CONSEIL DE L'EUROPE

COUNCIL OF EUROPE

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

SECOND SECTION

DECISION

AS TO THE ADMISSIBILITY OF

Application no. 57420/00
by Margaret YOUNGER
against the United Kingdom

The European Court of Human Rights (Second Section), sitting on 7 January 2003 as a Chamber composed of

Mr J.-P. COSTA, *President*,
Sir Nicolas BRATZA,
Mr L. LOUCAIDES,
Mr C. BÎRSAN,
Mr K. JUNGWIERT,
Mrs W. THOMASSEN,
Mr M. UGREKHELIDZE, *judges*,
and Mrs S. DOLLÉ, *Section Registrar*,

Having regard to the above application lodged on 21 March 2000,

Having regard to the observations submitted by the respondent Government and the observations in reply submitted by the applicant,

Having deliberated, decides as follows:

THE FACTS

The applicant, Ms Margaret Younger, is a United Kingdom national who was born in 1953 and lives in Cambridgeshire, England. She is represented before the Court by Mr M. Scott, a lawyer practising in London, England.

A. The circumstances of the case

The facts of the case, as submitted by the parties, may be summarised as follows.

The applicant's son, Stuart Gipp, was found hanging from his shoelaces which were attached to the bolt hole of his open cell hatch while he was in custody at Lion Yard Magistrates' Court, Cambridge, on 9 February 1999. He died in hospital at 9.55 a.m. on the following day, aged 20.

Stuart Gipp was arrested and taken into police custody at Parkside Police Station at 4.20 p.m. on 8 February 1999. At 5.15 p.m., when his detention was authorised, the arresting officer, Police Sergeant ("PS") MacLoughlan, remarked in a witness statement that Stuart Gipp was compliant and calm.

In a witness statement dated 21 February 1999 provided by Mr Milsom, Stuart Gipp's solicitor at the relevant time, he said that he had attended Stuart Gipp at Parkside Police Station at about 7.50 p.m. on 8 February 1999. Stuart Gipp confided in him that he was a heroin user and was just beginning to experience withdrawal symptoms. Mr Milsom asked if he wanted to see a police surgeon and explained to him that the practice of local police surgeons was to prescribe the drug temazepam for withdrawal symptoms. He added that numerous clients of his who had been in the same predicament had told him that temazepam did very little to relieve their discomfort and distress. He further explained that any contact that Stuart Gipp had with the police surgeon would not be confidential, as the surgeon would make an immediate written report on his custody record. He offered the advice that, if the custody sergeant became aware that Stuart Gipp was a heroin user, and that he was unemployed, that would greatly reduce his chances of obtaining bail either from the police or, subsequently, from the court. After some discussion Stuart Gipp told Mr Milsom that he had decided not to call the police surgeon at that time. Mr Milsom described Stuart Gipp as being unhappy and apprehensive about spending a night in police custody. However, he presented himself as rational and articulate.

Stuart Gipp was charged with the offences of dangerous driving, driving whilst disqualified, and driving without insurance or an MOT (a road worthiness certificate) at 10.59 p.m. on 8 February 1999, at which time police bail was refused.

At about 8.15 a.m. on 9 February 1999 Stuart Gipp's detention was reviewed. At that time he asked to see a doctor for a "personal reason". PS Sterne, the custody officer, noted on the custody record that he advised

Stuart Gipp that he would arrange for a surgeon to see him at the Lion Yard Magistrates' Court cells, to where he was shortly due to be transferred. At 8.25 a.m. PS Sterne noted the following on the custody record:

> "Conferred with police surgeon – Dr Gwynn. Problem is not an emergency. (DP [Detained Person] has stated it is a problem seeing doctor in prison – where he believes he will be going - and wishes to see one before his departure for prison). Issue to be handed over to Group 4 [a private security company that, pursuant to statutory provisions, provides escort and custody services under a contract with the Home Office] who will call a doctor themselves."

According to a statement made by PS Sterne on 10 February 1999, Stuart Gipp seemed satisfied with the above arrangement. PS Sterne explained that, at the time of requesting to see a doctor, Stuart Gipp stated that he would have waited until he got to prison, but that as it was difficult to see a doctor there he preferred to see one before he got there. It was for that reason that PS Sterne, in consultation with the police surgeon, Dr Gwynn, concluded that the matter was not an emergency.

