



COUR EUROPÉENNE DES DROITS DE L'HOMME  
EUROPEAN COURT OF HUMAN RIGHTS

THIRD SECTION

**CASE OF PAUL AND AUDREY EDWARDS  
v. THE UNITED KINGDOM**

*(Application no. 46477/99)*

JUDGMENT

STRASBOURG

14 March 2002

**FINAL**

*14/06/2002*

**In the case of Paul and Audrey Edwards v. the United Kingdom,**

The European Court of Human Rights (Third Section), sitting as a Chamber composed of:

Mr I. CABRAL BARRETO, *President*,

Sir Nicolas BRATZA,

Mr L. CAFLISCH,

Mr P. KÜRIS,

Mr R. TÜRMEŒEN,

Mrs H.S. GREVE,

Mr K. TRAJA, *judges*,

and Mr V. BERGER, *Section Registrar*,

Having deliberated in private on 21 February 2002,

Delivers the following judgment, which was adopted on that date:

## PROCEDURE

1. The case originated in an application (no. 46477/99) against the United Kingdom of Great Britain and Northern Ireland lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms (“the Convention”) by two United Kingdom nationals, Paul and Audrey Edwards (“the applicants”), on 14 December 1998.

2. The applicants were represented before the Court by Ms N. Collins, a solicitor working for Liberty, London. The United Kingdom Government (“the Government”) were represented by their Agent, Mr D. Walton, of the Foreign and Commonwealth Office.

3. The applicants alleged in particular that the authorities had failed to protect the life of their son, Christopher Edwards, who had been killed by another detainee while held in prison on remand. They relied on Articles 2, 6, 8 and 13 of the Convention.

4. The application was allocated to the Third Section of the Court (Rule 52 § 1 of the Rules of Court). Within that Section, the Chamber that would consider the case (Article 27 § 1 of the Convention) was constituted as provided in Rule 26 § 1.

5. By a decision of 7 June 2001 the Chamber declared the application admissible [*Note by the Registry*. The Court's decision is obtainable from the Registry].

6. The applicants and the Government each filed observations on the merits (Rule 59 § 1). The parties replied in writing to each other's observations. The Chamber decided, after consulting the parties, that no hearing on the merits was required (Rule 59 § 2 *in fine*).

7. On 1 November 2001 the Court changed the composition of its Sections (Rule 25 § 1). The above application remained with the newly composed Third Section (Rule 52 § 1).

## THE FACTS

8. The facts of this case were subject to investigation before a private, non-statutory inquiry, which issued a report on 15 June 1998, setting out extensive findings of fact. As these were not contested by the parties, the Court has relied on the report in its own assessment of the facts below.

### I. THE CIRCUMSTANCES OF THE CASE

9. Prior to his death, Christopher Edwards had shown signs of developing a serious mental illness. In 1991 a psychiatric assessment expressed the tentative diagnosis of schizophrenia. In July 1994 he stopped living at home with the applicants, his parents. At this time he stopped taking his medication.

10. On 27 November 1994 Christopher Edwards, then 30 years old, was arrested in Colchester by the police and taken to Colchester police station. He had been approaching young women in the street and making inappropriate suggestions. His behaviour before arrest, and at the police station where he attempted to assault a policewoman, led police officers to suspect that he might be mentally ill. He was assessed at the police station by an approved social worker, who discussed the matter on the telephone with a consultant psychiatrist. They agreed that, while there was some evidence of possible developing schizophrenia, he did not need urgent medical attention and that he was fit to be detained at the police station. Any psychiatric assessment could take place as part of a pre-sentencing exercise. Christopher Edwards was held in a cell on his own. The police officer responsible did not fill in a CID2 form identifying Christopher Edwards as an exceptional risk on ground of mental illness due to the opinion expressed by the social worker. The police officer did, however, note in the confidential information form (MG6A) her belief that if Christopher Edwards was not treated or seen by the mental health team he might seriously harm a female. She was not aware that her own suspicion of his mental state was sufficient to warrant categorising Christopher Edwards as an exceptional risk.

11. On 28 November 1994 Christopher Edwards was brought to Colchester Magistrates' Court. Immediately his handcuffs were removed, he pushed through the other prisoners and confronted a female prison officer. He was restrained, but struggled and tried to approach her again. He was

placed in a cell on his own. During the morning, he continually banged on the cell door and shouted: "I want a woman." He shouted obscenities about women. The applicants met the duty solicitor at about 9.45 a.m. and explained that their son was mentally unwell and that they wanted him to receive medical care and not to be remanded in custody. When the duty solicitor attempted to talk to Christopher Edwards in his cell, he received no assistance from his client who continued to make obscene suggestions about women. The duty solicitor discussed the problem with the Clerk to the Justices.

12. On his way to court and in the courtroom, Christopher Edwards repeated his earlier comments about women. The prosecutor had in her possession the MG6A form and had been requested by the police to obtain his remand in custody as there was a risk that he would reoffend and there was a real question mark about his mental state. The prosecutor informed the court that he was perceived as a risk to women, although it is unclear how much detail was given. She relied on the fact that an assessment by a psychiatrist had not yet been carried out in support of her application. Consideration was given by the Bench, together with the prosecutor, duty solicitor and Justice's Clerk as to whether he could be remanded to hospital. It was concluded that there was no power to do so under section 30 of the Magistrates' Courts Act 1980. No consideration was given, *inter alia*, to the application of civil provisions (sections 2, 3 or 4 of the Mental Health Act 1983) or to section 35 of the 1983 Act, which provided for remand to a hospital for assessment.

13. The magistrates decided to remand Christopher Edwards in custody for three days, which was a shorter period than usual, bringing forward the date to 1 December so that instructions could be taken and legal aid forms completed. Further consideration would then be given, *inter alia*, to the obtaining of a psychiatric report. After the hearing, the first applicant telephoned the probation service in Colchester and expressed concern about his son's mental health. He was advised to contact Chelmsford Prison. He rang the probation officer at the prison and informed her of his son's medical history. Her telephone note indicated that she had been told that he had been prescribed stelazine, though he had been refusing to take it or accept that he was mentally ill. The probation officer visited the health care centre and spoke to the senior medical officer, Dr F. Although there was later dispute as to how much detail she passed on to the doctor, he recalled being informed that Christopher Edwards was considered to be a risk to women. However, having regard to the psychiatric social worker's comments that Christopher Edwards was fit for detention in a police station and the fact that the court had not ordered any psychiatric reports, he stated that he would not interfere with the usual admissions procedure which meant that Christopher Edwards would be screened on arrival in the usual way and his location in the prison would depend on the result of that

process. Neither he nor the probation officer passed on any of this information to the reception staff.

14. A prison officer returning to Chelmsford Prison from the Magistrates' Court informed the officer in charge of reception staff that a female prison officer had been assaulted by a prisoner who was due to arrive later that day. The police officers at the Magistrates' Court custody area suspected from his behaviour that Christopher Edwards was mentally abnormal and might be a threat to women and decided to warn the prison staff. A police officer rang and spoke to the senior officer at the prison reception and told him, *inter alia*, that the magistrates had wanted to remand Christopher Edwards to a mental hospital and that he had assaulted a female prison officer. The senior officer was concerned at this information and contacted the Magistrates' Court to verify whether he was being remanded under a normal warrant. He also spoke to the duty governor about the allocation of Christopher Edwards and it was decided, subject to the health care screening, that he should be located on wing D-1 where no female officers worked.

15. In the late afternoon, Christopher Edwards was taken to Chelmsford Prison. The reception staff were aware of the information passed on from the police at the Magistrates' Court and that he was a potential danger to women. He was placed in a holding area while the other prison arrivals were processed. His behaviour was noted as "strange" and "odd" and when being placed in the holding cell he was aggressive and tried to punch a prison officer. After two hours he was screened by Mr N., a member of the prison health care staff, who saw no reason to admit him to the health care centre. Mr N. knew nothing about previous discussions in the court or the concerns passed on to the prison about Christopher Edwards's mental health. He was only aware that Christopher Edwards was alleged to have assaulted a female police constable. Mr N. followed the standard questionnaire. To question 5 (Have you ever been seen by a psychiatrist?), the answer was "three years ago". Christopher Edwards did not disclose that he had been taking stelazine. There was no evidence of active mental disturbance or bizarre behaviour during the interview, which was unlikely to have lasted more than ten minutes. No medical officer was on duty at the centre at this time, or was present in the prison. Christopher Edwards was admitted to the main prison and placed in cell D1-6.

