A judicial review to compel HMP Woodhill to comply with national prison standards on preventing self-inflicted deaths was a missed opportunity to advance the law. Eva Whittall, who assisted with INQUEST's intervention, examines the disappointing judgment.

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The High Court (the 'Court') has rejected a novel judicial review claim ('the claim') brought by the families of two men who took their own lives, and a third who remains at risk, while incarcerated in HMP Woodhill. The claimants, with INQUEST intervening, sought a declaration that there was an ongoing systemic failure to prevent self-inflicted deaths at the prison, and that this was in breach of Article 2 of the European Convention on Human Rights ('ECHR').

The Court declined to make a declaration, finding no more than a series of "distinct but separate operational mistakes in suicide prevention". The Court further concluded that, even if they had been convinced of the merits of the claim, the relief sought was inappropriate and would not have been granted.

The Court described the levels of agreement between the parties as "remarkable" (paragraph 6). This was unsurprising, given the comprehensive Coroner's reports and PPO investigations relating to the 18 self-inflicted deaths at the prison since 2013, and the fact that the relevant national policies to prevent self-inflicted deaths (Prison Service Instructions 64/2011 and PSI 03/2001) clearly set out the obligations of the prison. It was also agreed that the PSIs, amongst other provisions, provided an appropriate system to protect life across the whole prison estate.

The Court interpreted the legal dispute to be one of "emphasis" (paragraph 8). It was not in dispute that the Secretary of State for Justice and the Governor of HMP Woodhill were subject to Article 2 ECHR positive obligations to protect life; made up of a requirement to put in place appropriate systems to protect life (the 'systemic duty'), and an operational duty to protect those to whom the responsibility was owed. The sole focus of the claim was the systemic duty and whether that had been breached.

The deficiencies in the way the PSIs were implemented at HMP Woodhill were manifest and seemingly accepted by the Court, although with a disturbing lack of judicial concern or criticism. The prison did not comply with the mandatory requirements of PSI 64/2011 that "all staff in contact with prisoners must be trained to at least ACCT Foundation level" and could not show that all prison staff must understand the *Medical Emergency Response Code protocol*, as required by PSI 03/2013. The Court considered that the strongest aspects of the claim were the failure to ensure staff received adequate training and the failure to ensure cell checks were irregular.

In addition to the evidence submitted by the claimants, the court received evidence from INQUEST showing that there exists a systemic problem in failing to learn from previous deaths and make changes to save lives in future. Despite describing the intervention as "helpful" (paragraph 4) the Court did not engage with this evidence at all.

In essence, the defendants argued that the claim was inappropriate because the mere existence of the PSIs, and their professed commitment to implement them, was sufficient to meet the general duty to provide appropriate systems to protect life. The persistent failure to actually implement those PSIs was an operational matter and the Prison was taking action to tackle PPO and Coroner recommendations.

The legal dispute therefore revolved around how to categorise cases where a policy exists, but compliance with that policy is irregular, at best.

In considering what constitutes a systemic breach of Article 2 ECHR, the Court relied on the judgment in *R (Long) v Secretary of State for Defence [2015] EWCA Civ 770,* in which an order that soldiers should carry iridium satellite phones on all excursions was routinely ignored.

In *Long* Lord Dyson concluded that a breach of the systemic obligation under Article 2 could only arise from a "system or framework failure or failures of state control" and not from "individual human error", saying

the distinction is "not always easy to apply". Lord Dyson considered the European Court of Human Rights judgment *Stoyanovi v Bulgaria (App No 42980/04, unreported) 9 October 2010* and agreed that "a case which involves no more than an allegation of negligent conduct of an individual or the concatenation of unfortunate events" (see Stoyanovi para 61) will not engage Article 2.

Applying this approach, the Court concluded that the crucial legal issue was whether the suicide of each prisoner had been a result of a failure in the operation of the system, or a failure of the system itself (paragraph 54). There was undoubtedly strong evidence of a disturbingly large number of accepted failings in HMP Woodhill during the time period in question. However, in considering whether a series of operational failings were sufficient to amount to a systemic breach, they reasoned that it is not the number of errors which matters, but their "character". On their assessment, a single self-inflicted death could be symptomatic of a systemic failure but a large number of failings within one prison does not necessarily assist to establish a systemic failure.

On analysing the evidence of the failings, the Court was unwilling to find that they were evidence of a systemic failure as described by the claimants, rather than operational failings by individuals.

The court concluded that the series of self-inflicted deaths demonstrated that the system was "prone to operational error", but *not* that there had been a "failure of the system" (paragraph 58). The Court considered this "unsurprising, given that the 'system' concerns the inter-relationship between prison officer and prisoners". They concluded their discussion saying that "in situations of some stress and complexity, where there are inevitably numerous distractions from the performance of […] important but routine tasks, the scope for mistake is substantial" (paragraph 58).

This raises the question, at what point does a system prone to operational error become a failing system in breach of Article 2? This question is not considered by the Court. There is no consideration as to whether or why HMP Woodhill was more prone to operational error than other prisons and what the legal implication of this may be. The apparent lack of criticism of a system "prone to operational error" where the consequence is avoidable deaths of vulnerable people is disturbing.

At paragraph 67 the Court discussed the fact that the claimants "would not gain a legal remedy which would be conclusive in relation to any individual death from a declaration such as that sought here". This finding indicates an apparent lack of understanding of the claimants' reason for bringing the claim, namely to force HMP Woodhill "to make the changes needed as identified by the PPO, inquest juries and the Coroner"[1].

This judicial review highlights the difficulty in proving a breach of the systemic duty under Article 2 on the basis of multiple similar deaths. The tone of the judgment indicates a general reluctance by the Court to fully engage. This is disappointing when the lives of very vulnerable people are at stake.

Perhaps even more disappointing, at paragraphs 68 to 71, the Court effectively states that the claim was misconceived and, even if a systemic failure had been found by the Court, it would have refused any form of discretionary relief. This suggests the Court failed to recognise the importance of a declaration that the systemic duty under Article 2 was being breached, even if no further relief was granted.

Furthermore, the Court appears overly deferential to the Ministry of Justice, describing the solution to the problem of suicide in prison as lying with "those who have the unenviable task of managing prisons." Experience tells us that, even if those in charge of managing prisons hold the solution, they are sometimes unable or unwilling act, requiring judicial or other intervention.

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It also fails to recognise the reality that the claim had, in itself, already forced HMP Woodhill to take steps to address the multitude of concerns that had been repeatedly expressed over a disgracefully lengthy period in a way in which they had previously failed to do "without the looming scrutiny of the High Court."[2]

We reiterate INQUEST's concerns that this is a disappointing judgment[3]. There is a notable lack of appropriately strong language from the Court about how truly shameful the failings are, even in light of the Court's conclusions they did not prove the existence of a systemic failure.

[1] www.inquest.org.uk/media/pr/hmp-woodhill-JR-conclusion
[2] ibid
[3] ibid