-CAMHS discharged Kianna because she had been "feeling much better in herself since Dec 2018" and she had had "no more thoughts of harm to self or others". She had stopped taking her fluoxetine (an antidepressant) as she reported that she no longer needed them.

18. Ms Patton was very concerned about Kianna's cannabis use and the effect that it was having on the other children in the home. As a result, on 23 June 2019, she asked Kianna to leave the family home. Kianna did so and moved in with a friend. However, Ms Patton was concerned that Kianna was being allowed to smoke cannabis at that home.

19. On 28 June 2019 Ms Patton contacted the Police to inform them that Kianna was staying at the home of a friend without her consent. She indicated to the Police that it was not suitable accommodation for Kianna because she was being allowed to smoke cannabis there. The Police re-directed her to the Council on the basis that they have statutory powers to provide accommodation. The Police log records that the information Ms Patton had provided would be shared with the Council. However, although a Multi-Agency Referral Form ("MARF") was completed by the Police on 29 June 2019 and sent to a group local authority email address, the Council has no record of receiving it. It did not make its way on to Kianna's file.

20. On 29 June 2019 according to Ms Patton, she contacted the Council herself and provided the same information. Her evidence is that the Council told her that as her concerns involved recreational drug use, this was a matter for the Police. The Council has no record of this contact.

21. On 2 September 2019 Kianna visited her GP and stated that she was worried about schizophrenia and delusions (that her mother had killed herself and that she had been raped). She was hearing voices in her head. She was taking fluoxetine again. The following day, her GP made a further referral to S-CAMHS.

22. On 4 September 2019 Ms Patton submitted a written complaint to Stephen Crabb MP about the failure of the Council and the Police to help her with Kianna.

23. On 16 September 2019 Mr Crabb MP forwarded Ms Patton's correspondence to the Council. He asked the Council and the Police to agree a coordinated approach.

24. On 17 September 2019 S-CAMHS carried out an initial assessment of Kianna. She was assessed as posing low apparent risk to herself. Ongoing assessment was required with the Early Intervention in Psychosis Service ("EIPS").

25. On 23 September 2019 Ms Patton contacted the Council and again raised the issue of Kianna being allowed to smoke cannabis at the house where she was living, her mental health issues and the fact that she had taken an overdose in May 2018. The social worker advised Ms Patton to remain in contact with Kianna by sending text messages and recorded that Kianna's college youth worker would offer supported lodgings or foster care if Kianna had any concerns in relation to accommodation.

26. On 24 September 2019 the Director of Social Services responded to Mr Crabb MP stating that the CCAT would visit Ms Patton at home to ascertain Kianna's whereabouts and offer an Initial Assessment to see what, if any, intervention could be offered. Ms Patton's evidence is that this needs assessment did not take place.

27. On 25 September 2019 and 14 October 2019 Kianna had S-CAMHS appointments. In the latter of these she reported that she had ongoing thoughts to end her life but did not consider that she would act on them. "No current self-harming behaviour" was recorded.

28. On 21 October 2019 Kianna had an appointment with an S-CAMHS psychiatrist to further explore her symptoms and consider medication. On the same day, Police officers attended at Ms Patton's home to discuss the complaint to Mr Crabb MP. Ms Patton's evidence is that she was advised that as Kianna was 16 there was nothing they could do.

29. On 23 October 2019 Kianna was reported missing. On 24 October 2019 at around 6.00 pm her dead body was discovered.

30. An inquest into Kianna's death was duly opened.

31. On 6 November 2019 the mother of the friend Kianna had been living with provided a witness statement to the Police confirming that she had permitted Kianna to smoke cannabis in the garden of her home. She said that Kianna did this mainly at night, and that "when she took it at night, it used to help the voices in her head and she used to have a good night's sleep if she had taken it".

32. On 19 February 2021 a pre-inquest review took place. It was agreed that the Council and Police would provide witness evidence. Detailed written submissions were duly provided by all the Interested Parties on the question of whether or not Article 2 applied to the inquest and as to its scope.

33. On 6 August 2021 a further pre-inquest review took place at which the Article 2 issues were argued. On 8 August 2021 the Coroner provided the written ruling that is the subject of this challenge. This is set out in further detail below.

34. After the Coroner's ruling, disclosure was made of the Health Board's final report of its "review of concerns" relating to Kianna's death, although this was dated 21 May 2021. This report identified several issues with care delivery and the way in which Kianna's risk had been assessed; noted that safeguarding screening had not been completed when it was identified that Kianna was no longer living at home and that a friend's father had accompanied her to the appointments; and set out several lessons learnt and recommendations.

35. On 11 October 2021 this claim was issued.

The legal framework

The Coroners and Justice Act 2009 and Article 2

36. The matters to be ascertained at an inquest are derived from section 5 of the Coroners and Justice Act 2009 ("the 2009 Act"), which provides in material part as follows:

> **5. Matters to be ascertained**
>
> (1) The purpose of an investigation under this Part into a person's death is to ascertain—
>
> (a) who the deceased was;
>
> (b) how, when and where the deceased came by his or her death;
>
> (c) the particulars (if any) required by the 1953 Act to be registered concerning the death.
>
> (2) 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.

37. The outcome of an inquest is provided for at section 10 of the 2009 Act:

> **10. Determinations and findings to be made**
>
> (1) After hearing the evidence at an inquest into a death, the senior coroner (if there is no jury) or the jury (if there is one) must—
>
> (a) make a determination as to the questions mentioned in section 5(1)(a) and (b) (read with section 5(2) where applicable), and
>
> (b) if particulars are required by the 1953 Act to be registered concerning the death, make a finding as to those particulars.
>
> (2) A determination under subsection (1)(a) may not be framed in such a way as to appear to determine any question of—
>
> (a) criminal liability on the part of a named person, or
>
> (b) civil liability.
>
> (3) In subsection (2) "criminal liability" includes liability in respect of a service offence.

38. The Convention right typically in issue under section 5(2) is the right to life in Article 2. Article 2 imposes a duty on the state to conduct a proactive and effective investigation into the circumstances of certain deaths. Where necessary to ensure compliance with that obligation, section 5(2) applies to modify the purposes of a Coroner's investigation and section 10(1)(a) applies to modify the determinations and findings to be made.