16. He was detained in a cell on his own during this period.

17. Meanwhile, Richard Linford was arrested in Maldon on 26 November 1994 for assaulting his friend and her neighbour. At Maldon police station, he was seen by a police surgeon as it was suspected that he was mentally ill. The police surgeon certified that Richard Linford was not fit to be detained. Richard Linford was assessed by a psychiatric registrar who consulted on the telephone with a consultant psychiatrist, who decided that he did not need to be admitted to hospital and that he was fit to be

detained. Richard Linford was transferred to Chelmsford police station, where the police surgeon also found him fit to be detained. While his conduct before and after arrest was bizarre, it was attributed by the doctors to the effects of alcohol abuse, amphetamine withdrawal and to a deliberate attempt to manipulate the criminal justice system. The registrar, who had previously treated Richard Linford, knew that he had been diagnosed at various times as suffering from schizophrenia or as having a personality disorder, but also knew him as someone who became ill when abusing alcohol and drugs. Over the weekend, Richard Linford showed further bizarre behaviour and was violent towards police officers. He was not reassessed by a doctor. No CID2 form was filled in, although police officers remained of the opinion that he was mentally ill. On 28 November 1994 Richard Linford was remanded in custody by Chelmsford Magistrates' Court. The magistrates were presented with a "sane but dangerous" description of him. Richard Linford arrived at Chelmsford Prison shortly after Christopher Edwards, where he was screened by the same member of the prison health care service who had seen Christopher Edwards and who saw no reason to admit him to the health care centre. Richard Linford did not behave in a bizarre fashion during the screening. Mr N. did not have knowledge of Richard Linford's previous convictions, which would have alerted him to his admittance to hospital in 1988.

18. Initially, Richard Linford was placed in cell D1-11 on his own. He was then moved into cell D1-6 with Christopher Edwards. This was due to shortage of space, as all the other cells on the landing were doubly occupied.

19. Each cell had a green emergency light situated on the wall outside the cell next to the door which came on when the call button was depressed inside the cell. Additionally, once the button was pressed, a buzzer sounded on the landing and a red light lit up on a control panel in the office on the landing concerned, indicating the cell. The red light remained on and the buzzer continued to sound even if the prisoner ceased to press the button. At 9 p.m., either Christopher Edwards or Richard Linford pressed the call button. A prison officer saw the green light outside the cell and was told that they wished one of the cell lights, operated from the exterior, to be switched off. He agreed to do so. He saw that the two men appeared to be "getting on all right". He noticed that while the green light had gone on the buzzer which should have been sounding continuously had not done so. He did not report the apparent defect.

20. Shortly before 1 a.m. on 29 November 1994, a prison officer heard a buzzer sound. He saw no red light on the D-landing control panel and saw a prison officer go to check the other landings. Some time later, he heard continuous banging on a cell door on his landing. On going to investigate he saw the green light on outside cell D1-6. Looking through the spy hole, he saw Richard Linford holding a bloodstained plastic fork and noticed blood

on the floor and on Linford's feet. There was a delay of five minutes while officers donned protective clothing. They entered the cell to find that Christopher Edwards had been stamped and kicked to death. Richard Linford was making continual reference to being possessed by evil spirits and devils. D-landing had previously been patrolled at 12.43 a.m., which indicated that up to seventeen minutes could have elapsed since the pressing of the cell's call button.

21. At the time of the attack, Richard Linford was acutely mentally ill. He was transferred later on 29 November 1994 to Rampton Special Hospital.

22. On 21 April 1995 Richard Linford pleaded guilty at Chelmsford Crown Court to the manslaughter of Christopher Edwards by reason of diminished responsibility. The trial was therefore brief. The judge imposed a hospital order under section 37 of the Mental Health Act 1983 ("the 1983 Act"), together with a restriction order under section 41. Richard Linford is currently still at Rampton Special Hospital, diagnosed as suffering from paranoid schizophrenia.

23. A coroner's inquest had been opened but adjourned pending the criminal proceedings against Richard Linford. After Richard Linford's conviction, the coroner closed the inquest, as there was no obligation to continue in those circumstances.

24. On 16 October 1995 the applicants were advised by the Assistant Chief Constable that it was considered that there was insufficient evidence to establish the offence of manslaughter by gross negligence on the part of anyone involved in the case but that the matter would be probably reviewed at the conclusion of the inquiry which had been commenced by the statutory agencies concerned in the case.

25. In July 1995 a private, non-statutory inquiry was commissioned by three State agencies with statutory responsibilities towards Christopher Edwards – the Prison Service, Essex County Council and North Essex Health Authority. Its terms of reference were:

“To investigate the death of Mr Edwards in Chelmsford Prison, including factors in his and Mr Linford's detention which are relevant to that, and in particular: the extent to which their reception, detention, management and care corresponded to statutory obligations, Prison Service Standing Orders and Health Care Standards and local operational policies.

1. To examine the adequacy, both in fact and of relevant procedures, of collaboration and communication between the agencies (HM Prison Service, the Essex Police, the courts, MidEssex Community and Mental Health NHS Trust and its predecessor, and Essex County Council Social Services Department) involved in the care, custody and control of Mr Edwards and Mr Linford, or in the provision of services to them.

2. To examine the circumstances surrounding the arrest, detention and custody of Mr Linford and Mr Edwards by Essex Police, including whether all relevant

information was effectively and efficiently passed between Essex Police, the prison service, the courts, and any other relevant agencies ...;

3. To examine all the relevant circumstances surrounding the treatment and care of Mr Edwards and Mr Linford, by the health service and social services, and in particular: the extent to which Mr Edwards and Mr Linford's care corresponded to relevant statutory obligations, relevant guidance from the Department of Health ... and local operational policies.

4. To prepare a report and make recommendations to North Essex Health Authority, Essex County Council Social Services Department and HM Prison Service, and other such agencies as are identified as appropriate ...”

26. In February 1996 the applicants were advised by their solicitors that they had a claim for funeral costs and a potential claim for compensation and any pain and suffering between Christopher Edwards's injury and death, but that taking into account legal costs it would not be economic to bring such a claim.

27. In April 1996, the Criminal Injuries Compensation Board awarded the applicants 4,550 pounds sterling (GBP) for funeral expenses but decided that there should be no dependency or bereavement award.

28. The inquiry opened in May 1996. It was chaired by Mr Kieran Coonan QC, Recorder of the Crown Court, the other members of the panel consisting of Professor Bluglass (Emeritus Professor of Forensic Psychiatry at the University of Birmingham), Mr Gordon Halliday (former Director of Social Services, Devon County Council and member of the Mental Health Commission), Mr Michael Jenkins (former Governor of Oxford Prison and Long Lartin Prison and HM Deputy Chief Inspector of Prisons 1987-92) and Mr Owen Kelly (Commissioner of the City of London Police 1985-93). They were assisted by a firm of solicitors appointed by the commissioning agencies to provide secretarial and administrative support and to arrange for the attendance of witnesses. Two solicitors from this firm were appointed as advocates to the inquiry.

29. The inquiry received evidence on fifty-six days over a period of ten months. It sat in private. It had no powers of compulsion of witnesses or production of documents. Two prison officers refused to give evidence. The inquiry report later noted that one of these had potentially significant evidence and his refusal was said to be “all the more regrettable since he had passed by Christopher Edwards's cell shortly before he met his death”. The inquiry panel conducted visits to the police stations, Magistrates' Court building and prison concerned. Professor Bluglass, a member of the panel, interviewed Richard Linford in hospital. About 150 witnesses attended the inquiry to give evidence, while a considerable number of others submitted written evidence.

30. In November 1997 the applicants issued a summons in the County Court for negligence against the Chief Constable of Essex and Essex



County Council. They did not, however, serve it due to legal advice from their solicitors.

31. Draft extracts of the inquiry's preliminary findings were circulated to those subjected to criticism to allow them the opportunity to comment. A number of witnesses were recalled to give evidence on 27 April 1998.

