Inquests: recent developments

Leslie Thomas QC, Daniel Machover, Adam Straw and Tom Stoate highlight important policy and legislative developments and cases on suicides in prison, public interest immunity, jury directions at inquests involving killings by state agents, deprivation of liberty and state detention, and extra-territorial jurisdiction of the European Convention on Human Rights.

Leslie Thomas QC

Daniel Machover

Adam Straw

Tom Stoate

Policy and legislation

Policing and Crime Act 2017

The Policing and Crime Act (PCA) 2017 received royal assent on 31 January 2017.

Deprivation of liberty safeguards

One of the Act's key provisions affecting the nature and conduct of inquests is s178. This section amends Coroners and Justice Act (CJA) 2009 s48, and the provisions commencing on 3 April 2017 (Policing and Crime Act 2017 (Commencement No 1 and Transitional Provisions) Regulations 2017 SI No 399) now exclude from the definition of 'state detention' persons who are subject to Mental Capacity Act (MCA) 2005 deprivation of liberty safeguard (DoLS) provisions. The impact of this is that coroners are now no longer under a duty to conduct an inquest, which was usually a European Convention on Human Rights (ECHR) article 2-compliant inquest, in all cases where the deceased had an authorisation for the deprivation of his/her liberty either under a MCA 2005 DoLS or a Court of Protection order.

Despite the changes, however, it will be even more important for advisers of bereaved families of those who died while under the subject of a DoLS order to make representations to the coroner where the death is said to be *violent, unnatural, or of an unknown cause or suspicious*. The investigative duty on coroners to look into the death in such cases will be triggered and an inquest hearing should normally be conducted. Coroners who are in doubt as to whether to investigate and hold a hearing will have to hear submissions and make decisions that are potentially subject to judicial review. Despite this safeguard, however, it has to be acknowledged that s178 removes a key overriding scrutiny of state detention that was an automatic check, namely an immediate inquest referral in such cases, which has now been lost. This has to be considered as a backwards step and one that does little to protect the human rights of this vulnerable class of persons.

As stated above, it is important to note that coroners will continue to have a duty to conduct investigations where a person dies in custody or otherwise in state detention, and whose death was violent, unnatural, or of unknown cause. Therefore, when a person has died while deprived of his/her liberty under the MCA 2005 on or after 3 April, the death should still be referred in the normal way to the coroner where there are any concerns about the cause of death, including where there is a concern that a failure of care may have contributed to the death. The chief coroner has, in the light of s178, amended his guidance to coroners dealing with DoLS cases (*Deprivation of liberty safeguards (DoLS) – 3rd April 2017 onwards*, Guidance No 16A, 27 March 2017).

Scrutiny and discipline of the police

Under PCA 2017 s33, the Independent Police Complaints Commission (IPCC) is to be rebranded as the Independent Office for Police Conduct (IOPC), and the role of the chair will become the director general, who will be appointed by Her Majesty. Section 34 deals with the exercise of the office's functions and s35 deals with its public records. However, the date for the coming into force of these provisions has yet to be determined.

Section 29 is an important change as it allows for disciplinary action to be taken against former or retired police officers or members of the police force and former special constables if a number of conditions are satisfied. Section 29 will amend sections 50 and 51 of the Police Act 1996. The amendment will enable regulations to be produced, which provide for disciplinary proceedings to be brought against any person where:

(3A) ...
(a) an allegation relating to the conduct, efficiency or effectiveness of the person comes to the attention of a chief officer of police, a local policing body or the Independent Police Complaints Commission,
(b) at the time of the alleged misconduct, inefficiency or ineffectiveness the person was a member of a police force, and
(c) condition A, B or C is satisfied in relation to the person.

(3B) Condition A is that the person ceases to be a member of a police force after the allegation first comes to the attention of a person mentioned in subsection (3A)(a).

(3C) Condition B is that the person had ceased to be a member of a police force before the allegation first came to the attention of a person mentioned in subsection (3A)(a) but the period between the person having ceased to be a member of a police force and the allegation first coming to the attention of a person mentioned in subsection (3A)(a) does not exceed the period specified in regulations under this section.

(3D) Condition C is that –
(a) the person had ceased to be a member of a police force before the allegation first came to the attention of a person mentioned in subsection (3A)(a),
(b) the period between the person having ceased to be a member of a police force and the allegation first coming to the attention of a person mentioned in subsection (3A)(a) exceeds the period specified for the purposes of condition B, and
(c) the alleged misconduct, inefficiency or ineffectiveness is such that, if proved, the person could have been dealt with by dismissal if the person had still been a member of a police force.