39. The extensive and complex case law relating to the different Article 2 duties was recently comprehensively reviewed by the Divisional Court (Popplewell LJ, Garnham J and HHJ Teague, Chief Coroner of England and Wales) in *R (Morahan) v West London Assistant Coroner* [2021] EWHC 1603; [2021] QB 1205 at [29]-[31] and [38]-[121]. At [122], Popplewell LJ, with whom Garnham J and HHJ Teague agreed, distilled the following principles about the enhanced investigative duty under Article 2:

> "(1) There is a duty on the state to investigate every death. This is part of its framework duty under article 2 by way of positive substantive obligation. This duty may be fulfilled simply by identifying the cause of death. It may require

> further investigation and some explanation from state entities, such as information and/or records from a GP or a hospital.
>
> (2) In certain circumstances there is also a distinct and additional enhanced duty of investigation which requires the scope of the investigation to have the minimum features summarised by Lord Phillips in [*R (Smith) v Oxfordshire Assistant Deputy Coroner* [2010] UKSC 29; [2011] 1 AC 1] at paragraph 64. In this country the enhanced investigative duty is usually, but not always, to be fulfilled by a *Middleton* inquest.
>
> (3) The enhanced investigative duty is procedural and parasitic on a substantive duty. It cannot exist where there is no substantive duty.
>
> (4) The circumstances in which an enhanced investigative duty, as a procedural parasitic duty, arises are twofold:
>
> (a) whenever there is an arguable breach of the state's substantive article 2 duties, whether the negative, systemic or positive operational duties; and
>
> (b) in certain categories of circumstances, automatically".

40. Ms Patton relied on the category within [122(4)(a)] of *Morahan*. She did not suggest that there had been any arguable breach of the positive 'operational' duties. Rather, she contended that there had been an arguable breach of the state's 'systemic' duty, otherwise referred to in the authorities as the 'general' or 'framework' duty.

41. This duty was described in *Morahan* at [30(2)(a)] thus:

> "…a duty to put in place a legislative and administrative framework to protect the right to life, involving effective deterrence against threats to life, including criminal law provisions to deter the commission of offences, backed up by a law enforcement machinery for the prevention, suppression and sanctioning of breaches of such provisions; and in the healthcare context having effective administrative and regulatory systems in place (*Van Colle v Chief Constable of the Hertfordshire Police* [2009] 1 AC 225 at para 28, [*Rabone v Pennine Care NHS Trust* [2012] 2 WLR 391] at paras 12 and 93)".

42. In the healthcare context, the general duty was described in *Savage v South Essex Partnership NHS Foundation Trust* [2009] 1 AC 681 at [45] as "an obligation to adopt appropriate (general) measures for protecting the lives of patients in hospitals. This will involve, for example, ensuring that competent staff are recruited, that high professional standards are maintained and that suitable systems of working are put in place". The European Court of Human Rights has been clear that if hospital authorities have performed these obligations, "casual acts of negligence by members of staff will not give rise to a breach of article 2": *Savage* at [45], quoting *Powell v United Kingdom* (2000) 30 EHRR CD 362, 364.

43. These principles were reiterated by the Divisional Court (Singh LJ, Foskett J and HHJ Lucraft) in *R (Parkinson) v HM Senior Coroner for Kent* [2018] EWHC 1501 thus:

> "86. The enhanced duty of investigation, which falls upon the state itself to initiate an effective and independent investigation, will only arise in medical cases in limited circumstances, where there is an arguable breach of the state's own substantive obligations under Article 2.
>
> 87. 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 an error of judgment on the part of a health professional or negligent coordination among health professionals in the treatment of a particular patient are not sufficient of themselves to call the state to account under Article 2.
>
> 88. However, there may be exceptional cases which go beyond mere error or medical negligence, in which medical staff, in breach of their professional obligations, fail to provide emergency medical treatment despite being fully aware that a person's life would be put at risk if that treatment is not given. In such a case the failure will result from a dysfunction in the hospital's services and this will be a structural issue linked to the deficiencies in the regulatory framework
>
> 89. At the risk of over-simplification, the crucial distinction is between a case where there is reason to believe that there may have been a breach which is a "systemic failure", in contrast to an "ordinary" case of medical negligence.
>
> 90. Furthermore, we do not regard the principles in [*Lopez Fernandez v Portugal* (2017) European Court of Human Rights (Grand Chamber)] as being inconsistent with what the courts of this country have said under the HRA. Rather the distinction between a systemic failure and ordinary negligence cases is one which is also to be found in the domestic case law, for example in *Savage* and *Rabone…Humberstone* makes the same distinction".

44. In *R (Dove) v HM Coroner for Teesside and Hartlepool* [2021] EWHC 2511 at [57], Farbey J emphasised that:

> "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)".

45. In *R (Boyce) v Teesside and Hartlepool Senior Coroner* [2022] EWHC 107 at [41], HHJ Boucher (sitting as a Judge of the High Court) observed that the general duty is concerned "at a relatively high level with systems and procedures".

46. In *R (Humberstone) v Legal Services Commission* [2011] 1 WLR 1460, Smith LJ held that "care should be taken to ensure that allegations of individual negligence are not dressed up as systemic failures": [71]. These observations were repeated in *Parkinson* at [91].

47. The test for determining whether there has been an arguable breach of one of the state's substantive article 2 duties has been described as "anything more than fanciful" and a "low" threshold. However, it must be "more than mere speculation": and involve a "a real evidential basis which makes the suggestion of a breach…a credible one": *Morahan* at [75].

48. There must be a link between the breach complained of and the harm which the patient sustained: *Parkinson* at [75]. The appropriate Article 2 causation test is loss of a substantial chance of a different outcome: see, for example, *Daniel v St George's Healthcare NHS Trust* [2016] 4 WLR 32 at [30]-[31]; see also *R (Long) v Secretary of state for Defence* [2015] 1 WLR 5006 at [32], where Lord Dyson MR described a failure to take measures which "could have had a real prospect of avoiding the deaths".

The Social Services and Well-being (Wales) Act 2014 and related Regulations

49. Mr Howells, who has appeared on behalf of Ms Patton before the Coroner throughout, relied on the following domestic law provisions in support of his submission that the enhanced investigative duty was engaged in the inquest into Kianna's death.

50. Sections 76(1)(c) and 76(3) of the Social Services and Well-being (Wales) Act 2014 ("the 2014 Act") provide as follows:

> **76. Accommodation for children without parents or who are lost or abandoned etc**
>
> (1) A local authority must provide accommodation for any child within its area who appears to the authority to require accommodation as a result of—
>
> (a) there being no person who has parental responsibility for the child,
>
> (b) the child being lost or having been abandoned, or
>
> (c) the person who has been caring for the child being prevented (whether or not permanently, and for whatever reason) from providing the child with suitable accommodation or care…
>
> (3) A local authority must provide accommodation for any child within its area who has reached the age of 16 and whose well-being the authority considers is likely to be seriously prejudiced if it does not provide the child with accommodation.