32. The inquiry report was published on 15 June 1998. It concluded that ideally Christopher Edwards and Richard Linford should not have been in prison and in practice they should not have been sharing the same cell. It found "a systemic collapse of the protective mechanisms that ought to have operated to protect this vulnerable prisoner". It identified a series of shortcomings, including poor record-keeping, inadequate communication and limited inter-agency cooperation, and a number of missed opportunities to prevent the death of Christopher Edwards.

33. The findings included the following:

(a) Ideally, if suitable beds had been available, Christopher Edwards should have been admitted to hospital for assessment under section 2 of the Mental Health Act 1983.

(b) It was a serious omission, and breach of Code C of the Code of Practice under the Police and Criminal Evidence Act 1984 ("PACE"), that no doctor had been asked by the custody officer to see Christopher Edwards.

(c) It was a serious failure by Essex Police that a CID2 form was not completed describing Christopher Edwards as a prisoner reasonably suspected of being an exceptional risk on the grounds of mental disturbance, though it was noted that even if he had been so described by the police this would not have been enough, by itself, to ensure that he was admitted to the health care centre at Chelmsford Prison.

(d) At the Magistrates' Court hearing on 28 November 1994 no consideration was given to section 35 of the 1983 Act which provided for a remand to hospital for assessment.

(e) No attempt was made by the court to notify the prison authorities, in particular the senior medical officer, that Christopher Edwards was suspected of suffering from a mental illness.

(f) Information provided to the prison by the applicants about Christopher Edwards's psychiatric background was not recorded or passed on to the person carrying out the screening.

(g) When Christopher Edwards arrived at Chelmsford Prison there was no medical officer on duty, in breach of the Prison Service Health Care Standards.

(h) The prison health care worker, Mr N., who assessed Christopher Edwards was inadequately trained in the recognition of mental disorder and had been given insufficient guidance. The screening was rushed and superficial and did not take place in adequate conditions of privacy.

(i) Mr N. had not been provided with any information about the concerns as to Christopher Edwards's mental condition by the police or the court. If he had received a CID2 form identifying mental disturbance or the court had expressed some concern, this might have prompted sufficient residual doubts to cause him to err on the side of caution and have him admitted to the health centre for the first night.

(j) The cell's call system was defective; it had been pressed up to seventeen minutes before the alarm was raised by Richard Linford banging on the door and the warning buzzer had not sounded, or if it did it only sounded briefly. If it had functioned, a prompt response might have saved Christopher Edwards's life. The system could be disabled simply by wedging a matchstick behind the re-set button on the control panel and it could not be ruled out that it might have been tampered with by a prison officer or prisoner who wanted a "quiet night". The fact that it could so easily be disabled rendered the system inadequate and unsafe. It was also noted that according to good practice, where the cell's call system was defective, either the occupants should be moved to another cell or effective visual monitoring should be provided, as a cell could not be certified fit for occupation without a method of communication in working condition.

(k) Richard Linford had a history of violent outbursts and assaults, including a previous assault on a cell-mate in prison. He had been admitted to mental hospital in 1988, and subsequently had been diagnosed as suffering from schizophrenia. Despite psychotic episodes and further assessments, he was not admitted to hospital after September 1994, as he was not considered to be suffering from acute mental illness. A case conference was held on 24 October 1994, where one of Richard Linford's general practitioners and a police officer expressed the view that he was capable of serious violence or murder. However, no formal risk assessment was carried out. The consultant psychiatrist did not accept that the risk to public safety was serious and it was decided to make one last attempt to induce Richard Linford to take depot medication before detaining him under section 3 of the 1983 Act. On 7 November 1994, it was reported to the consultant that Richard Linford was refusing depot medication.

(l) After Richard Linford's arrest on 26 November, no attempt was made to locate his medical notes before being assessed. The psychiatric registrar was unaware of the case conference or the outline plan to detain him.

(m) No CID2 form was filled in by the police for Richard Linford despite his attacks on two officers, as the officer concerned did not know that such a form existed.

(n) The police, prosecution and magistrates were aware that Richard Linford was described as dangerous but no formal warning was given to the prison authorities.

(o) At Chelmsford Prison, Richard Linford was screened by Mr N., who knew nothing about him except that he had been "difficult" in the police

station; although the provision of a CID2 form would not have been conclusive, information about his previous convictions (and admittance to hospital) might have prompted a closer appraisal and he might have had sufficient doubts to have him admitted to the health care centre despite the absence of really bizarre symptoms.

34. Following the publication of the report, the applicants sought advice as to whether there were any civil remedies available to them in the light of the findings of the inquiry. At a conference on 2 October 1998, they were advised by counsel that there were still no available civil remedies. The inquiry had made no relevant findings in relation to whether any time elapsed between their son being injured and his death, which would have determined whether they had any action in respect of pain and suffering experienced by their son before he died.

35. By letter of 25 November 1998, the Crown Prosecution Service maintained their previous decision that there was insufficient evidence to proceed with criminal charges. The applicants' counsel advised on 10 December 1998 that, notwithstanding the numerous shortcomings, there was insufficient material to found a criminal charge of gross negligence against any individual or agency.

36. By letter dated 15 December 2000, the Police Complaints Authority (PCA) provided the applicants with a report on their complaints about police conduct in dealing with Christopher Edwards and on the subsequent investigation into his death. The report upheld fifteen of the complaints and made a number of recommendations to Essex Police in relation to practice and procedure. It found, *inter alia*, a breach of the Code of Practice under PACE in that the police failed to summon a doctor to the police station when Christopher Edwards's behaviour led them to believe that he might be suffering from a mental illness and that, as regarded the failure of the officers to fill in a CID2 form identifying Christopher Edwards and Richard Linford as exceptional risks on grounds of mental disturbance, the officers concerned had been insufficiently informed as to the existence and purposes of the form. It also upheld complaints about the police investigation after the death, including a failure by the police investigators to test the cell buzzer properly to establish its effectiveness, the loss of the list of prisoners held on the relevant landing on the night of the incident and a failure to interview relevant persons in the prison, for example, Mr N., the health care worker, the prison doctor and the prison probation officer concerning the allegation of criminal negligence raised by the applicants.

## II. RELEVANT DOMESTIC LAW AND PRACTICE

### A. Proceedings for death caused by negligence

37. Under the common law, no one can recover damages in tort for the death of another.

38. The Fatal Accidents Act 1976 confers a right of action for a wrongful act causing death. Section 1(1) provides:

“If death is caused by any wrongful act, neglect or default which is such as would (if death had not ensued) have entitled the person injured to maintain an action and recover damages in respect thereof, the person who would have been liable if death had not ensued shall be liable to an action for damages, notwithstanding the death of the person injured.”

39. However, the statutory right of action is reserved to the deceased's dependants (section 1(2) which allows the recovery of their pecuniary loss). If there are no dependants, there is no pecuniary loss to recover as damages. Bereavement damages (fixed at GBP 7,500) are only available to the parents of a child under the age of 18 (section 1A(2)). Funeral expenses are recoverable (section 3(5)).

40. The Law Reform (Miscellaneous) Provisions Act 1934 provides for the survival of causes of action for the benefit of the deceased's personal estate. The relevant part of section 1(1) provides:

“Subject to the provisions of this section, on the death of any person after the commencement of this Act all causes of action subsisting against or vested in him shall survive against, or, as the case may be, for the benefit of, his estate.”

41. This enables recovery on behalf of the estate of damages for losses suffered by the deceased before he died, including any non-pecuniary loss such as damages for pain and suffering experienced between the infliction of injury and death. Where death is instantaneous, or where it cannot be proved that the deceased experienced pain and suffering before death, damages are not recoverable under the 1934 Act and the only recoverable amount would be funeral expenses.

### B. Cases under the Human Rights Act 1998

42. Two cases have arisen since the entry into force on 2 October 2000 of the Human Rights Act 1998 concerning deaths in custody in which the domestic courts have examined the requirements of Articles 2 and 3 of the Convention.