Subsection (3E) provides that any such regulations must state that these disciplinary proceedings may only be taken if the IPCC determines that:

... taking such proceedings would be reasonable and proportionate having regard to –
(a) the seriousness of the alleged misconduct, inefficiency or ineffectiveness,
(b) the impact of the allegation on public confidence in the police, and
(c) the public interest.

Regulations may not provide for disciplinary proceedings to be taken against a person who ceased to be a member of a police force or a special constable before the amendments in s29 come into force. But they may provide for disciplinary proceedings against a person who leaves the police force after the amendments come into force, but where there was an allegation of misconduct, which was capable of leading to dismissal, and which occurred before that date. The amendments have not yet come into force.

Draft statutory guidance on achieving best evidence in death or serious injury matters

On 10 January 2017, the IPCC published draft guidance (*Draft statutory guidance to the police service on achieving best evidence in death or serious injury matters*) on how evidence should be collected in the immediate aftermath of an incident where a member of the public has died or been seriously injured during contact with the police, including firearms operations and incidents in

custody. The guidance deals with 'the critical period immediately following a death or serious injury involving the police', and states that '[i]t is crucial that appropriate steps are taken at this time to ensure that the investigation is able to fully establish the facts and that the opportunity to learn lessons is not missed' (page 2).

If approved by the home secretary, the guidance will apply to all police forces within England and Wales. It should be noted that good reason is needed to depart from the guidance; indeed, the IPCC states that those who do not follow the guidance will:

... need to have a sound rationale for departing from it. This rationale should be accurately recorded as soon as it is practicable to do so. Any failure to follow the guidance and the officer's rationale for not doing so may come under scrutiny in any future proceedings where the evidence-gathering process is relevant (for example an inquest or disciplinary proceedings) (page 3, para 2).

Key points in the guidance include:

- It is essential that careful attention is given to preserving evidence that is potentially relevant to an investigation as soon as practical.
- 'Evidence' includes, but is not limited to, information from personal accounts, documents and material object(s) that may potentially be used to establish facts in an investigation. Further, the guidance makes it clear that if an individual reasonably considers the evidence to have the potential to assist the investigation, it should be preserved even if the relevance of some of the evidence may not be immediately apparent.
- Everyone in the police service has a responsibility to bring any potential evidence to the attention of the investigation throughout the life of the investigation.

When a death or serious injury (DSI) occurs, the police have the responsibility to ensure that evidence is not lost or compromised, including by:

- establishing a perimeter to control and protect any scene;
- maintaining an accurate scene log recording details of everyone who enters and leaves;
- protecting samples of forensic evidence from any damage or contamination; and
- preventing the overwriting of visual or audio footage.

The guidance recognises that it may be preferable to act immediately and without waiting for IPCC approval:

- where the immediate removal or seizure of evidence is necessary to prevent its loss or deterioration; or
- where action is necessary to protect the public from harm (eg, where a firearm is placed within reach of members of the public).

If immediate action is taken before the IPCC's approval, however, the justification needs to be clearly documented.

The guidance sets out what the IPCC will expect following these incidents. Key policing witnesses (officers directly involved in the incident) should:

- be separated as soon as operationally safe to do so, so as not to confer, or unintentionally influence each other's accounts;
- provide personal initial witness accounts before they go off duty, to enable the IPCC to identify lines of enquiry and secure evidence that might otherwise be lost; and
- not view their own body-worn video before offering an initial witness account, so that those accounts recall what officers experienced during the incident, rather than what they saw or heard on the video.

The guidance has been produced as a result of a review of the IPCC's investigation into the death of Sean Rigg, the IPCC's own review of its investigations into deaths, a public consultation and observations made in the Court of Appeal's judgment in *R (Delezuch) v Chief Constable of Leicestershire Constabulary; R (Duggan) v Association of Chief Police Officers* [2014] EWCA Civ 1635 about the lawfulness of post-incident procedures and best practice, which commended the IPCC's position.

Domestic case law

Suicides in prison

- **R (Scarfe, Barber and Blyde) v Governor of Woodhill Prison and Secretary of State for Justice**
  [2017] EWHC 1194 (Admin), 23 May 2017

This was a judicial review claim that sought to bring about action to reduce the rate of suicide at HMP Woodhill. From May 2013 to the end of 2016 there were 18 self-inflicted deaths at the prison. When the proceedings were initiated at the start of September 2016, there had already been six suicides that year, a rate of about one every 40 days. There were seven self-inflicted deaths in HMP Woodhill in 2016 and five in 2015. For both years, that was the highest number and rate in any prison in the country and that is at a time when the rate of prison suicide in the country as a whole is at a historic high.