51. Under section 3(3) of the 2014 Act, a child is a person under the age of 18.

52. The duties under section 76 are a restatement of those in section 20 of the Children Act 1989. Accommodation of a child under section 20 can involve a delegation of parental responsibility by the parents to the local authority, but this is not required in every case: *Williams and another v London Borough of Hackney* [2018] UKSC 37, [2018] 3 WLR 503 at [39], [41] and [64], per Lady Hale.

53. Under section 74(1)(b) of the 2014 Act, a child who is provided with accommodation by the authority in the exercise of one of the section 76 duties is a 'looked after child'.

54. Section 78 of the 2014 Act provides as follows in relation to looked after children:

> **78 Principal duty of a local authority in relation to looked after children**
>
> (1) A local authority looking after any child must—
>
> (a) safeguard and promote the child's well-being, and
>
> (b) make such use of services available for children cared for by their own parents as appears to the authority reasonable in the child's case.
>
> (2) The duty of a local authority under subsection (1)(a) to safeguard and promote the well-being of a child looked after by it includes, for example—
>
> (a) a duty to promote the child's educational achievement;
>
> (b) a duty—
>
> (i) to assess from time to time whether the child has care and support needs which meet the eligibility criteria set under section 32, and
>
> (ii) if the child has needs which meet the eligibility criteria, to at least meet those needs.

55. Section 83(2) provides that if a child becomes looked after by a local authority, and does not already have in place a care and support plan, the local authority must prepare one. Care and support plans are addressed further by regulation 5 of the Planning, Placement and Case Review (Wales) Regulations 2015 (the 2015 Regulations). Regulation 5(1)(b) indicates that a care and support plan must include a record of the arrangements made by the responsible authority to meet a looked after child's needs in relation to health, education and training, emotional and behavioural development and a range of other areas. Regulation 7(1)(a) makes provision for a looked after child to be examined by healthcare professionals before a placement or review of their case.

56. Reliance was also placed on *Salford City Council v W* [2021] EWHC 1689 (Fam), where MacDonald J set out the correct approach to section 20, in summary, thus:

(i) The court's task is to take its own view of the evidence and come to a conclusion as to whether, on the balance of probabilities, a child appears, at the relevant time, to require accommodation by reason of the parent being prevented from providing them with suitable accommodation or care: [40].

(ii) Where one party has already taken a decision as to what the evidence demonstrates as a matter of fact, but that factual determination is disputed it will be necessary for the court determine for itself whether the evidence can bear that conclusion or not: [40].

(iii) In determining whether a child is a looked after child, the court must consider whether it can be said that it appeared to the relevant local authority that the child required accommodation by reason of the person who had been caring for the child being

prevented, whether or not permanently, and for whatever reason, from providing the child with suitable accommodation or care: [46].

(iv) The statutory test is an objective one and "prevented" within section 76(1)(c) must be given "the widest possible scope". The test in section 76(1)(c) must be read in light of the general duties set out in section 78. The guiding principle is the need to safeguard and promote the child's welfare so it makes no difference whether the reason is one which the carer has brought about by their own act or is one which they are resisting to the best of their ability: [48].

(v) The duty to provide accommodation arises when it appears to the local authority that the child requires accommodation as a consequence of the matters specified in section 76(1). It can arise prior to any steps being taken by the local authority: [56(iii)].

(vi) Once the duty has arisen the child is looked after: [56(iv)].

(vii) The duty to provide accommodation is a mandatory one: [56(v)].

The Article 2 arguments before the Coroner and the Coroner's ruling

Ms Patton's submissions

57. Ms Patton provided a witness statement setting out her concerns about the actions of the various Interested Persons before Kianna's death.

58. Mr Howells relied on Ms Patton's contact with the Council and the Police on 28/29 June 2019. Through this contact, it was arguable that the Council had received information to the effect that (i) she had been prevented from providing Kianna with suitable accommodation; and/or (ii) there was a risk that Kianna's accommodation was likely to seriously damage her well-being, in particular her mental health. On that basis, it was said that (i) as a matter of law, the Council was under a duty to provide Kianna with accommodation, most likely a foster placement, under section 76(1)(c) of the 2014 Act; and/or (ii) the Council had failed to consider Kianna under section 76(3) as a child whose well-being was likely to be seriously prejudiced by living at her friend's home, and had they done so, accommodation would have been provided.

59. Had such accommodation been provided under section 76, Kianna would have become a looked after child (under section 74), the Council would have assumed concurrent parental responsibility for her, and in any event would have been under duties to safeguard and promote her well-being (under section 78) and to implement a care and support plan for her (under section 83(2)). This plan would have addressed her health needs, including her mental health, following a medical assessment (under regulations 5(1)(b)(i) and 7(1)(a) of the 2015 Regulations).

60. His core submission was that, based on the matters set out above, "it is arguable that there was a failure to take the steps the Council ought to have taken, which would have meant that it exercised a significant degree of control over a most vulnerable child, who had proven to be a suicide risk. That relationship is sufficient to engage the general duty under [Article 2] and indicates state responsibility in Kianna's death" (paragraph 11 of his written submissions).

61. Support was drawn for this proposition from the observations of Lord Rodger in *Savage* at [11], [17] and [46]-[49]. In the latter of these passages, Lord Rodger highlighted that the vulnerability of people suffering from mental illness, and the consequential need to protect them, is relevant to the nature of the general duty. It means that hospital authorities will have to "take account of the vulnerability of these patients - including a heightened risk they may commit suicide" and put in place "appropriate systems… for preventing patients, who were known to be suffering from mental illness, from committing suicide". Reliance was also placed on *Smith* at [118].

62. Further, Mr Howells submitted that the Council's failures evidenced arguable breaches of the general duty, because, in summary, (i) no explanation had been provided for why the information received on 28/29 June 2019 had not been acted upon; (ii) the same information had not been acted upon when it was received from Ms Patton's MP or when Ms Patton provided it again on 16 and 23 September 2019 respectively; (iii) there was evidence suggesting that neither the social worker to whom Ms Patton complained on 23 September 2019 nor her supervisor had identified the section 76 duties, suggesting a failure of knowledge, training and supervision; (iv) it was entirely inappropriate and an unlawful delegation of duty to leave the youth worker at Kianna's college to discuss accommodation with her; (v) despite the indication given to Ms Patton's MP that a needs assessment would be carried out, this had not been done; (vi) there was no evidence that Kianna or her friend's mother had been spoken to by a social worker at all, or any information obtained from Kianna's GP, between 28 June 2019 and Kianna's death; and (vii) multi-agency co-operation and safeguarding procedures had not been followed.