43. In *R. on the application of Wright v. the Secretary of State for the Home Department* ([2001] High Court, Administrative Court (England and Wales) 520, 20 June 2001), proceedings were brought by the mother and aunt of a man who died in custody as a result of a severe asthma attack in

which it was alleged that his treatment prior to his death did not comply with Articles 2 or 3 of the Convention and that there had been a failure to provide a proper investigation into his death. The High Court found that it was arguable that the Prison Service had breached Articles 2 and 3 in its treatment of this prisoner and that, as the inquest and civil proceedings did not constitute an effective official investigation for the purpose of the procedural obligations under these provisions, the claimants were entitled to an order that the Secretary of State set up an independent investigation into the circumstances of the death. Although the death had occurred prior to 2 October 2000, the court held that there was a continuing obligation after that date to provide an effective investigation in the special circumstances of that case where the death was still the subject of active debate and controversy.

44. In *R. on the application of Amin v. the Secretary of State for the Home Department* ([2001] High Court, Administrative Court (England and Wales) 719, 5 October 2001), where 19-year-old Zahid Mubarek was bludgeoned to death by a violent and racist prisoner, there was a claim that the Secretary of State had failed to hold an open and public investigation into the circumstances of the death. The High Court found that internal inquiry by the Prison Service and the criminal trial of the assailant did not constitute an effective investigation for the purposes of the procedural obligation under Article 2, principally as it did not establish why on that night Zahid Mubarek was sharing a cell with his assailant. The claimants were accordingly entitled to a declaration that an independent public investigation with the family legally represented, provided with the relevant material and able to cross-examine the principal witnesses, must be held to satisfy the obligations imposed by Article 2 of the Convention.

## THE LAW

### I. ALLEGED VIOLATION OF ARTICLE 2 OF THE CONVENTION

45. Article 2 of the Convention provides, in its first sentence:

“1. Everyone's right to life shall be protected by law. ...”

46. The applicants complain that the authorities failed to protect the life of their son and were responsible for his death. They also complain that the investigation into their son's death was not adequate or effective as required by the procedural obligation imposed by Article 2 of the Convention.

#### A. Concerning the positive obligation to protect life

### *1. Submissions of the parties*

#### **(a) The applicants**

47. The applicants submit that there was a breach of the positive obligation imposed on the authorities to protect the life of their son. Although the scope of such a positive obligation might vary, it was particularly stringent where an individual died in custody. The test was whether the authorities knew or ought to have known at the time of the existence of a real and immediate risk to his life from the criminal acts of a third party and whether the authorities failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk. It was incorrect therefore to focus on what the authorities knew, as proposed by the Government, – a subjective approach – rather than the objective approach of considering what the authorities ought to have known. It is clear that the prison authorities knew, or least ought to have known, that there was a real and immediate danger to Christopher Edwards's life when they placed Richard Linford in his cell. They were aware or ought to have been aware of Richard Linford's dangerous condition and of Christopher Edwards's vulnerability. That the authorities actually knew is indicated, *inter alia*, by evidence given at the inquiry which showed that prison officers knew that Christopher Edwards needed to be isolated from other prisoners for his own safety and that they knew Richard Linford, who had been continuously involved in fighting, was not fit to be with other prisoners. The only reason given for placing both men together was to free a cell for other detainees. The Government's assertion that the procedures applied to the reception of prisoners was adequate is at odds with the changes made to the system following this case and others which raised public concern about mental-health screening of prisoners on their arrival at a prison.

48. The applicants refer to the inquiry report's findings of various failures of one public authority to pass on to another information about the risks Richard Linford presented. In particular, although the police, the Crown Prosecution Service and the magistrates were all aware that he was dangerous and prone to violence, no formal warning was passed on to the prison, nor was any information made available about his past criminal or medical records. In addition, the positive obligation imposed by Article 2 rests on all public authorities, not only the prison authorities. The test should not be construed narrowly to focus on the particular agency or officer dealing with the victim at the time of the incident, but should take into account systemic failure involving a number of different authorities.

49. Having regard to the knowledge available, or which should have been available to them, the authorities should reasonably have placed Christopher Edwards and Richard Linford in separate cells or, alternatively, they could have repaired the cell buzzer which was known to be defective or

arranged for effective visual monitoring of the cell in which they were held. This case could be distinguished from *Osman v. the United Kingdom* (judgment of 28 October 1998, *Reports of Judgments and Decisions* 1998-VIII), which concerned a series of missed opportunities in an investigation which might possibly have led to the detention of the individual who committed the killing, as in this case Christopher Edwards was actively exposed to the risk of harm by another by the very authorities in whose care he had been placed. Each of the identified failures were significant contributory factors in a chain of omissions which culminated in a fatal decision to place Richard Linford in a cell with Christopher Edwards.

**(b) The Government**

50. The Government submit that there was no failure in any positive obligation imposed by Article 2 to protect the right to life of Christopher Edwards. The information available to the prison authorities in the period leading up to his death, when viewed objectively and without the benefit of hindsight, demonstrated that there was no real or immediate risk about which the prison authorities knew or ought to have known. Regard had to be paid to the medical evidence available and the consideration that the authorities had to act in a way which respected the other rights and freedoms of individuals.

51. In this case, an experienced social worker and a consultant psychiatrist found that Christopher Edwards was fit to be detained in a police station and did not require urgent medical attention. Even if a doctor had been called to the police station, it is unlikely that this would have had any material impact on what happened. The inquiry found that the advice given by the consultant psychiatrist that Christopher Edwards was fit to be detained was reasonable. It is also a matter of speculation to claim that if the police had filled in a CID2 form, this would have led to his placement in the health care centre of Chelmsford Prison. When Christopher Edwards was admitted to prison and examined for admission to the health care centre, there was no evidence of bizarre behaviour. Nor do the Government accept that there was any failure to pass on information to the prison about his illness. A police officer had telephoned from the court to inform the prison reception that the court had wanted to commit him under the Mental Health Act 1983; a probation officer left a message that Christopher Edwards might be a risk to women, while the first applicant informed the prison probation officer of his son's mental illness. They emphasise that it was only necessary for a prisoner to be examined on reception in prison if the health care worker assessed him to be in need of urgent medical attention, the purpose of the screening being principally to identify quickly those prisoners in need of urgent treatment. The current policy is that new prisoners should be seen by a medical officer within twenty-four hours of admission, it being

impossible to conduct thorough examinations of all newcomers on arrival in a busy prison.

52. The Government also submit that it was normal policy in the prison for prisoners to share a cell and there was no evidence that the prison authorities knew that Christopher Edwards's cell's call system was defective. Further, after his arrest, Richard Linford was found by two doctors to disclose no signs of psychosis and was afterwards noted to be acting rationally and without aggressive behaviour. Even if the doctors who saw him at this stage had seen his medical notes and contacted his consultant psychiatrist, the inquiry noted that the consultant would have been content for Linford to remain in custody. Linford was also found not to be acting in such a way as to justify admission to the prison health care centre. It was his injuries and uncooperative attitude which initially led him to be placed in a cell by himself, not any suspected mental illness. Therefore, even if a CID2 form had been completed, it would be speculative to claim that this would have made any difference, as it would be to draw conclusions from the omissions made in the transmission of information about Linford. When the two prisoners were last seen together, there was no suspicion that Richard Linford would act violently towards his cell-mate.

53. The Government accept that the inquiry's conclusion was critical of the "systemic" collapse of a number of mechanisms which, taken together, contributed to the death of Christopher Edwards. That, however, did not establish that the authorities had failed to comply with the positive obligation. The Government regretted this state of affairs and, in particular, the operational failure of the cell's call system, which had proved to be easily disabled. However, no system could rule out the possibility of mechanical defects. They argued that these matters were insufficient to lead to the conclusion that the authorities failed to do what they reasonably could, given their state of knowledge at the time.

## 2. *The Court's assessment*

### (a) **General principles**

54. The Court reiterates that the first sentence of Article 2 § 1 enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction (see *L.C.B. v. the United Kingdom*, judgment of 9 June 1998, *Reports* 1998-III, p. 1403, § 36). This involves a primary duty on the State to secure the right to life by putting in place effective criminal-law provisions to deter the commission of offences against the person backed up by a law-enforcement machinery for the prevention, suppression and punishment of breaches of such provisions. It also extends in appropriate circumstances to a positive obligation on the authorities to take preventive



operational measures to protect an individual whose life is at risk from the criminal acts of another individual (see *Osman*, cited above, p. 3159, § 115).