Dr Gwynn recalled in a witness statement that he was telephoned by PS Sterne at about 8.25 a.m. and told that Stuart Gipp had a personal problem that he wanted to discuss with a doctor and thought that if the court sent him to prison it would be harder for him to talk to one of the prison doctors about it. He was further told that, while Stuart Gipp had been in custody, he had acted at all times in a normal fashion, showing no particular signs of physical or mental distress. Based on that information, Dr Gwynn formed the opinion that medical attention was not urgently required and that Stuart Gipp could be transferred into the care of Group 4 as arranged, ensuring that the day's court proceedings were not delayed. Dr Gwynn asked PS Sterne to inform Group 4 of Stuart Gipp's request to see a doctor and left it with them to call him from the Magistrates' Court later on if he was still required.

PS Sterne commented that, while Stuart Gipp was in his custody, he neither proved to be any problem nor exhibited any visible signs that he had any medical problems, was calm throughout and seemed quite resigned to the fact that he was going to go to prison. PS Sterne proceeded to tell both the civilian detention officer, Mr Miller, and the gaoler, PC Hine, that Group 4 should be informed that Stuart Gipp wanted to see a doctor.

At about 8.47 a.m. Stuart Gipp was handed over to Group 4 custody in order to be transported to court.

According to the witness statement of Mr Miller of 11 February 1999, at the time of his hand-over, Mr Miller explained to the Group 4 officers that Stuart Gipp wished to see the police surgeon on a personal matter the nature of which he would not reveal, that Dr Gwynn had been contacted by PS Sterne and that Group 4 should contact the doctor from the court cells to come out to see Stuart Gipp.

Mr Miller found Stuart Gipp's request to see a doctor on a personal matter, without revealing what it was, to be very unusual and a factor which he specifically remembered. He also remembered making a flippant comment to one of the Group 4 staff that it was unlikely that they would call out the police surgeon. This resulted from his understanding from other prisoners that Group 4 was reluctant to call out doctors for any matter, by reason of the cost of so doing. Group 4, a private company, was responsible for the costs of the visit of a doctor. The Group 4 member of staff replied that it was unlikely that a doctor would be called.

At about 9.30 a.m. Stuart Gipp arrived at the Magistrates' Court.

Some time later that morning (recorded in the report carried out by the Prisoner Escort and Custody Services ("PECS"), a division of the Home Office, as being at about 9.50 a.m., but possibly later in the light of the evidence in the witness statement of Mr Milsom set out below), Stuart Gipp asked Principal Custody Officer ("PCO") Banks whether he could see a doctor. According to his interview with the PECS investigators on 17 February 1999, PCO Banks asked Stuart Gipp to tell him what the problem was. Stuart Gipp did not do so, but just kept saying that he wanted to see a doctor. PCO Banks explained that it was Group 4 policy that a doctor would not be called unless there was something specific to report. As he had only worked for Group 4 for a fairly short time, PCO Banks called PCO Stevens over to speak to Stuart Gipp.

In his interview with the PECS investigators on 18 June 1999, PCO Stevens stated that he asked Stuart Gipp a few questions. On not getting any response, he went into the cell, put his arm around Stuart Gipp and asked him what was wrong. He replied that he was a drug user and did not want anyone to know. PCO Stevens continued to talk to Stuart Gipp for a short while, after which the latter appeared to perk up a little. PCO Stevens stated that he reported the facts to Senior Custody Officer ("SCO") Davis, who said that she would try to get his case in front of the court as soon as possible. PCO Stevens reported this back to Stuart Gipp who appeared to him to be quite happy.

PCO Stevens denied that PCO Banks had mentioned to him Stuart Gipp's request to see a doctor on that occasion. However, PCO Stevens stated that he reported both Stuart Gipp's initial request to see a doctor, which had been passed on to him by the police earlier that morning, and the fact that he was a drug user to SCO Davis. He stated that he did not enter these facts on Stuart Gipp's Prisoner Escort Record ("PER"). He further revealed that, as a drug user, he was concerned about Stuart Gipp's health, but that he was not concerned about his safety. He added that Stuart Gipp did not show any signs of being physically unwell and was quite chatty after PCO Stevens had spoken with him.