63. There were also arguable breaches of the general duty by S-CAMHS in that (i) despite the referral made by her GP on 2 September 2019, Kianna had not received any treatment before her death; (ii) S-CAMHS had not informed Ms Patton of the referral or involved her thereafter, despite having done so previously; (iii) there was no evidence that S-CAMHS had satisfied themselves that Kianna had capacity (and it was known that she was hearing voices in her head, telling her to "off herself" and was having delusions); (iv) despite Kianna attending S-CAMHS with an adult who was not her parent, no enquiries had been made about this; and (v) S-CAMHS had not provided or sought information from the Council, suggesting a failure of multi-agency co-operation. It was also unclear whether S-CAMHS had provided Kianna with treatment following her overdose in 2018 before her discharge in June 2019.

64. There were also arguable failings by the Police in that (i) they had not satisfied themselves that the Council had received and acted upon the information sent to them on 28 June 2019; (ii) they had not spoken to Ms Patton until 21 October 2019 despite the assurances given to her MP the previous month; (iii) they had not spoken to Kianna at all in 2019; and (iv) they had not held a strategy meeting as they had done in 2018.

65. Finally, Mr Howells argued that (i) had the Council implemented a care and support plan either in June or September 2019, which would have triggered a medical assessment; or (ii) had S-CAMHS treated Kianna more urgently than they did, it was arguable that the outcome would have been different, thus satisfying the Article 2 causation test.

The Council's submissions

66. The Council relied on a witness statement from Darren Mutter, Head of Children's Services. It was denied that the Article 2 investigative duty was engaged.

67. It was submitted that the provisions of neither of the section 76 duties relied on by Ms Patton were satisfied. As to section 76(1)(c), Ms Patton had not been prevented from providing Kianna with suitable accommodation as she had requested Kianna to leave the family home; and as Kiana had turned 16 in June 2019, she had autonomy as to where she lived, and was legally able to live independently. As to section 76(3), the Council entirely appropriately did not consider, nor had any reason to consider, that Kianna's well-being was likely to be seriously prejudiced if the Council did not provide her with accommodation.

68. Concerns about the use of cannabis within the home where Kianna was living would not in themselves have led to any intervention by the Council leading to a provision of accommodation. Her mother's concern about potential harm was distinct from actual harm. It was relevant that Kianna had been and was at the time of her death under the care of, and receiving treatment, from S-CAMHS. At the time of her death, Kianna had left mainstream school, was working and had enrolled at a college, which had raised no concerns to the Council. Reliance was placed on the fact that throughout Kianna's life Ms Patton had retained parental responsibility for her. It was submitted that even if the section 76 duty was engaged, the Council would not have received parental responsibility for Kianna. Kianna was therefore at no stage a looked after child.

69. The Council cited *R (Kent County Council) v HM Coroner for Kent* [2012] EWHC 2768; [2013] ACD 1, in which a 14 year old boy ("EB") had died, apparently from an accidental methadone overdose. The relevant Social Services department had had contact with EB for around 9 months before he died, during which time he had had difficulties at home, sometimes staying away, problems at school despite having been previously a model student and high achiever, was confused about his sexuality and started abusing drink and drugs. He claimed that he had made a suicide attempt and been subjected to physical abuse. His parents had sought support and had requested alternative accommodation for him: [11] and [13].

70. The Coroner accepted EB's family's submissions that the Article 2 investigative duty applied to the inquest and Kent County Council sought judicial review of that decision. The Divisional Court (Foskett J and HHJ Thornton QC) quashed the Coroner's decision, holding that on the facts, there was insufficient evidence of an arguable breach of the Article 2 operational duty: [43]-[49]. The Court then said the following, from which the Council in this case drew the proposition that in "childcare cases", it is only where the operational duty is owed that the general duty is also owed:

> "49. Tragic, of course, as this case was, there was, in our judgment, no operational duty in place at the time of EB's death and, accordingly, no scope for an Article 2 inquest. The claimant did not have parental responsibility for EB and he was not 'in care' in the sense that no proceedings had been commenced under section 31 of the Children Act 1989. He was not therefore living within the control or under the direct responsibility of the local authority. If there was no operational duty in place, there could be no breach of it. If there was no breach of any operational duty (the extra layer to the general duty) there could have been no breach of the general duty. In the absence of any breach of duty it follows that no procedural duty arises. There is, therefore, no burden upon the state to inquire under that duty by way of a *Middleton* inquest".

71. Relying on *Parkinson* in particular, the Council argued that Kianna's case was not one which involved a breach of the general duty. There clearly were systems in place. In a wide sense, there was a regulatory framework created and imposed by the state to which the Council was subjected. In a narrower sense, the Council's Children Services teams had engaged with Kianna and her family pursuant to their statutory obligations, in the context of the active involvement of other agencies, including S-CAMHS, the Police, and Kianna's school, college and GP. The specific breaches relied on by Ms Patton were denied, but in any event it was submitted that they were at their highest examples of individual and not systemic failings, and were thus outwith Article 2.

72. Further, it was pure speculation to submit that it would have been appropriate to offer Kianna a foster placement, or that she and her mother would have agreed to it, and what any such placement would have led to in terms of Kianna's risk of taking her own life.

The Health Board's submissions

73. The Health Board relied on the fact that Kianna was not detained under the Mental Health Act 1983 or a voluntary in-patient at the time of her death. To the best of its knowledge, Article 2 has not been engaged on the basis of an arguable breach of the general duty in an inquest where the person was living in the community and able to function to a reasonable level, that is to continue with studies and work, as Kianna was.

74. The Health Board denied that any of the breaches of the general duty alleged by Ms Patton, as summarised at [63] above, were arguable. The response to the GP referral in September 2019 had been entirely appropriate and timely. Kianna had had an initial assessment with the EPIS and a further assessment with a psychiatrist and a nurse. In order to commence any treatment, due to the potentially serious side effects, it was necessary to carry out certain physical investigations such as a head CT scan. These had been arranged following the appointment on the 21 October 2019. Kianna had been due to attend again on 4 November 2019 for treatment options to be discussed. There was nothing in her presentation to suggest that she lacked capacity. The fact that she spoke of hearing voices would not be sufficient in itself to rebut the presumption of capacity. Staff would not have contacted her mother unless Kianna had given them permission to do so, which she had not. When she arrived at the appointment with her friend's father this did not give rise to any safeguarding concerns. However, even if it should have done, this was an example of an individual failing and not a systemic one. She had received proper treatment after the overdose in 2018.