The claimants were relatives of individuals who had killed themselves, and also a prisoner who was at risk of killing himself in the prison. The claimants were not seeking new investigations; nor were they asking the court to make determinations of contentious fact as to whether there were violations of the ECHR in an individual case. Some of the claimants were pursuing civil claims for damages separately, and those claims could resolve whether there had been operational or systemic breaches of article 2 in their individual cases.

Rather, the claimants sought an order from the court that the defendants take reasonable steps to ensure that those working in the prison understand, are trained in, and have sufficient time to comply with, prison service policy on the protection of inmates from suicide, in particular in Prison Service Instruction 64/2011 (*Management of prisoners at risk of harm to self, to others and from others (safer custody)*). In order to obtain that order, it was necessary to establish that there was a specific, ongoing, systemic failure by the governor and/or the justice secretary that required altering in order to prevent future deaths.

Prisons and Probation Ombudsman and coroner investigations into individual deaths had identified various failures by prison staff. However, the court concluded that although those reports demonstrated that there had been a number of one-off, individual, operational errors, they did not show that there was a systemic failing. The court held that, in determining whether there was a systemic failure, what matters is not the number of errors, but their character. Where there are identical, or very similar, errors of practice, that may point to a systemic fault in the design or supervision of the system; where there are repeated, but different, operational errors, it may be impossible fairly to characterise that as a system fault. The reports that had been produced demonstrated a series of distinct but separate operational mistakes in suicide prevention at HMP Woodhill, rather than proving systemic fault.

The claim was dismissed. However, there were a series of changes that occurred at the prison subsequent to the claim being issued. Shortly after the claim was issued at the start of September 2016, the governor at Woodhill was replaced. Further, after the claim was issued, the defendants commissioned an independent review of what was going wrong at the prison by Stephen Shaw, the former prisons and probation ombudsman. A series of substantive changes were also put in place at the prison, following the claim. For example, a number of staff were given suicide prevention training, who had not previously received it. It has been decided that Woodhill will, from March 2018, no longer take remand prisoners and will only be a training prison. The great majority of prisoners who killed themselves were on remand. Finally, since the claim was issued, only one person has killed himself at the prison, and none have done so in 2017.

Secret material and public interest immunity

- **Secretary of State for the Home Department v HM Senior Coroner for Surrey**
  [2016] EWHC 3001 (Admin), 23 November 2016

Some information is too sensitive, whether because of national security concerns or otherwise, for an ordinary coroner to see. There is also some information that an ordinary coroner cannot see by law, such as intercept material obtained under Regulation of Investigatory Powers Act 2000 Part I (intended to be replaced by section 56 of the Investigatory Powers Act 2016). This case involved the question of the procedure, and in particular how a public interest immunity (PII) application should be resolved, when the coroner currently presiding over the inquest is unable to see some or all of the potentially relevant material.

Alexander Perepilichnyy was providing evidence to a Swiss criminal investigation into a $230m fraud allegedly committed by Russian officials and Russian organised criminals. He was out running in Surrey, when, aged 44 and healthy, he suddenly dropped dead. Another man, Sergei Magnitsky, who had also been investigating that fraud, had died in custody in Russia having been severely beaten. One of the issues at the inquest was whether Mr Perepilichnyy was murdered, possibly by agents of the Russian state.

The coroner who was investigating Mr Perepilichnyy's death sent requests to the home secretary for any information in the possession of the security service pertaining to third-party involvement in the death, and other matters. The home secretary produced some information in response, but said it was sensitive for reasons of national security. The information was provided to the coroner's counsel, who was able to view it as he was 'developed vetting' (DV) cleared, which is the highest

level of security clearance. It was not provided to the coroner because he did not have sufficient security clearance. The coroner's counsel deemed that the information was potentially relevant to the issues at the inquest. A gisted form of the material was made available to the coroner on a read-and-return basis. However, he ruled that he was not in a position, on that basis, to decide whether the material should be disclosed more widely.

He asked the home secretary to provide full submissions, a certificate, and evidence in support of a PII application. The home secretary said the PII application would contain information that it was not possible to show the coroner as it was sensitive. The home secretary then made an application for PII to the High Court. Several parties asked that the coroner be replaced by a judge who had sufficient security clearance to view the sensitive material. High Court and circuit judges can generally see all sensitive material. It was argued that this would be a much better way of resolving the matter, in part because a presiding coroner would have a better understanding of the factual background and would be obliged to keep the issue of PII under review.