In her interview with the PECS investigators, SCO Davis denied that she was made aware at any time prior to 3.50 p.m. on 9 February 1999 that

Stuart Gipp had asked to see a doctor or that she was ever told that he was a drug user.

At 11.00 a.m. the community psychiatric nurse arrived at the cells. According to SCO Davis in her interview with the PECS investigators, such nurses usually saw any prisoner that they had not seen before, but that was a matter left to their discretion. Group 4 staff only referred a prisoner to the nurse if they had a serious concern about a prisoner or if they had been asked to do so by a solicitor. Stuart Gipp was neither seen by nor referred to the nurse.

At 11.15 a.m. on 9 February 1999 Mr Milsom attended again on Stuart Gipp, in the Magistrates' Court cells. In his witness statement, Mr Milsom stated that, at that time, Stuart Gipp appeared rather unwell but not dramatically so. Mr Milsom suggested that the time had now arrived for Stuart Gipp to ask the Group 4 custody officers to call a doctor. He explained that the findings of the doctor were unlikely to be relayed to the prosecutor, the court clerk or the magistrates and that a doctor's visit was unlikely at that stage to prejudice his chances of being granted bail. During that attendance, Mr Milsom stated that Stuart Gipp was calm, rational and responsive. He stated that there was nothing unusual about his behaviour and responses. He was clearly worried about the possibility of being remanded in custody. He further stated that he would think about calling a doctor: one of the factors weighing upon him was that he did not want his mother to know that he was dependent on heroin. However, Mr Milsom told the PECS investigators that during this visit Stuart Gipp told him that he had already requested to see a doctor, but that he had not yet been seen.

Mr Milsom did not express any concerns about the well-being of Stuart Gipp to his custodians at the conclusion of his legal visit at 11.37 a.m. Thereafter, Stuart Gipp's cell was checked, as was normal, he made a visit to the toilet and he was provided with lunch.

At about 2.50 p.m. Stuart Gipp was produced in court, where an application for bail was made. The magistrates retired for about 20 minutes and refused the application. Stuart Gipp was remanded in custody to Glen Parva Young Offenders Institution ("Glen Parva") for 7 days. In a statement by Mr Ingle, the Magistrates' Court clerk, he recalled that at no time during the court hearing was anything said on Stuart Gipp's behalf to indicate that he was distressed.

The Group 4 officer who accompanied Stuart Gipp to his court appearance, PCO Moore, told the PECS investigators that, on the way to court, he was talking to her without any apparent problem and that during the hearing itself he appeared calm and behaved normally. At the time at which the magistrates retired to consider their decision, Stuart Gipp talked and joked with her. She described him as fine, good-natured and conversational during this period. Once the magistrates announced that he was to be remanded at Glen Parva she described his reaction as follows:

> "Almost instantly his demeanour changed in the dock. He became unresponsive, shut down and went quiet. He was not emotional at all and didn't cry, shout or anything of that kind. He was told to go with the officer as is usual and I went to put the cuff on him and he pulled his arm away, resisting me. I spoke to him kindly and said 'come on, let's get you downstairs'. He then let me put the cuff on. As we reached the dock door he wiggled the cuff on his wrist but didn't really try to get it off... I was talking to him all the time but he didn't respond to me. He didn't pull or refuse to come with me, he was just quiet... His reaction was not unusual and didn't alarm me more than usual."

The change in Stuart Gipp's demeanour was not noted on the PER form.

Raymond Gipp, Stuart Gipp's brother, made a statement after the death in which he described Stuart Gipp's demeanour in court that day differently. He stated that he was at the back of the court when Stuart Gipp came in and that he appeared upset and looked as if he had been crying and that he put his head down in court and started to cry. He also stated that Stuart Gipp "screamed and screamed" as he went down the corridor with the Group 4 officer after the hearing. He added that Stuart Gipp had never wanted to talk about his experiences at Glen Parva the previous time that he was there and that one of Stuart Gipp's friends had said that he had said that he would kill himself if he had to go back to Glen Parva.