55. Bearing in mind the difficulties in policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources, the scope of the positive obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities. Not every claimed risk to life, therefore, can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising. For a positive obligation to arise, it must be established 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 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 (*ibid.*, pp. 3159-60, § 116).

56. In the context of prisoners, the Court has had previous occasion to emphasise that persons in custody are in a vulnerable position and that the authorities are under a duty to protect them. It is incumbent on the State to account for any injuries suffered in custody, which obligation is particularly stringent where that individual dies (see, for example, *Salman v. Turkey* [GC], no. 21986/93, § 99, ECHR 2000-VII). It may be noted that this need for scrutiny is acknowledged in the domestic law of England and Wales, where inquests are automatically held concerning the deaths of persons in prison and where the domestic courts have imposed a duty of care on prison authorities in respect of detainees in their custody.

**(b) Application in the present case**

57. Christopher Edwards was killed while detained on remand by a dangerous, mentally ill prisoner, Richard Linford, who was placed in his cell. As a prisoner he fell under the responsibility of the authorities who were under a domestic-law and Convention obligation to protect his life. The Court has examined, firstly, whether the authorities knew or ought to have known of the existence of a real and immediate risk to the life of Christopher Edwards from the acts of Richard Linford and, secondly, whether they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk.

58. As regards the state of knowledge of the authorities, the Court notes that it was considered in the inquiry report that any prisoner sharing a cell with Richard Linford that night would have been at risk to his life. It seems therefore to the Court that the essential question is whether the prison authorities knew or ought to have known of his extreme dangerousness at the time the decision was taken to place him in the same cell as Christopher Edwards.

59. That Richard Linford was mentally ill was known to the doctors who were treating him – he had been admitted to hospital in 1988 and been diagnosed as suffering from schizophrenia. He also had a history of violent outbursts and assaults. However, some weeks prior to his arrest on 26 November 1994, while fears had arisen that he was capable of serious violence, the consultant psychiatrist considered that one more effort to manage his behaviour through depot medication was required before steps were taken to detain him under the Mental Health Act 1983. At the police station, after his arrest, his bizarre behaviour led the police to suspect that he was mentally ill and the police surgeon considered that his mental state was such that he was not fit to be detained. This view was overruled, somewhat to the surprise of the police, by the psychiatric registrar who examined him and concluded that his behaviour could be a result of substance abuse and a deliberate attempt at manipulation. The registrar did not consult Richard Linford's notes which would have shown him that he was under consideration for compulsory committal. While in the police station, Richard Linford's behaviour continued to fluctuate with violent and bizarre episodes. When he arrived at the prison after being remanded in custody by the court, he bore visible signs of injury and was known to the screening health worker to have been “difficult”. The screening health worker was not, however, made aware of his prison record or his previous committal to hospital and the police, prosecution and court did not pass on any detailed information relating to his conduct and his known history of mental disturbance.

60. The Court is satisfied that information was available which identified Richard Linford as suffering from a mental illness with a record of violence which was serious enough to merit proposals for compulsory detention and that this, in combination with his bizarre and violent behaviour on and following arrest, demonstrated that he was a real and serious risk to others and, in the circumstances of this case, to Christopher Edwards, when placed in his cell.

61. As regards the measures which they might reasonably have been expected to take to avoid that risk, the Court observes that the information concerning Richard Linford's medical history and perceived dangerousness ought to have been brought to the attention of the prison authorities, and in particular those responsible for deciding whether to place him in the health care centre or in ordinary location with other prisoners. It was not. There was a series of shortcomings in the transmission of information, from the failure of the registrar to consult Richard Linford's notes in order to obtain the full picture, the failure of the police to fill in a CID2 form (exceptional risk) and the failure of the police, prosecution or Magistrates' Court to take steps to inform the prison authorities in any other way of Richard Linford's suspected dangerousness and instability.

62. The Government have pointed out that even if a CID2 form had been filled in by the police, this would not have conclusively led the prison to place Richard Linford in the health care centre rather than a cell with another prisoner. They submit that the screening process concentrated on the behaviour of the prisoner on admission and was not expected to be a full medical or psychiatric examination, a doctor generally visiting each prisoner within a day of arrival. However, the inquiry report considered that if the screening health worker had been properly informed of Richard Linford's background, he would have perhaps paid closer attention, noticing that Linford had lied in his answers in the questionnaire and he might in those circumstances have erred on the side of caution and not placed him on ordinary location. It is true that this is speculation to some extent. However, the Court considers that it is self-evident that the screening process of the new arrivals in a prison should serve to identify effectively those prisoners who require for their own welfare or the welfare of other prisoners to be placed under medical supervision. The defects in the information provided to the prison admissions staff were combined in this case with the brief and cursory nature of the examination carried out by a screening health worker who was found by the inquiry to be inadequately trained and acting in the absence of a doctor to whom recourse could be had in case of difficulty or doubt.

63. It is apparent from the inquiry report that in addition there were numerous failings in the way in which Christopher Edwards was treated from his arrest to his allocation to a shared cell. In particular, despite his disturbed mental state, no doctor was called to examine him in the police station, no CID2 form was filled in by the police and there was a failure to pass on to the prison screening officer information provided informally by the applicants, the probation service at the court and an individual police officer. However, although it would obviously have been desirable for Christopher Edwards to be detained either in a hospital or the health care centre of the prison, his life was placed at risk by the introduction into his cell of a dangerously unstable prisoner and it is the shortcomings in that regard which are most relevant to the issues in this case. On the same basis, while the Court deplors the fact that the cell's call button, which should have been a safeguard, was defective, it considers that on the information available to the authorities, Richard Linford should not have been placed in Christopher Edwards's cell in the first place.

64. The Court concludes that the failure of the agencies involved in this case (medical profession, police, prosecution and court) to pass information about Richard Linford on to the prison authorities and the inadequate nature of the screening process on Richard Linford's arrival in prison disclose a breach of the State's obligation to protect the life of Christopher Edwards. There has therefore been a breach of Article 2 of the Convention in this regard.

## **B. The procedural obligation to carry out effective investigations**

### *1. Submissions of the parties*

#### **(a) The applicants**

65. The applicants consider that the procedural obligation under Article 2 required the authorities to carry out an effective investigation into the circumstances of their son's death. Any distinction between acts or omissions by State agents was irrelevant, the purpose being to ensure accountability for deaths occurring under potential State responsibility. While there was no particular form of inquiry imposed, they argue that a more rigorous scrutiny was required in this case due to the fact that the circumstances in which Christopher Edwards died were unclear, there was no criminal trial, as Richard Linford pleaded guilty to manslaughter on grounds of diminished responsibility and there was no coroner's inquest. Nor was the police investigation effective having regard to the complaints upheld by the PCA.

66. The non-statutory inquiry did not, in their view, provide a thorough and effective investigation either. They refer to the fact that the inquiry was privately commissioned by the agencies which were themselves the subject of investigation and which themselves fixed the terms of reference and appointed the inquiry chairman, panel and counsel. The proceedings were held in private and the applicants were only able to attend to give evidence. Nor were the applicants legally represented or able to have witnesses cross-examined. Furthermore, the inquiry had no power to compel witnesses. A number of witnesses failed to appear, including a crucial witness, a prison officer who had passed by the cell shortly before Christopher Edwards died. Therefore, the inquiry was deprived of "potentially significant evidence". It was in addition neither prompt nor reasonably expeditious, commencing only in May 1996 and the final report being published some three and a half years later in June 1998, time being taken to give witnesses an opportunity to comment on draft findings in proceedings which the applicants themselves were not entitled to attend.

#### **(b) The Government**

67. As regards the procedural obligation under Article 2, the Government point out that its requirements would inevitably vary with the circumstances and did not invariably require a particular form of investigation or that the family of the victim should enjoy rights to legal representation, for example. The primary obligation under Article 2 was for the State to refrain from the unlawful taking of life. In other cases, where the allegation was negligence, less formal investigations would be required, if at all, and the availability of civil proceedings might suffice. The focus of Article 2 was on the effectiveness of the investigation and not the right to a

fair and public hearing for particular individuals. They submit that the non-statutory inquiry in this case was an effective investigation: it was chaired by senior counsel; its members were senior and experienced professionals; its terms of reference were broad and designed to enable the fullest possible investigation; it was the longest and most expensive inquiry of its kind (lasting three years and costing about GBP 1,000,000) and it was serviced by an independent firm of solicitors. The fact that the inquiry was commissioned by agencies that were in part the subject of the investigation and appointed the chairman did not remove its independence. It was precisely such agencies that had the best reason to set up the inquiry so that they might learn lessons for the future.