The Police's submissions

75. The Police also denied the specific failings alleged against them by Ms Patton, as set out at [64] above. There could be no actionable duty to ensure that correspondence has been received nor any obligation on Police officers to satisfy themselves that another emanation of the state is acting upon any information that is shared. There could be no sustainable complaint that officers had not spoken to Ms Patton until 21 October 2019 given the advice she had been given on 28 June 2019 to speak to the Council: that was entirely appropriate as they had the power to intervene or assist. There was no basis for the criticism that officers had not spoken to Kianna at all in 2019. Accordingly, Ms Patton's submissions did not identify any arguable breach of a Convention right by the Chief Constable's officers.

The Coroner's ruling dated 8 August 2021

76. At the outset of his written ruling, the Coroner confirmed that he had considered the written and oral submissions from the Interested Persons and authorities.

77. He identified the different duties to be derived from Article 2. He correctly indicated that Ms Patton was not contending for a breach of the operational duty. Instead, her argument was there had been an arguable breach of the general duty, such as to trigger the Article 2 investigative duty.

78. The Coroner rejected the Council's argument that in childcare cases, it is only where the operational duty is owed that the general duty is also owed, partly by reference to a later part of *Kent County Council* ([52]) in which the Divisional Court concluded that the evidence did not support an arguable breach of "the general duty or operational duty". The Coroner's conclusion was that "…the general and operational duty can be engaged separately or in tandem in any type of inquest and there is no special or limited category of inquests where the general duty only arises when there is an arguable breach of the operational duty".

79. He then turned to Ms Patton's arguments that "the basis for an Article 2 engagement emerges from the statutory obligation placed on the [the Council] by [section 76]" and that "the failure to follow these mandatory legislative requirements are indicative of a systemic failure on the part of the [Council]". The remainder of his ruling is as follows:

> "I reject that submission in this instance. My reasons are as follows.
>
> [Kianna] was not a person requiring accommodation. Whilst she had been excluded from the family home, she had the support of her best friend's parents who permitted her to reside with them, albeit an arrangement which [her] mother did not approve of. She did not present to the authority as homeless or a child requiring accommodation. In my view no obligation to provide accommodation arose either by virtue of a lack of accommodation or because her well-being was likely to be seriously prejudiced. That being the case, at no stage would or should [parental responsibility] have assumed or been given to [the Council] and [Kianna] would not have become a looked after child with the obligations that are then placed on a local authority.
>
> There is a clear legislative framework in place which has been closely examined insofar as it may not have been properly applied and complied with by PCC. However, there is no arguable case that PCC has fallen short of its statutory responsibilities. That argument is simply not made out. It follows Article 2 is not engaged in this inquest although my determination will remain under consideration throughout these proceedings".

Ms Patton's grounds in overview

80. Ms Patton advances three grounds of judicial review. She contends that (1) the Coroner erred in law in concluding that the Council did not owe a duty to provide Kianna with accommodation under section 76(1)(c); (2) the Coroner failed to provide adequate reasons for the finding that no obligation to provide accommodation to Kianna arose under section 76(3); and (3) his decision that section 5(2) was not engaged was in breach of section 6 of the Human Rights Act 1998.

Prematurity

81. The Coroner and the Council argued that Ms Patton's claim was premature and unnecessary. The Coroner's decision was expressly provisional and would be kept under review. The scope of the inquest has not yet been decided. It is well recognised that the scope of an inquest can be the same whether or not Article 2 is engaged (see, for example, *R (Hurst) v London Northern District Coroner* [2007] 2 AC 189 at [121], per Baroness Hale). When the scope is determined, it might become clear that Ms Patton's concerns will be fully explored in the inquest.

82. Reliance was placed on *Boyce* at [71]-[73], where HHJ Boucher cited the words of Lord Mance JSC in *Smith* at [208] to the effect that a "practical solution" where Article 2 is in issue is for the Coroner to be alert to the possibility that the Article 2 investigative duty may be engaged in the future, and to be ready to adapt the scope of the investigation accordingly.

83. On this basis it was said that the Claimant should await the determination of scope or the end of the inquest before bringing any claim.

84. Ms Patton argued that the Coroner's ruling on Article 2 is one based on pure law, and is unlikely to change. She relied on general public law principles set out in cases such as *R v Secretary of state for Trade and Industry, ex p Greenpeace Limited* [1998] Env LR 415 at 424, per Laws J (as he then was) indicating that judicial review claims should be brought as soon as the grounds are made out, so as to avoid prejudicing the proper business of government and the reasonable interests of third parties. It would not be proportionate or in the public interest to wait for the end of the inquest and then bring the challenge: such a course could result in a significant loss of time and resources. Although the Coroner's ruling at this stage will not necessarily affect scope, it will have significant practical consequences on her ability to secure public funding for representation at the inquest.

85. I do not interpret the passages from *Smith* and *Boyce* referred to above as establishing any principle that a Coroner's decision as to the applicability of Article 2 cannot or should not be challenged as soon as the ruling is made. The observations in these passages were made in the context of discussions about the practical differences between Article 2 and non-Article 2 inquests, principally the potential differences as to scope. None of them were made in the context of a specific argument that a judicial review claim had been brought prematurely and should be dismissed for that reason alone. None of them engaged with the argument advanced to me that it would not be right to expect a bereaved relative to continue with an inquest, on a potentially legally flawed basis, likely without funding for representation, and then bring a challenge.

86. Further, I note that in *Boyce* HHJ Boucher ruled on the substance of the challenge to the Coroner's ruling on Article 2 before the inquest had been concluded, rather than dismissing it outright for prematurity. There are other examples of judicial review claims of interlocutory decisions on Article 2 being fully determined on their merits, rather than dismissed for prematurity, not least the *Kent County Council* and *Morahan* cases referred to above. In *Morahan* at [70], the Divisional Court specifically acknowledged the impact of an adverse Article 2 ruling on bereaved families' public funding.

87. On the facts of this case, I am not persuaded that Ms Patton's claim should be dismissed on grounds of prematurity. I agree with Ms Patton that the Coroner's ruling in this case is one of law. It is unlikely that the evidence will change the Coroner's approach to the section 76 duties. If the ruling is wrong in law, it is more sensible for it to be corrected now, so that the inquest can proceed on a proper basis, in accordance with general public law principles. It has already been over 2 years since Kianna died and the inquest is still at an early stage. The potential for further delay, and potentially wasted resources, is another reason in favour of resolving the legal issues now rather than requiring Ms Patton to wait, potentially some time, to bring her challenge. I also accept that the ruling has immediate practical consequences for Ms Patton in terms of funding, which militates against the "wait and see" approach.