According to the entries on the PER form, Stuart Gipp was returned to his cell at 3.25 p.m. and Mr Milsom visited him there at 3.35 p.m. PCO Cannon went to open Stuart Gipp's cell door to allow Mr Milsom to conduct his legal visit. She saw Stuart Gipp with his head in his hands. She informed him that his solicitor had come to see him. He did not respond, but just walked into the interview room without saying anything. In his witness statement, Mr Milsom described that visit. Upon being asked by Mr Milsom, Stuart Gipp stated that he had asked to see a doctor some time previously but that he had not been seen by one. Mr Milsom observed that Stuart Gipp was very unhappy about the decision of the court and stated that he would not be able to stand it. He referred generally to difficulties he had experienced when he was previously at Glen Parva, but did not want to discuss these further. Mr Milsom described the ensuing conversation as follows:

> "I told Stuart that in 7 days time we could make another bail application. If that failed we could ask a Judge in Chambers for bail. At that point he said: 'I may not be here'. I asked him what he meant and he said that he might kill himself. I took this seriously because although he said it in a tone that appeared to lack conviction, he had his head deeply bowed throughout this conversation except when he was smoking a cigarette. He seemed to feel defeated."

According to the timings on the PER form, the legal visit concluded at 3.45 p.m. At 3.50 p.m., Mr Milsom informed SCO Davis that Stuart Gipp had requested to see a doctor. SCO Davis stated that she was unaware of that request. She further explained that no doctor was available at that time as she had been trying to get one to attend another detainee since 2.50 p.m.

without success. Mr Milsom also mentioned that Stuart Gipp was threatening to take his own life. SCO Davis noted on the PER form that he may try to harm himself and, at 3.52 p.m., initiated a self-harm form F2052SH as a result. At about 3.53 p.m., PCO Cannon went to check Stuart Gipp's cell. Having initially not been able to see Stuart Gipp, PCO Cannon re-checked the cell. As she opened the outer gate, she found Stuart Gipp hanging from his shoe-laces from the bolt hole of the open hatch on his cell door.

Stuart Gipp was cut down and attempts were made to resuscitate him. An ambulance was called, paramedics and police arrived to assist and Stuart Gipp was transported to Addenbrookes Hospital, Cambridge. It was there that he subsequently died.

Two PER forms were created in respect of Stuart Gipp. According to the Government, the second form was created after Stuart Gipp had hanged himself, but before he died. This was because the first form was taken by the police for the purpose of the police investigation into the hanging.

The front page of the first PER form contains a tick next to the box marked "no known risk", which the Government state was filled in by Mr Miller at the time that Stuart Gipp was handed over to Group 4 custody. There is also a tick by the box marked "suicidal/self harm" and, under the box marked "further information" are recorded the words "may try to harm himself". None of the entries on the front sheet of the form are timed. On the second page of the form appear timed entries of various events between 8.47 a.m. and 4.15 p.m., at which time it was noted that the police arrived. This includes an entry timed at 3.50 p.m. that Mr Milsom had stated that Stuart Gipp may try to take his own life.

The front page of the second PER form contains only Stuart Gipp's personal details and a record of his property. The timed entries on the second page of the form commence at 4.15 p.m.

PECS carried out an inquiry into Stuart Gipp's death. The resulting report was handed to the coroner on 26 August 1999. A copy of the report was forwarded to the applicant's solicitors on 17 November 1999 and received by them on 18 November 1999.

The report made, *inter alia*, the following findings:

– the police did not hand over to Group 4 a copy of the PER form or the police custody record relating to the time that Stuart Gipp was held at Parkside Police Station, nor was the request to see a doctor while in police custody recorded on the PER form by the police;

– the PER form failed to record the following matters, all of which should have been recorded: Stuart Gipp had requested to see a doctor, both in police custody and later that morning in the Magistrates' Court cells, Stuart Gipp was a drug user and PCO Stevens was concerned about Stuart Gipp's health, not his safety, and Stuart Gipp's demeanour had changed following his remand by the court to Glen Parva;

– Stuart Gipp was not referred to the community psychiatric nurse;

– on finding Stuart Gipp hanging, the staff handling the situation worked with speed and skill and did all that they could to revive him.

The report also referred to a memorandum to all Group 4 court and escort staff in area 4 dated 10 January 1999 (one month before Stuart Gipp's hanging) which stated as follows:

"**Cell Door Hatches**

With immediate effect all hatches in cell doors are to remain in the closed position when the cell is occupied.

Any faults in hatches are to be reported immediately to the Court Manager."