68. The fact that the inquiry sat in private, as in many inquisitorial inquiries, did not detract from its effectiveness. Nor was its inability to compel witnesses an issue since this did not prevent the inquiry from being able to conduct a thorough investigation and reach findings many of which were critical of the authorities. There was no indication that the missing prison officer who had given two witness statements would have had anything different or additional to say at the inquiry. Sufficient public accountability was secured by the publication of the report and the applicants were able to participate in the inquiry to the extent necessary to safeguard their own legitimate interests, namely, by giving evidence to it.

## 2. *The Court's assessment*

### (a) **General principles**

69. The obligation to protect the right to life under Article 2 of the Convention, read in conjunction with the State's general duty under Article 1 of the Convention to "secure to everyone within [its] jurisdiction the rights and freedoms defined in [the] Convention", also requires by implication that there should be some form of effective official investigation when individuals have been killed as a result of the use of force (see, *mutatis mutandis*, *McCann and Others v. the United Kingdom*, judgment of 27 September 1995, Series A no. 324, p. 49, § 161, and *Kaya v. Turkey*, judgment of 19 February 1998, *Reports* 1998-I, p. 324, § 86). The essential purpose of such investigation is to secure the effective implementation of the domestic laws which protect the right to life and, in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility. What form of investigation will achieve those purposes may vary in different circumstances. However, whatever mode is employed, the authorities must act of their own motion, once the matter has come to their attention. They cannot leave it to the initiative of the next-of-kin either to lodge a formal complaint or to take responsibility for the conduct of any investigative procedures (see, for example, *mutatis mutandis*, *Ilhan v. Turkey* [GC], no. 22277/93, § 63, ECHR 2000-VII).

70. For an investigation into an alleged unlawful killing by State agents to be effective, it may generally be regarded as necessary for the persons responsible for and carrying out the investigation to be independent from those implicated in the events (see, for example, *Güleç v. Turkey*, judgment of 27 July 1998, *Reports* 1998-IV, p. 1733, §§ 81-82, and *Oğur v. Turkey* [GC], no. 21954/93, §§ 91-92, ECHR 1999-III). This means not only a lack of hierarchical or institutional connection but also a practical independence (see, for example, *Ergi v. Turkey*, judgment of 28 July 1998, *Reports* 1998-IV, pp. 1778-79, §§ 83-84, and the recent Northern Irish judgments, for example, *Hugh Jordan v. the United Kingdom*, no. 24746/94, § 120, and *Kelly and Others v. the United Kingdom*, no. 30054/96, § 114, both of 4 May 2001).

71. The investigation must also be effective in the sense that it is capable of leading to a determination of whether the force used was or was not justified in the circumstances (see, for example, *Kaya*, cited above, p. 324, § 87) and to the identification and punishment of those responsible (see *Oğur*, cited above, § 88). This is not an obligation of result, but of means. The authorities must have taken the reasonable steps available to them to secure the evidence concerning the incident, including, *inter alia*, eyewitness testimony, forensic evidence and, where appropriate, an autopsy providing a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death (see, for example, *Salman*, cited above, § 106; *Tanrikulu v. Turkey* [GC], no. 23763/94, § 109, ECHR 1999-IV; and *Gül v. Turkey*, no. 22676/93, § 89, 14 December 2000). Any deficiency in the investigation which undermines its ability to establish the cause of death or the person or persons responsible will risk falling foul of this standard (see the recent Northern Irish judgments concerning the inability of inquests to compel the security-force witnesses directly involved in the use of lethal force, for example, *Hugh Jordan*, cited above, § 127).

72. A requirement of promptness and reasonable expedition is implicit in this context (see *Yaşa v. Turkey*, judgment of 2 September 1998, *Reports* 1998-VI, pp. 2439-40, §§ 102-04; *Çakıcı v. Turkey* [GC], no. 23657/94, §§ 80, 87 and 106, ECHR 1999-IV; *Tanrikulu*, cited above, § 109; and *Mahmut Kaya v. Turkey*, no. 22535/93, §§ 106-07, ECHR 2000-III). While there may be obstacles or difficulties which prevent progress in an investigation in a particular situation, a prompt response by the authorities in investigating a use of lethal force may generally be regarded as essential in maintaining public confidence in their adherence to the rule of law and in preventing any appearance of collusion in or tolerance of unlawful acts (see, for example, *Hugh Jordan*, cited above, §§ 108 and 136-40).

73. For the same reasons, there must be a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory. The degree of public scrutiny required may well vary from case to case. In all cases, however, the next-of-kin of the victim must

be involved in the procedure to the extent necessary to safeguard his or her legitimate interests (see *Güleç*, cited above, p. 1733, § 82; *Oğur*, cited above, § 92; *Gül*, cited above, § 93; and recent Northern Irish judgments, for example, *McKerr v. the United Kingdom*, no. 28883/95, § 148, ECHR 2001-III).

**(b) Application in the present case**

74. The Court finds, first of all, that a procedural obligation arose to investigate the circumstances of the death of Christopher Edwards. He was a prisoner under the care and responsibility of the authorities when he died from acts of violence of another prisoner and in this situation it is irrelevant whether State agents were involved by acts or omissions in the events leading to his death. The State was under an obligation to initiate and carry out an investigation which fulfilled the requirements set out above. Civil proceedings, assuming that such were available to the applicants (see below, concerning the applicants' complaints under Article 13 of the Convention) which lie at the initiative of the victim's relatives would not satisfy the State's obligation in this regard.

75. The Court observes that no inquest was held in this case and that the criminal proceedings in which Richard Linford was convicted did not involve a trial at which witnesses were examined, as he pleaded guilty to manslaughter and was subject to a hospital order. The point of dispute between the parties is whether the inquiry into the care and treatment of Christopher Edwards and Richard Linford provided an effective investigative procedure, fulfilling the requirements identified above (see paragraphs 69-73).

76. The Court notes that this inquiry heard a large number of witnesses and reviewed in detail the way in which the two men were treated by the various medical, police, judicial and prison authorities. The report of the inquiry, which ran to 388 pages, reached numerous findings of defects and made recommendations for future practice. It is a meticulous document, on which the Court has had no hesitation in relying on assessing the facts and issues in this case. Nonetheless, the applicants have impugned the inquiry proceedings on a number of grounds.

*(i) Alleged shortcomings in the investigation*

77. The applicants have complained that the police omitted certain significant steps in their investigation, for example, they failed properly to test the defective call buzzer, to interview certain prison witnesses and lost a list of prisoners detained on the landing, therefore rendering it impossible to call anyone but prison officers. As pointed out by the Government, however, the prison witnesses in question were called before the inquiry and there is no indication that the police omission prevented their testimony from being accurate or helpful. As regards the loss of the list of prisoners

and the incomplete testing of the call buzzer, the Court is not persuaded that this prevented the inquiry from establishing the principal facts of the case.

*(ii) Lack of power to compel witnesses*

78. The inquiry had no power to compel witnesses and as a result two prison officers declined to attend. One of the prison officers had walked past the cell shortly before the death was discovered and the inquiry considered that his evidence would have had potential significance. The Government have drawn attention to the fact that this witness had, in any event, submitted two statements and that there is no indication that he had anything different or additional to add. However, the Court notes that he was not available for questions to be put to him on matters which might have required further detail or clarification or enabled any inconsistency or omissions in that account to be tested. The applicants had argued in their observations on admissibility that the evidence of the witnesses on the scene at the prison had been of particular importance since it potentially concerned the timing and duration of the attack (see the decision of admissibility in this case of 7 June 2001) and therefore might disclose matters relevant to their claims for damages.

79. The Court finds that the lack of compulsion of witnesses who are either eyewitnesses or have material evidence related to the circumstances of a death must be regarded as diminishing the effectiveness of the inquiry as an investigative mechanism. In this case, as in the Northern Irish judgments referred to above, it detracted from its capacity to establish the facts relevant to the death, and thereby to achieve one of the purposes required by Article 2 of the Convention.