Ground 1: Section 76(1)(c)

The Claimant's submissions

88. On behalf of Ms Patton, Mr Howells focussed on the passage in the Coroner's ruling where he noted that Kianna did not require accommodation because "whilst she had been excluded from the family home, she had the support of her best friend's parents who permitted her to reside with them, albeit an arrangement which [her] mother did not approve of. She did not present to the authority as homeless or a child requiring accommodation".

89. He argued that the Coroner had erred by focusing on the fact that Kianna had accommodation rather than whether it was suitable or not. Applying *Salford City Council*, he should have made his own assessment of the suitability question, because:

    (i) The duty to accommodate only arises if the parent is prevented from providing "suitable" care and support so it must follow that the duty is not negated where there is alternative unsuitable accommodation;

    (ii) The section is to be given a purposive interpretation so that it is interpreted consistently with the general duties in section 78. Such an approach must mean that the words "appears to require accommodation" cannot lead to a conclusion that accommodation is not required where there is alternative accommodation, but it is unsuitable for the child and their needs; and

    (iii) The suitability of the alternative accommodation was so obviously material that no reasonable decision could be made about section 76(1)(c) without having regard to that consideration: see *R (Friends of the Earth Ltd) v Heathrow Airport Ltd* [2020] UKSC 52 at [114]-[134].

90. It was therefore argued that the Coroner had erred in his approach to section 76(1)(c). Further, it was at least arguable that the accommodation was not suitable given Kianna's mental health issues and the fact that she was permitted to smoke cannabis there, there being "known links" between adverse mental health and cannabis use.

The Council's submissions

91. The Council's position, as set out in the written submissions, can be summarised as follows. It was not appropriate to look at section 76 in isolation. It was part of a much wider system of statutory regulation in Wales under the 2014 Act. This system included section 6(2) of the

2014 Act which requires the local authority, so far as is reasonably practicable, to ascertain and have regard to the views, wishes and feelings of the individual to whom care and support is being provided. A range of matters would have to be considered before a decision was made to remove a child from their current accommodation. Only a minority of children who cannot live with their parents for whatever reason are looked after by the local authority. Many more are brought up in "family and friends care". Whether or not a child should become looked after by the local authority is decided on a case-by-case basis, depending on an assessment of the child's needs and circumstances. These principles indicate that decisions about children are not taken in a binary sense and that the wording of section 76 does not generate a mandatory or immutable duty on the council.

92. On a proper reading of section 76(1)(c), the duty is only triggered where it actually "appears" to the local authority that the child requires accommodation and that did not apply in Kianna's case. The Claimant accepted that the duty under section 76(3) is only triggered where the local authority actually "considers" that the child's well-being is likely to be seriously prejudiced if it does not provide the child with accommodation, and so it was anomalous that a different approach to the construction of section 76(1)(c) was being contended for.

93. Further, while the term "prevented" in section 76(1)(c) involves an objective test this simply did not apply here given that Ms Patton herself had asked Kianna to leave the family home. This, and the fact that Kianna was in fact accommodated elsewhere meant that there could not be a mandatory duty to accommodate her on the Council. It was pure speculation to submit that Kianna would have been offered a foster placement, or that she or her mother would have accepted it.

94. The Claimant's reliance on *Salford City Council* was misplaced: that case was focussed on the court determining whether a child had been accommodated under section 20, ie. the actual decision made at the relevant time by the local authority in the exercise of its discretion. It was not therefore necessary for the Coroner to make findings of fact about whether the accommodation in which Kianna was residing was suitable. In any event he had available to him and had considered a detailed statement from Mr Mutter, together with submissions from the Council setting out the reasons why it was not considered a requirement to accommodate Kianna. In summary the Council, its social workers and management had taken into account the fact that Kianna was 16; there is no suggestion that she was at significant risk of harm; she had been at her friend's family home for several months; her mother had had no contact with her throughout that time; she had support at college; she had proactively engaged with S-CAMHS and she had a support network around her.

95. Finally, even if the Coroner had erred with respect to this ground, it is not arguable that there had been any breaches of the general duty for the reasons advanced before the Coroner: at its highest the Claimant's allegations related to individual failings rather than any dysfunctional or systemic failure.

96. The Coroner's decision therefore did not involve any error of law and was correct.

The Coroner's submissions

97. The Coroner's position was that, having heard the competing submissions, he preferred those of the Council, to the effect that there was no "immutable" obligation on the Council to accommodate Kianna under section 76. Further, if he had erred in this respect, applying the

interpretation of the Article 2 general duty set out in *Parkinson*, any errors in determining whether Kianna should have been accommodated or not would appear to amount to individual and not systemic or structural failings for Article 2 purposes.

Analysis and conclusion

98. Before turning to the detail of Ground 1, it is necessary to look at some broader matters about how the case has been argued, not least because these have shaped the Coroner's ruling.

99. Deciding whether the enhanced Article 2 procedural obligation is engaged in a particular inquest is often complex. Perhaps with the benefit of the hindsight and time that the judicial review process has afforded, it now appears that the decision-making process in this case has been complicated by a range of factors.

100. *First*, there was continued confusion among the parties as to whether Ms Patton was arguing that her case was one of those where the enhanced investigative duty automatically applies. Some of the language from the authorities on automatic engagement scenarios (particularly the phrase that a certain context, without more, "necessarily gives rise…to a legitimate ground to suspect state responsibility": *Morahan* at [122](7)) had permeated the submissions, including Mr Howells core proposition before the Coroner: see [60] above. However, Mr Howells confirmed in his reply submissions at the end of the judicial review hearing that he was not relying on the automatic engagement cases as a route to the enhanced investigative duty.

101. *Second*, during the judicial review hearing, it became clear that there were fundamental disagreements between the parties, that did not appear to have been fully ventilated previously, as to whether the general duty applied in principle to the facts of Kianna's case, before the question of any arguable breaches of it was even considered.

102. Ms Patton's case throughout was that she needed to satisfy a "gateway" into the general duty by virtue of the section 76 duties. She sought to pass through that gateway by arguing that properly applied, the section 76 duties would have led to the Council having a significant degree of control over, and delegated parental responsibility for, a very vulnerable child, who had proven to be a suicide risk. It was this group of factors which led to the general duty being engaged.

103. The Council's argument before the Coroner was, as set out at [69]-[70] above, that the general duty could not be engaged because the operational duty had not been. This argument was rejected by the Coroner. The Council did not formally challenge his ruling on that basis or renew the *Kent County Council* argument with any enthusiasm before me. Instead, the Council took a different approach, arguing in the oral submissions that the section 76 issues were something of a "distraction", as the general duty was owed to a wider group than those children who were or should have been accommodated under section 76. Issues around assumption of responsibility, vulnerability and matters of that nature were more pertinent to the triggering of the operational duty than the general duty.