The High Court noted first that, until this case, where information of a high level of sensitivity has had to be considered, a High Court or circuit judge has replaced the original coroner. This has 'obvious benefits', in particular that issues of PII could be considered within the inquest process.

The chief coroner has issued relevant guidance. In December 2014, the then chief coroner, HHJ Peter Thornton QC, produced guidance entitled *Duty to notify chief coroner in certain cases*. This stated that where very sensitive material may be involved, such as intercept material that ordinary coroners are unable to see, he should be notified as early as possible, with a view to considering whether to replace the coroner with a judge. On 27 September 2016, he issued further confidential guidance entitled *Sensitive material*. Although this was disclosed to the parties in the case, it has not yet been made public, so far as we are aware. The High Court's judgment describes the guidance in some detail at paras 52–53. If this issue arises at an inquest, it is advisable to ask the chief coroner or coroner to disclose the guidance in full. A policy should normally be published: *R (Lumba) v Secretary of State for the Home Department* [2011] UKSC 12; [2012] 1 AC 245.

The sensitive material guidance sets out the procedure senior coroners should adopt. First, if the senior coroner believes there may be sensitive material in existence relating to a particular case, s/he should notify the chief coroner as soon as possible, who will give advice as to how to proceed (para 7 of guidance). If the case is obviously one for a nominated judge, the chief coroner will so advise. If not, the senior coroner is advised to consider instructing DV counsel, who may review sensitive material without being under the obligation to disclose such material to the senior coroner (para 11 of guidance). DV counsel will conduct a review for relevance, without informing the senior coroner of the nature or content of the material (para 13 of guidance). If some material is identified as relevant or potentially relevant, DV counsel will inform the coroner and seek to obtain disclosure in a redacted or summarised (gisted) form (para 15 of guidance). If the material can be gisted, the senior coroner is to decide whether it can be disclosed after submissions from the relevant parties (para 16 of guidance). If not, DV counsel advises the senior coroner that a High Court or circuit judge should take over the investigation and inquest (para 17 of guidance). The High Court said the guidance is 'lawful and sensible' (para 54).

The High Court determined that it did have jurisdiction to resolve an application for PII in respect of an inquest in exceptional cases. The procedure that should be followed is that under either Civil Procedure Rules 1998 r31.19 or r40.20. In addition, the High Court can and should make an order that interested persons at the inquest be able to attend and make submissions before the High Court to the same extent as they could before the inquest.

The court held that it can only exercise its jurisdiction to resolve a PII application relating to an inquest 'as a last resort' (para 70). It accepted the importance of the presiding coroner resolving PII, but in this exceptional case, the inquest had reached an impasse and there was simply no alternative to the High Court resolving PII.

The court upheld the PII application, applying the usual principles. It further observed that, in light of that conclusion, the coroner's position had become untenable. He could not have sight of relevant, sensitive material and so could not conduct a full and fair inquest. It was for the chief coroner to arrange for a replacement who was able to view the sensitive material and continue the inquest. Any coroner would need to keep the question of PII under review, and decide whether particular lines of questioning were relevant in light of the PII material and whether a public inquiry was needed. A circuit judge, HHJ Hilliard QC, was subsequently appointed to conduct the inquest.

Jury directions at inquests involving killings by state agents

- **R (Duggan) v HM Assistant Deputy Coroner for the Northern District of Greater London**
  [2017] EWCA Civ 142,
  29 March 2017

This was a challenge to the conclusion at the inquest into the fatal shooting of Mark Duggan. The jury were given a questionnaire, within which the majority concluded that they were sure that, at the time Mr Duggan was shot, he was not holding a gun. That conflicted with the account of the officer who fired the shots, known as V53, who said that the reason he fired was that both before his first and his second shots Mr Duggan had a gun in his hand, which he was moving towards V53.

The jury were also asked to decide whether the killing was lawful. In doing so, they were directed to consider self-defence. There are two limbs to the test for self-defence. Limb 1 is different as between criminal and civil law. In civil law, the question is whether the defendant had an honest and reasonable belief that there was an imminent threat of attack from the claimant. If the defendant honestly believed there was an imminent threat of attack, but that belief was an unreasonable mistake, s/he does not have a defence. By contrast, in criminal law, the question is simply whether the defendant had an honest belief that there was an imminent threat of attack. If s/he is mistaken, s/he can still rely on that mistaken belief no matter how irrational. Limb 2 asks whether the lethal force used was reasonable in the circumstances.