*(iii) Alleged lack of independence*

80. The inquiry was set up by the Prison Service, Essex County Council and North Essex Health Authority, who were agencies with statutory responsibilities towards both Christopher Edwards and Richard Linford. They established the terms of reference, appointed the chairman and members of the panel as well as the solicitors who assisted the inquiry. It is not however apparent to the Court from the submissions of the applicants that this connection between the agencies and the inquiry deprived it of independence. The chairman was, as is often the case in public inquiries, a senior member of the bar, with judicial experience, while the other members were eminent or experienced in the prison, police or medical fields. None had any hierarchical link to the agencies in question. It is not asserted that they failed to act with independence or that they were constrained in any way. They acted, as far as the Court can see, in an independent capacity and not as the employees or agents of the bodies whose fulfilment of their statutory duties was under consideration. Nor is it shown that the solicitors



appointed to assist the inquiry were present in any representative capacity of those bodies.

81. The Court finds no lack of independence in the inquiry.

*(iv) Alleged lack of public scrutiny*

82. The inquiry sat in private during its hearing of evidence and witnesses. Its report was made public, containing detailed findings of fact, criticisms of failures in the various agencies concerned and recommendations.

83. The Government argued that the publication of the report secured the requisite degree of public scrutiny. The Court has indicated that publicity of proceedings or the results may satisfy the requirements of Article 2, provided that in the circumstances of the case the degree of publicity secures the accountability in practice as well as in theory of the State agents implicated in events. In the present case, where the deceased was a vulnerable individual who lost his life in a horrendous manner due to a series of failures by public bodies and servants who bore a responsibility to safeguard his welfare, the Court considers that the public interest attaching to the issues thrown up by the case was such as to call for the widest exposure possible. No reason has been put forward for holding the inquiry in private, any possible considerations of medical privacy not preventing the publication of details of the medical histories of Richard Linford and Christopher Edwards.

84. The applicants, parents of the deceased, were only able to attend three days of the inquiry when they themselves were giving evidence. They were not represented and were unable to put any questions to the witnesses, whether through their own counsel or, for example, through the inquiry panel. They had to wait until the publication of the final version of the inquiry report to discover the substance of the evidence about what had occurred. Given their close and personal concern with the subject matter of the inquiry, the Court finds that they cannot be regarded as having been involved in the procedure to the extent necessary to safeguard their interests.

*(v) Alleged lack of promptness and reasonable expedition*

85. Christopher Edwards died on 29 November 1994. The decision to hold an inquiry was taken in July 1995 and the proceedings opened in May 1996, approximately eighteen months after the death had occurred. The bulk of the witnesses and evidence were heard over the following ten-month period. After some witnesses were recalled in April 1998, the report was finally released on 15 June 1998, some two years after the inquiry opened and three and a half years after Christopher Edwards's death.

86. The Court reiterates that it is crucial in cases of deaths in contentious situations for the investigation to be prompt. The passage of time will inevitably erode the amount and quality of the evidence available and the

appearance of a lack of diligence will cast doubt on the good faith of the investigative efforts, as well as drag out the ordeal for the members of the family. In this case, it notes the considerable amount of preparation required for an inquiry of this complexity, the number of witnesses involved in the proceedings (about 150 attended the inquiry while others submitted written evidence) and the wide scope of the investigation which covered the involvement of numerous public services. The panel also carried out visits to the places involved in the events and interviewed Richard Linford in hospital. The compilation of the report, whose thoroughness the Court has already remarked upon, was a sensitive and complex endeavour. It was also reasonable to invite the witnesses to comment on the draft findings, given that these involved censure of official practices and individual professional performances. While the time which elapsed before holding the inquiry may perhaps attract some criticism, it is not comparable to the delays found in previous cases (see, for example, *Kelly and Others*, cited above, where eight years elapsed before the opening of the inquest, or *Hugh Jordan*, cited above, where there was a delay of twenty-five months in holding the inquest). In the circumstances of this case, the Court finds that the authorities may be regarded as having acted with sufficient promptness and proceeded with reasonable expedition.

(vi) *Conclusion*

87. The Court finds that the lack of power to compel witnesses and the private character of the proceedings from which the applicants were excluded, save when they were giving evidence, failed to comply with the requirements of Article 2 of the Convention to hold an effective investigation into Christopher Edwards's death. There has accordingly been a violation of the procedural obligation of Article 2 of the Convention in those respects.

## II. ALLEGED VIOLATIONS OF ARTICLES 6 AND 8 OF THE CONVENTION

88. The relevant part of Article 6 § 1 of the Convention provides:

“In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. ...”

The relevant parts of Article 8 of the Convention provide:

“1. Everyone has the right to respect for his private and family life ...

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the

country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.”

89. In their original application, the applicants complained, under the above provisions, that they had been deprived of effective access to a court to bring civil proceedings in connection with the deprivation of their son's life and that the lack of an independent investigative mechanism and the lack of access to a court, as the parents of a deceased son, disclosed a failure to respect family life. No further submissions have been made by the applicants pursuing these complaints.

90. In so far as any issues arise separate from the complaints made under the procedural aspect of Article 2 of the Convention, such issues fall to be considered under Article 13 of the Convention below.

### III. ALLEGED VIOLATION OF ARTICLE 13 OF THE CONVENTION

91. Article 13 of the Convention provides:

“Everyone whose rights and freedoms as set forth in [the] Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity.”

#### *1. Submissions of the parties*

##### **(a) The applicants**

92. The applicants argue that Article 13 required both the payment of compensation where appropriate and a thorough and effective investigation capable of leading to the identification and punishment of those responsible for the deprivation of life. It was not enough for the Government to refer to a range of remedies which might in principle be available. An action for negligence was not available in the absence of sufficient evidence as to the responsibility of any particular individual or authority or any findings as to the time between injury and death which determined whether the applicants had any action for the pain and suffering experienced by their son before his death. Adequate damages would not have been available for the harm suffered. Nor could they make any dependency claim under the Fatal Accidents Act 1976. The inquiry was not thorough or effective as an investigation for the reasons set out above (see paragraphs 65-66) and, in any event, did not have the power to award any compensation for non-pecuniary damage.

93. The applicants dispute that a remedy could still be regarded as effective where it would not be economic to bring the claim. Article 13 should be interpreted so as to make its guarantee practical and effective and genuine practical obstacles to bringing a claim undermined the effectiveness of the procedure. The Human Rights Act 1998 was of no assistance either, since it only covered events which took place after the Act came into force

on 2 October 2000. While the *Wright* case (see paragraph 43 above) indicated that the courts could apply the Act even though the death had occurred before that date, where the circumstances were still the subject of active and ongoing controversy, this was not so in the present case. Damages would only have been available for the failure to provide an effective investigation after that date and not in relation to the death itself. Finally, the Health and Safety Executive investigation, which was still ongoing, was a mere administrative procedure which could not be an effective remedy for the purpose of Article 13.

**(b) The Government**

94. The Government submit that the proper approach is for the Court to examine the full range of remedies which were available. The applicants had a combination of mechanisms by which the responsibility of any public authority for the death of their son could be established, in particular the independent inquiry, which provided a thorough and effective investigation into the circumstances surrounding his death. The applicants could have brought a claim for negligence against the prison or other authorities on behalf of his estate. The applicants also had a remedy available for any loss of dependency. They argue that the fact that a person could not bring a case because of legal advice that it was not economic did not mean that an effective remedy was not available or that the Contracting State had failed to comply with its obligation under Article 13. Nor, in their view, was there any right to a particular form of remedy or any particular amount of compensation. Article 13 left a certain discretion to the Contracting States as to how they complied with its requirements.

95. Furthermore, they point out that other remedies were possible: criminal proceedings could have been brought and an inquest procedure was available. In addition the Health and Safety Executive were conducting an investigation into the incident, focusing on the management of the two prisoners in prison, which could in principle lead to the criminal prosecution of individuals. From October 2000, the Human Rights Act 1998 enabled courts to consider complaints under Article 2 of the Convention and to grant appropriate relief. In *Wright* (cited above), the High Court held that there was a continuing obligation on the Home Office after 2 October 2000 to investigate a death in custody which had occurred before that date. Although the claim for damages was dismissed in that case, it was in principle available, although only in respect of any continuing breach of rights since the date of entry into force of the Act.