104. The Coroner's position in the judicial review was that the general duty "arises in a wide range of contexts".

105. I consider that the final analysis advanced by the Council as set out at in the latter part of [103] above is the correct one. In *Rabone* at [21]-[25] and [118] Lord Dyson JSC and Lord Mance JSC considered the relevance of an assumption of responsibility by the state for the individual's welfare and safety (including by the exercise of control) and the vulnerability of the individual. However, these factors were held to be relevant to the existence of the operational duty, rather than the general duty. This interpretation was reiterated by Farbey J in *Dove* at [52]-[55] and by the Divisional Court in *Morahan* at [44].

106. That the general duty exists more widely than the circumstances advanced by Ms Patton is also apparent from the way in which it was described in *Morahan* at [30(2)(a)], namely a general duty "to put in place a legislative and administrative framework to protect the right to life involving effective deterrence against threats to life, including criminal law provisions to deter the commission of offences, backed up by a law enforcement machinery for the prevention, suppression and sanctioning of breaches of such provisions". This formulation does not require that the element of the state in question has assumed responsibility or exercised control over an individual, or that they are particularly vulnerable: rather the focus is on ensuring that the state, through a range of entities, has in place an adequate legislative and administrative framework for the protection of life. In the healthcare context, the general duty was described in *Morahan* at [30(2)(a]) as simply requiring "effective administrative and regulatory systems". Again, no reference was made to assumptions of responsibility or particular vulnerability.

107. Further support for this approach can be drawn from (i) *Dove*, where there appeared to be no dispute that the general duty applied in principle to the Department for Work and Pensions, absent an assumption of responsibility or particular vulnerability, with a focus instead on whether there was any arguable breach of it: [87]-[88]; and (ii) *Boyce*, where the Claimant argued that the general duty was not dependent on a specific risk to a specific individual and where the parties appeared agreed as the existence of the general duty in the childcare context, with the focus in that case being on causation: [41] and [43].

108. *Third*, matters were complicated by the fact that Ms Patton relied on the Council's alleged failings with respect to section 76 as evidence of not only the existence of the general duty ("the duty issue") but also of arguable breaches of it by the Council ("the breach issue"). Further, she argued that different standards of proof applied to the two issues in that (i) she had to prove the duty issue through the section 76 "gateway" to the balance of probabilities standard; but (ii) she only needed to prove the breach issue to the arguability threshold, which is a low one. No detailed submissions were made before me on (i), but (ii) is well-established by authority: see [47] above.

109. The combined effect of the resolution of these issues is, in my view, that the Coroner should have proceeded on the basis that the general duty was, in principle, applicable to the relationship between Kianna and the Council, without the need for Ms Patton to show a breach of the section 76 duties. Consideration should also have been given to whether the general duty existed as between Kianna and the Police and Health Board. Once those matters had been resolved, or perhaps conceded, the focus should have been on whether there were any arguable breaches of the general duty, applying the low arguability threshold, and bearing in mind the key distinction between systemic and individual failings. Such arguable breaches could have related to the manner in which the Council approached the question of Kianna's accommodation, but any such breaches did not have to be determined to the balance of probabilities standard for the purposes of this argument, but rather to the low arguability

threshold. Finally, it was necessary to address whether any proven arguable breaches meant that there had been a loss of a substantial chance of a different outcome: see [48] above. It is also right to recall that alleged failings by the state can be explored in an inquest even if they are not of a nature that can be characterised as arguable breaches of the general duty.

110. The Coroner's ruling is very brief, and it does not deal separately with the issues of existence of the general duty, arguable breach of it, and causation. Perhaps because of this, there remains some confusion between the parties as to what he actually decided. Mr Howells' understanding was that the Coroner had only addressed the duty issue and had made no findings on the breach issue. The Health Board appeared to share that view, as their counsel Mr Berry relied on the absence of a clearly reasoned decision on the breach issue as support for the proposition that if I found in favour of Ms Patton on Ground 1, I should remit the case back to the Coroner so that a "first" decision on the breach issue could be made. The Coroner's finding that there was "no arguable case that [the Council] had fallen short of its statutory obligations" does, at first reading, suggest he had made a decision on the breach issue. However, given the overlap between the duty and breach issues in the arguments (see [108] above) this could, in fact, be one of the Coroner's reasons for rejecting the argument on the existence of the duty. The ruling is not explicit and the Coroner's own submissions on the issue were a little equivocal. Whether or not the Coroner actually decided the breach issue in respect of the Council therefore remains unclear. He certainly made no findings on the breach issue in respect of S-CAMHS or the Police, or on causation.

111. Putting all these matters to one side, Ground 1 distils to a single question, namely whether the Coroner was required to conduct his own assessment of the suitability of Kianna's accommodation and erred by failing to do so.

112. Having reviewed the *Salford City Council* case I am satisfied that Mr Howells' submissions on its meaning are well-founded. The ratio of the judgment is that where there is a dispute between the parties as to whether a child was looked after, the court must conduct its own assessment, by applying the statutory framework to the evidence before it, applying an objective scope, and giving the word "prevented" within section 76(1)(c) "the widest possible scope": [40], [46] and [48]. Macdonald J therefore rejected the argument advanced by the Council before me that the court should simply look at what actually "appeared" to the local authority under section 76(1)(c) rather than what "should have" appeared to them: [39] and [67]. As an example of the sort of exercise that was required, Macdonald J went on to set out the factors in favour of the children in question being looked after, and the factors against that proposition, at various points in time, in detail: before finally concluding that they were not: [68]-[86] and [88].

113. I also agree with Mr Howells that inherent in this analysis must be consideration of whether the accommodation where the child is currently located is suitable, for the reasons he advanced, namely that the thrust of the duty is to ensure that suitable accommodation is provided, the section must be given a purposive interpretation and the suitability issue is plainly a material one for the overall section 76(1)(c) assessment.

114. The Coroner's reasons for ruling that the section 76(1)(c) duty did not apply were essentially twofold: (i) Kianna did actually have accommodation at her friend's home; and (ii) the Council did not consider her to be homeless or requiring accommodation.

115. As to (i), there are good arguments to the effect that the fact that Kianna did actually have accommodation does not negate the potential section 76(1)(c) duty if the accommodation was unsuitable, for the reasons given above, and the Coroner therefore erred by not engaging with that issue.