Mrs Duggan initially argued that the jury should be directed according to the civil test. However, after the Grand Chamber's decision in the case involving Jean Charles de Menezes' death, *Da Silva v UK* App No 5878/08, 30 March 2016; (2016) 63 EHRR 12, her submissions altered. She submitted that, if the jury are to be directed according to the criminal law test, and if the officer may have had a mistaken belief that there was a threat, then the jury should be given the following direction: they should consider whether any mistaken belief was based on reasonable grounds, and, if not, it is likely they will have difficulty in accepting the belief was honest.

Mrs Duggan relied on *Da Silva*, which indicated that in addressing the officer's belief the coroner's court 'will have to consider whether the belief was subjectively reasonable' (para 248, cited at para 73 of the present judgment). That means the court should consider whether the officer had good reasons in the circumstances as s/he understood them at the time. For example, if s/he sees an individual pointing an exact replica firearm, a court may well conclude that this was a subjective good reason to think s/he was under threat, even if, in fact, the firearm later turned out to be a replica. The Grand Chamber continued: 'If the belief was not subjectively reasonable (that is, it was not based on subjective good reasons), it is likely that the court would have difficulty accepting that it was honestly and genuinely held' (para 248).

The Court of Appeal concluded that the direction sought by Mrs Duggan should be given if the honesty of the belief and its reasonableness were in issue and it was considered that a direction would assist the jury in reaching its decision. However, on the facts of the case, it had not been necessary to give this direction to the jury and since the coroner had reminded the jury of all relevant features of the evidence going to the question of the reasonableness of V53's belief, there had been no misdirection.

Deprivation of liberty and state detention

- **R (Ferreira) v HM Senior Coroner for Inner South London**
  [2017] EWCA Civ 31,
  26 January 2017

This case concerned the question of whether a person in intensive care could be described as being in 'state detention'. The appellant appealed against a decision that a coroner was not obliged to hold an inquest with a jury following the death of her sister, Maria Ferreira, in a hospital's intensive care unit.

Maria had Down's syndrome and learning difficulties, and was of 'unsound mind' for the purposes of ECHR article 5. She had been admitted to intensive care with pneumonia and heart problems. She was intubated and sedated, but died (aged 45) following a cardiac arrest. The hospital had not sought any authorisation for depriving Maria of her liberty under the MCA 2005, and had not admitted her under the Mental Health Act 1983.

The coroner considered that it was necessary to hold an inquest into Maria's death, but decided to do so without a jury – finding that she had

not been in 'state detention' under CJA 2009 s7 (which would have necessitated empanelling a jury). The appellant argued that the coroner was obliged to hold an inquest with a jury under s7 because Maria's hospital treatment meant she had been deprived of her liberty for the purposes of article 5(1) and had therefore been in 'state detention'. Because Maria had been under the continuous supervision and control of the hospital, it was argued, the coroner should have applied the test set out in *Cheshire West and Chester Council v P* [2014] UKSC 19.

Dismissing the appeal, the court held:

1. CJA 2009 s7 was not designed to implement an ECHR right: there was no ECHR right to a jury inquest. A person whose liberty of movement had been restricted might not have been deprived of his/her liberty even though none of the exceptions in article 5(1) applied. Deprivation of liberty resulting from life-saving treatment fell within the category of interferences described as 'commonly occurring restrictions on movement' in *Austin and others v UK* App Nos 39692/09, 40713/09 and 41008/09, 15 March 2012; (2012) 55 EHRR 14 (para 59). Decisions might have to be made that interfered with – or even removed – the liberty that Maria would have been able to exercise for herself before the condition emerged.
2. The *Cheshire West* decision was distinguished on the basis that it dealt with a different situation (living arrangements for persons of unsound mind), and provided no guidance on article 5 in the context of urgent medical care. The court held that the policy reasons for finding the violation in *Cheshire West* did not apply because, in the case of physical illness, there was generally no need for a person of unsound mind to have the benefit of safeguards against the deprivation of liberty where the treatment was given in good faith and was essentially the same treatment as would be given to a person of sound mind with the same physical illness.
3. A death in intensive care was not, in the absence of special circumstances, a death in 'state detention' for the purposes of the CJA 2009 – parliament had not provided that such death would require a jury inquest.
4. Even if it had been necessary to apply the *Cheshire West* acid test, Maria was physically restricted in her movements by her physical infirmities and by the treatment that she received, but the root cause of her loss of liberty was her physical condition, for which the state was not responsible. The question of whether Maria would have been free to leave would have been answered in the affirmative. If any intensive care patient tried to leave, it was likely that clinicians would attempt to dissuade him/her, but it was unlikely that they would go so far as to prevent him/her doing so. In Maria's case, there had been continuous supervision and control, but no lack of freedom to leave.