*2. The Court's assessment*

96. As the Court has stated on many occasions, Article 13 of the Convention guarantees the availability at the national level of a remedy to enforce the substance of the Convention rights and freedoms in whatever

form they might happen to be secured in the domestic legal order. The effect of Article 13 is thus to require the provision of a domestic remedy to deal with the substance of an “arguable complaint” under the Convention and to grant appropriate relief, although Contracting States are afforded some discretion as to the manner in which they conform to their Convention obligations under this provision. The scope of the obligation under Article 13 varies depending on the nature of the applicant's complaint under the Convention. Nevertheless, the remedy required by Article 13 must be “effective” in practice as well as in law. In particular, its exercise must not be unjustifiably hindered by the acts or omissions of the authorities of the respondent State (see *Aksoy v. Turkey*, judgment of 18 December 1996, *Reports* 1996-VI, p. 2286, § 95; *Aydın v. Turkey*, judgment of 25 September 1997, *Reports* 1997-VI, pp. 1895-96, § 103; and *Kaya*, cited above, pp. 329-30, § 106).

97. Where alleged failure by the authorities to protect persons from the acts of others is concerned, Article 13 may not always require that the authorities undertake the responsibility for investigating the allegations. There should, however, be available to the victim or the victim's family a mechanism for establishing any liability of State officials or bodies for acts or omissions involving the breach of their rights under the Convention. Furthermore, in the case of a breach of Articles 2 and 3 of the Convention, which rank as the most fundamental provisions of the Convention, compensation for the non-pecuniary damage flowing from the breach should, in principle, be available as part of the range of redress (see *Z and Others v. the United Kingdom* [GC], no. 29392/95, § 109, ECHR 2001-V, and *Keenan v. the United Kingdom*, no. 27229/95, § 129, ECHR 2001-III).

98. On the basis of the evidence adduced in the present case, the Court has found that the Government are responsible under Article 2 for failing adequately to protect the life of Christopher Edwards while he was in the care of the prison authorities. The applicants' complaints in this regard are therefore “arguable” for the purposes of Article 13 (see *Boyle and Rice v. the United Kingdom*, judgment of 27 April 1988, Series A no. 131, p. 23, § 52; *Kaya*, cited above, pp. 330-31, § 107; and *Yaşa*, cited above, p. 2442, § 113).

99. The Court observes that, in general, actions for damages in the domestic courts may provide an effective remedy in cases of alleged unlawfulness or negligence by public authorities (see, for example, *Hugh Jordan*, cited above, §§ 162-63). While in this case a civil action in negligence or under the Fatal Accidents Act before the domestic courts might have furnished a fact-finding forum with the power to attribute responsibility for Christopher Edwards's death, this redress was not pursued by the applicants. It is not apparent (and the Government have not argued) that damages (for the suffering and injuries of Christopher Edwards before his death or the distress and anguish of the applicants at his death) would

have been recoverable or that legal aid would have been available to pursue them. The Court does not find that this avenue of redress was in the circumstances of the case of practical use. Similarly, while it does not appear inconceivable that a case might be brought under the Human Rights Act 1998, this would relate only to any continuing breach of the procedural obligation under Article 2 of the Convention after 2 October 2000 and would not provide damages related to the death of Christopher Edwards, which preceded the entry into force of the Act.

100. The Government have not referred to any other procedure whereby the liability of the authorities can be established in an independent, public and effective manner. While they laid weight on the inquiry, the Court has found above that, although it provided, in many respects, a thorough and useful investigation, it failed for reasons of procedural defects to comply with the procedural obligation imposed by Article 2 of the Convention. And as pointed out by the applicants, it did not provide any possibility of obtaining damages.

101. Notwithstanding the aggregate of remedies referred to by the Government, the Court finds that in this case the applicants did not have available to them an appropriate means of obtaining a determination of their allegations that the authorities failed to protect their son's right to life and the possibility of obtaining an enforceable award of compensation for the damage suffered thereby. In the Court's view, this is an essential element of a remedy under Article 13 for a bereaved parent.

102. Accordingly, there has been a breach of Article 13 of the Convention.

#### IV. APPLICATION OF ARTICLE 41 OF THE CONVENTION

103. Article 41 of the Convention provides:

“If the Court finds that there has been a violation of the Convention or the Protocols thereto, and if the internal law of the High Contracting Party concerned allows only partial reparation to be made, the Court shall, if necessary, afford just satisfaction to the injured party.”

##### **A. Damage**

104. The applicants claim compensation for non-pecuniary damage in respect of the anxiety, fear, pain and injury suffered by their son Christopher immediately before his death, their own anguish, severe distress and grief suffered at the loss of their son and the ongoing stress and associated ill-health suffered by the second applicant as a result of the traumatic loss and

ongoing frustration at the inability to pursue an effective avenue of redress. They do not specify a sum.

105. The Government have not commented on these claims.

106. The Court observes that it has found above that the authorities failed to protect the life of Christopher Edwards or to provide a public investigation meeting the requirements of Article 2 of the Convention. In addition to the pain and suffering which Christopher Edwards must have experienced, it finds that the applicants, his parents, must be regarded as having suffered anguish and distress from the circumstances of his death and their inability to obtain an effective investigation or remedy. Making an assessment on an equitable basis and bearing in mind the amounts awarded in other cases, the Court awards the sum of 20,000 pounds sterling (GBP) for non-pecuniary damage.

### **B. Costs and expenses**

107. The applicants claim costs and expenses incurred, domestically and before the Court, in respect of themselves, their solicitors and counsel. These include a sum of GBP 2,616 for the applicants' own costs of postage and travel together with estimated costs of GBP 1,500 for attendance at any hearing and GBP 1,000 for expenses incurred in pursuing domestic remedies; the sum of GBP 14,702.30 for solicitors' costs and expenses, including estimated costs of attendance at an oral hearing; and the sums of GBP 17,654.38 for junior counsel and GBP 1,175 for leading counsel. This amounts to a total of GBP 33,531.68, inclusive of value-added tax (VAT).

108. The Government considered that the costs claimed were excessive, in particular for the drafting of observations in October 2001 (GBP 5,000 for junior counsel and GBP 1,000 for leading counsel). They pointed out that the costs included those estimated for an oral hearing which did not take place.

109. The Court observes that this case has involved several rounds of written submissions and may be regarded as factually and legally complex. Nonetheless, it finds the fees claimed to be on the high side when compared with the awards made in other cases from the United Kingdom and is not persuaded that they are reasonable as to quantum. It has discounted the sums estimated for an oral hearing which did not take place. Having regard to equitable considerations, it awards the global sum of GBP 20,000, plus any VAT which may be payable.

### **C. Default interest**

110. According to the information available to the Court, the statutory rate of interest applicable in the United Kingdom at the date of adoption of the present judgment is 7.5% per annum.

FOR THESE REASONS, THE COURT UNANIMOUSLY

1. *Holds* that there has been a violation of Article 2 of the Convention as regards the circumstances of Christopher Edwards's death;
2. *Holds* that there has been a violation of Article 2 of the Convention as regards the failure to provide an effective investigation;
3. *Holds* that no separate issue arises under Articles 6 or 8 of the Convention;
4. *Holds* that there has been a violation of Article 13 of the Convention;
5. *Holds*
  - (a) that the respondent State is to pay the applicants, within three months from the date on which the judgment becomes final according to Article 44 § 2 of the Convention, the following amounts:
    - (i) GBP 20,000 (twenty thousand pounds sterling) in respect of non-pecuniary damage;
    - (ii) GBP 20,000 (twenty thousand pounds sterling) in respect of costs and expenses, plus any value-added tax that may be payable;
  - (b) that simple interest at an annual rate of 7.5% shall be payable from the expiry of the above-mentioned three months until settlement;
6. *Dismisses* the remainder of the applicants' claim for just satisfaction.

Done in English, and notified in writing on 14 March 2002, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Vincent BERGER  
Registrar

Ireneu CABRAL BARRETO  
President