116. As to (ii), *Salford City Council* makes clear that the views of one of the parties as to whether a child is in fact looked after are not determinative, and the court must conduct its own assessment of whether a child should have been considered as such. The brevity of the Coroner's reasons in this case make it hard to have confidence that he undertook this exercise.

117. However I have further concerns about the Coroner's approach to the section 76(1)(c) issue, flowing from the issues discussed at [101]-[109] above, in that in the paragraph of his ruling where he makes his findings on section 76(1)(c) it is not clear whether he is addressing the duty issue or the breach issue.

118. That he was considering the duty issue would be consistent with the case as argued before him by Ms Patton. It is also suggested by the fact that he makes no reference to the arguability test in this paragraph. If he was addressing the duty issue in this paragraph, then his reasoning was flawed because a breach of the section 76(1)(c) duty is not an essential element of the existence of the general duty: see [101]-[107] above. He was effectively answering a question he need never have asked himself.

119. For all these reasons I consider that the Coroner's approach to the section 76(1)(c) question was flawed.

Ground 2: Section 76(3)

120. In relation to this ground, Mr Howells relied on the following passage in the Coroner's ruling: "In my view no obligation to provide accommodation arose either by virtue of a lack of accommodation or because her well-being was likely to be seriously prejudiced".

121. He submitted that this did not provide adequate reasoning for the Claimant to understand the basis on which the Coroner did not consider the section 76(3) duty to be applicable, and thus why she had lost the argument before the Coroner. It was therefore unlawful applying the general principles set out in *Oakley v South Cambridgeshire District Council* [2017] EWCA Civ 71; [2017] 1 WLR 3765 at [30]-[32], per Elias LJ and *South Buckinghamshire District Council v Porter (No. 2)* [2004] 1 WLR 1953 at [36], per Lord Brown.

122. This case was on all fours with *R (Cash) v Northamptonshire Coroner* [2007] EWHC 1354 (Admin); [2007] 4 All ER 903. In that case the Coroner had heard submissions as to whether an unlawful killing verdict should be left to the jury. In giving her decision, she simply indicated that she had applied the necessary legal test and decided that she would only leave the jury with an accidental death verdict or an open verdict: [26]. The Administrative Court (Keith J) considered that this reasoning was insufficient:

> "45…[t]he coroner gave no reasons at the time for ruling that there was no evidence on which the jury, properly directed, could have returned a verdict of unlawful killing. The coroner has said in her witness statement that essentially she preferred the submissions of Mr Beggs to those of Mr Simblet, the implication being that she adopted his submissions as her reasons. But she did

> not say that at the time, and I have no doubt that she should have given reasons for her ruling – even if those reasons had been no more detailed than those given in paras. 9 and 10 of her witness statement. Indeed, she was invited by Mr Beggs "to give a structured, reasoned ruling". Not only would the formulation of reasons have concentrated her mind on the issues in a focussed way, but Ms Cash was entitled to know why the coroner thought that a verdict of unlawful killing would not have been a permissible verdict on the evidence, so that she could make a more informed decision on whether to proceed with the claim for judicial review of the ruling"

123. The Council submitted that the Coroner had provided reasons for his decision which were adequate: a lengthy ruling was not required provided the key points had been covered: see, for example, *Kent County Council* at [55].

124. The Coroner argued that it was clear from his decision that he had preferred the submissions of the Council and that his ruling had to be read in the context of those submissions, particularly the last three pages thereof.

125. On balance I consider that the Coroner did not give adequate reasons for his finding in respect of section 76(3)(c).

126. As Lord Brown said in South *Buckinghamshire District Council* at [36]:

> "The reasons for a decision must be intelligible and they must be adequate. They must enable the reader to understand why the matter was decided as it was and what conclusions were reached on the "principal important controversial issues", disclosing how any issue of law or fact was resolved. Reasons can be briefly stated, the degree of particularity required depending entirely on the nature of the issues falling for decision. The reasoning must not give rise to a substantial doubt as to whether the decision-maker erred in law, for example by misunderstanding some relevant policy or some other important matter or by failing to reach a rational decision on relevant grounds."

127. Here, the Coroner simply re-stated the statutory test in section 76(3)(c), saying that "no obligation to provide accommodation arose because...Kianna's well-being was likely to be seriously prejudiced". He gave no reasons for his decision that no obligation arose. The main, if not the only, point advanced by Ms Patton was that accommodation where Kianna was permitted to smoke cannabis, despite her mental health issues, would self-evidently seriously prejudice her well-being. Accordingly, this was the "principal important controversial issue" and it was therefore incumbent on the Coroner to explain, even in brief terms, how he had resolved it.

128. Again, I am concerned that the Coroner may have used his decision on the section 76(3) issue as a basis for finding that no general duty was owed, which was incorrect.

129. For these reasons I consider that the Coroner's approach to the section 76(3) issue was also flawed.

Ground 3: Section 5(2)

130. Mr Howells argued that if I was satisfied that the Coroner had erred in the manner alleged in Ground 1 and/or 2, it followed that his decision on the section 5(2) question was incorrect.

131. The basis on which I have found that the Coroner erred with respect to Grounds 1 and 2 means that his decision needs to be quashed. It does not, necessarily, mean that his overall decision on the section 5(2) decision was wrong, but a new decision on it is needed.

132. Mr Howells invited me to make the section 5(2) decision afresh. He relied on *R (Skelton) v HM Senior Coroner for West Sussex* [2020] EWHC 2813 (Admin); [2021] QB 525 at [91], per Popplewell LJ, as support for the proposition that this court could conduct the same exercise as the Coroner and determine whether Article 2 required a section 5(2) investigation.

133. Mr Berry on behalf of the Health Board submitted that if I found in favour of the Claimant on Grounds 1 or 2, I had a discretion as to next steps, but it would be preferable to remit the case to the Coroner. This was because, unlike in *Skelton*, the Coroner had not given a fully reasoned decision on the breach issue. Further, remitting the case back to the original decision-maker would be the usual course if a reasons challenge such as Ground 2 succeeded.

134. On balance I consider that the most sensible and fair course is for me to remit the decision to the Coroner to make the section 5(2) decision afresh. The judicial review process has illustrated that the entire approach to the general duty in this case needs to be reconsidered. It is not clear that the Coroner has made a decision on the breach issue with respect to the Council, and he has certainly not addressed the breach issue with respect to S-CAMHS and the Police. Causation issues may also need to be addressed. In my view these questions should be remitted to the Coroner so that the parties have the benefit of a fully reasoned decision on the issues.

Conclusion

135. For all these reasons, the claim succeeds. The Coroner's ruling dated 8 August 2021 is quashed and the issue remitted to the Coroner for re-determination.