This decision is probably best understood in public policy terms. At para 111, the court concluded that 'to require authorisation of the deprivation of liberty in what would be a normal ICU case would involve a significant dilution and distraction of clinical resource, time and attention. That must inevitably risk jeopardising the outcome for all ICU patients'.

European Court of Human Rights case law

Extra-territorial jurisdiction of the ECHR

- **Güzelyurtlu and others v Cyprus and Turkey**
  App No 36925/07,
  4 April 2017

The applicants' relatives were found murdered on the side of a road in territory controlled by the Republic of Cyprus. The applicants complained that there had been a failure by both Turkey and Cyprus to conduct an effective investigation and this breached the article 2 procedural obligation. The court noted that, generally, the procedural obligation under article 2 falls on the respondent state under whose jurisdiction the victim was at the time of death. However, where there are cross-border elements to an incident of unlawful violence leading to loss of life, the fundamental importance of article 2 requires that the authorities of the state to which the suspected perpetrators have fled, and in which evidence of the offence could be located, of their own motion, take effective measures in that regard. Otherwise, those indulging in cross-border attacks will be able to operate with impunity and the authorities of the contracting state where the unlawful attacks have taken place will be foiled in their own efforts to protect the fundamental rights of their citizens and, indeed, of any individuals within their jurisdiction.

In the present case, as the deaths took place in Cyprus, Cyprus was subject to a procedural obligation under article 2 to investigate them. However, Turkey was also subject to that obligation. The suspected perpetrators of the murder of the applicants' relatives are or were within Turkey's jurisdiction, and the Turkish authorities were informed of the crime and 'Red Notices' concerning the suspects were published. The court held that '[t]hese elements engage Turkey's procedural obligation under article 2 and thus justify departure from the general approach' (para 187). The complaints against Turkey were within the jurisdiction of the ECHR, even though the death occurred in Cyprus.

There was no evidence that state agents had been involved in the death. In consequence, the procedural duty was that set out in *Angelova and Iliev v Bulgaria* App No 55523/00, 26 July 2007. That is the duty on the state to bring about some form of effective official investigation when there is reason to believe that an individual has sustained life-threatening injuries in suspicious circumstances. The investigation must be capable of leading to the establishment of the facts and, where appropriate, the identification and punishment of those responsible. 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 that provides a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death. This obligation may include taking steps to secure relevant evidence located in other jurisdictions or, where the perpetrators are outside its jurisdiction, to seek their extradition.

Although both states took a number of steps to investigate the matter, the court concluded that there had been a violation of article 2 under its procedural aspect by virtue of the failure of the respondent governments to co-operate.

- **Huseynova v Azerbaijan**
  App No 10653/10,
  13 April 2017

The applicant's husband was murdered in Azerbaijan. There was no evidence that the state was implicated in the killing. Two suspects were identified, but they were in Georgia. The court concluded that there was a breach of the article 2 procedural duty. That was first because Azerbaijan failed to examine the feasibility of transferring the criminal case to the Georgian authorities in order for the murder charge to be prosecuted there. The applicant did not have the possibility to apply directly to the Georgian authorities and the alleged perpetrators of the murder could be prosecuted in Georgia only at the request of the Azerbaijani authorities following a transfer of the criminal case.

Second, the investigating authorities constantly denied the applicant access to the case file during the criminal investigation and she only obtained copies of some documents from the case file for the first time when the government submitted its observations to the ECtHR. This was unacceptable.

Third, there were allegations that the deceased was killed as a result of his political journalism, which were 'not at all implausible'. This meant the authorities were obliged to explore 'with particular diligence' whether the murder could be linked to his journalistic activities, or to come up with another plausible explanation for the motives behind the murder (para 115). Adequate steps were not taken in this regard. Finally, the investigation was also not sufficiently prompt.

Leslie Thomas QC and Tom Stoate are barristers at Garden Court Chambers, London. Daniel Machover is a partner at Hickman and Rose Solicitors, London. Adam Straw is a barrister at Doughty Street Chambers, London.