**High Court Declines to Extend Article 2 State Detention Categories in Police-Related Death Cases**

The King (on the application of Mrs Veronica Robinson) v HM Assistant Coroner for Blackpool & Fylde and Chief Constable of Lancashire [2025] EWHC 781 (Admin).

**Background**

This judicial review arose from a jury inquest that was heard over 5 days in Blackpool. On 11 March 2021, Mr Robinson was driving a vehicle through Blackpool, the vehicle was registered as stolen. He drove past a vehicle of the Police Constabulary, which was fitted with an ANPR camera, this camera activated. After a very short police chase, Mr Robinson stopped his vehicle, he exited to the pavement and was seen to turn towards the police officers with one hand concealed in his pocket. In a very fast moving situation, the two police officers, who were armed response officers, sought to restrain him. In the struggle Mr Robinson placed a package into his mouth and he very quickly became unresponsive. The police officers called for an ambulance and commenced CPR.

It transpired that the package taken by Mr Robinson was a package of drugs. This package had lodged in his throat and caused a blockage of his airway, leading to his death by acute upper airways obstruction. Owing to its place in his airway, the package could only be removed by the paramedics using magill forceps. The incident, including the CPR and arrival of the paramedics, was recorded on the police car’s dashcam and officer’s BWV, this evidence was played to the jury.

The Defendant Coroner had deferred the decision of the engagement of Article 2 until after the evidence had been heard. After hearing evidence over the course of four days, the Defendant Coroner received submissions on day five. The family sought to engage Article 2, and to leave the conclusion of unlawful killing to the jury and also to leave them neglect. The Defendant Coroner left the conclusions of misadventure and a narrative to the jury, and declined to engage Article 2. Having heard the evidence, the Defendant Coroner also wrote a Letter of Concern to the National College of Policing to address issues around the training of officers around the removal of drug packages and subsequent management.

The jury returned a short form conclusion of misadventure.

The family applied to judicially review the decision not to engage Article 2, to write a Letter of Concern instead of a PFD, it was also alleged that the summing up to the jury had been inadequate.

The claim for judicial review was dismissed by the High Court and the Defendant Coroner’s approach upheld.

**Article 2**

It was argued that the engagement of Article 2 was compulsory as the case fell within the category of cases which necessarily gave rise to legitimate grounds to suspect state responsibility in the form of a breach of one of the state’s substantive Article 2 duties. The Applicant submitted that the categories in which the state’s procedural article 2 obligation arises automatically, cannot be considered as closed. The categories should include:

1. unnatural death occurring while in the involuntary (whether lawful or unlawful) custody or control of the state;
2. unnatural death occurring while in the involuntary custody or control of the police following the deceased committing an intentional act liable to cause himself harm;
3. unnatural death occurring while in the involuntary custody or control or the police at a time when the arresting or detaining officers are aware that the person has swallowed a package that consequently poses a risk to life;
4. death in police custody or control after the deceased entered a physical or mental state needing medical emergency care, of which the police were or should have been aware; and
5. death occurring after the use of force by police officers to effect or in the course of an arrest or physical control.

It was further submitted that, on the facts, there was clearly an arguable breach by state agents of the positive operational duty under article 2 to protect life. The operational duty arose because the police officers knew or ought to have known that there was a real and immediate risk to Mr Robinson’s life.

The Court found no good reason to extend the existing categories of case in which Article 2 applies automatically. The circumstances of the death must be such that “they fall into a category which necessarily gives rise, in every case falling within the category, to a legitimate ground to suspect state responsibility by way of breach of a substantive article 2 obligation” (Popplewell LJ in *Morahan* at [122(7)]).

The court concluded some of the criticisms of the police were far-fetched. The coroner was right to ask himself whether there was, on the evidence before him, an arguable breach of the positive operational duty to protect Mr Robinson’s life and found no fault with this approach, which was sound and the conclusions correct. The challenge to the Article 2 decision therefore did not succeed.

**Summing Up**

Prior to handing down his summing up and directions, the Defendant Coroner had distributed a draft to the IP’s at the inquest. It was argued by the Applicant that, even on the footing that an Article 2 inquest was not required, the Defendant Coroner’s summing up was defective. It did not seek out and record as many of the facts as the public interest requires. It was argued that the family were “left without any answers to what is independently and judicially made (by the jury) of the police conduct seen on the video and evidenced in the inquest”.

The court did not find that there was much force in the criticisms of the summing up and held it was adequate. The jury were not obliged to a narrative conclusion, and the Defendant Coroner elicited the findings and determinations as the public interest required. All the relevant facts were before the jury. The scope of the inquest was wide because of the possible application of Article 2, which had been deferred until the end of hearing the evidence.

**PFD**

Giving evidence at the inquest Dr Forrest, the medical director of the Anaesthesia, Trauma and Critical Care (**ATACC**) Group, which provides professional training and clinical governance to Lancashire Constabulary; and medical director of Cheshire Fire & Rescue Service, Hampshire Fire and Rescue Service, recommended that removal of the drugs packages and subsequent management should be highlighted nationally to senior officers in each force.

The Applicant submitted that the Defendant Coroner did not discharge his duty to make a PFD report. It was asserted that he evaded his statutory duty to do so and that to write a “letter of concern” instead was contrary to that duty and to the chief coroner’s guidance, and was wrong in principle.

This ground was dismissed. It was held that the Defendant Coroner had taken a properly considered and rational view that was not out of line with what is said on the subject in Revised Guidance No. 5.

**Conclusion**

The court found none of the grounds of challenge made out. The third ground, had it succeeded, would not have led to a direction for a fresh inquest. The court went on to state that it was unlikely that a fresh inquest would have been directed even if either or both of the first two grounds had succeeded. The scope of the inquest was wide and the evidence plentiful and thorough. The cause of death was undisputed. Aside from the bar on judgmental language in a narrative verdict, the conduct of the inquest was akin to an Article 2 inquest.

The growth of narrative verdicts, has to be balanced against discouragement of lengthy narrative accounts of the circumstances of a death. Here, the short form misadventure verdict clearly pointed to the view of the jury that the officers were not significantly to blame for Mr Robinson’s death. The evidence supported that proposition. It was obvious the officers thought Mr Robinson had swallowed something, did not realise his airway was completely blocked, attributed his unresponsiveness to the effect of drugs, would probably have called for medical help sooner if they had realised his airway was blocked, but could not be expected to detect and remove the blockage themselves. They called the paramedics once they realised this was a medical emergency.

Any fresh inquest would be likely to lead to those findings being the subject of the same evidence called again and the findings being repeated. Any narrative conclusion would be likely to state those findings or the gist. Thus, a fresh inquest would elicit no new material facts.

**Comment**

The decision may be of some interest to those involved in police cases, in so far as the non-application of Article 2 is concerned. The court rejected an attempt to expand the categories in which the state’s procedural Article 2 obligation arises automatically.

The Court preferred the word verdict to conclusion in the judgment.

The case also reinforces the line of authorities in *Ayesha Siddique v Assistant Coroner for the Eastern Area of Greater London [2017]* and *R (On the application of Diarra Dillon) v HM Assistant Coroner for Rutland and North Leicestershire & Others [2022] EWHC 3186 (KB) (Admin)*, that challenging an issue around PFD’s would not lead to a direction for a fresh inquest.