The memorandum did not give any indication that the reason for the change in practice regarding cell hatches was a suicide prevention measure designed to ensure that all potential suspension points within the cell were eliminated, thereby reducing or eliminating the opportunity for acts of self-harm. The PECS report recommended that all court escort contractors should be alerted to the risk and dangers posed by allowing a cell door hatch to be in the open position and that, unless further close supervision was available, the cell door hatch should be closed.

On 19 and 20 January 2000, an inquest was heard into Stuart Gipp's death by the Cambridgeshire Coroner, sitting with a jury.

At the inquest, the Group 4 staff stated in evidence that it was the practice to keep all cell hatches open at Cambridge Magistrates' Court. They further stated that they were unclear as to what general policy, if any, Group 4 had regarding cell hatches. All Group 4 staff who gave evidence at the inquest were either uncertain as to whether the memorandum had been brought to their attention prior to Stuart Gipp's hanging, or adamant that it had not been. They were further unclear what training, if any, they had received on the suicide risks of open cell hatches. SCO Davis, who had overall responsibility for the safety of prisoners in the custody of Group 4 at the Magistrates' Court, testified at the inquest that she had still, almost one year after Stuart Gipp's death, not been made aware of the purpose of the memorandum.

In delivering a verdict that Stuart Gipp had killed himself, the jury found that failures of responsible persons to follow some procedures and Stuart Gipp's knowledge of his place of detention contributed towards his death.

On 23 September 1999 the applicant instructed a firm of solicitors to advise and assist her in connection with the inquest into her son's death. The applicant was advised that neither she (not being a dependant of Stuart Gipp) nor Stuart Gipp's estate had any viable cause of action for damages which would justify the grant of a civil legal aid certificate on a cost benefit analysis. That advice was re-iterated to her by her solicitor on 23 February 2000 and by counsel on 3 March 2000, following her receipt of the PECS

report on 18 November 1999 and the inquest. She was therefore unable to pursue any action which would have examined the liability of Stuart Gipp's custodians for failing to prevent him from killing himself in custody and which would have afforded the possibility of compensation in respect of his death.

The applicant lodged her application with the Court on 21 March 2000.

B. Relevant domestic law and practice

1. Inquests

The duty to hold an inquest arises under section 8 of the Coroners Act 1988. Where there is reasonable cause to suspect that the deceased died in prison the coroner is obliged to hold an inquest together with a jury.

Inquest proceedings are directed solely to ascertaining the following limited matters: (i) who the deceased was; (ii) how, when and where the deceased came by his death ("how" meaning "by what means" as opposed to "in what broad circumstances") and (iii) the particulars required by the Registration Acts to be registered concerning the death (Section 11(5) of the Coroner's Act 1988 and rule 36 of the Coroners Rules 1984, as interpreted by *R. v. North Humberside and Scunthorpe Coroner, ex parte Jamieson* [1995] QB 1 ("*ex parte Jamieson*")).

The Court of Appeal in *ex parte Jamieson* defined the role of the coroner as follows at page 26C:

> "It is the duty of the Coroner as the public official responsible for the conduct of inquests, whether he is sitting with a jury or without, to ensure that the relevant facts are fully, fairly and fearlessly investigated. He is bound to recognise the acute public concern rightly aroused where deaths occur in custody. He must ensure that the relevant facts are exposed to public scrutiny, particularly if there is evidence of foul play, abuse or inhumanity."

Rule 42 of the Coroners Rules 1984 provides:

> "No verdict shall be framed in such a way as to appear to determine any question of- (a) criminal liability on the part of a named person, or (b) civil liability."

Rule 42 was stated to express the following in *ex parte Jamieson* at page 24B:

> "It is not the function of a coroner or his jury to determine, or appear to determine, any question of criminal or civil liability, to apportion guilt or attribute blame."

In *R (on the application of Amin and Middleton) v. Secretary of State for the Home Department* [2002] EWCA Civ 390, the Court of Appeal held that, in the light of the enactment of the Human Rights Act 1998, which came into force in October 2000 and imposed a duty on coroners' courts to act compatibly with rights set out in the Convention thereafter, in order to satisfy the investigative obligation under Article 2 it would be necessary, in

an appropriate case, to permit a jury to return a verdict of "system neglect" in circumstances where, previously, domestic law, specifically *ex parte Jamieson*, forbade such an outcome (§§ 91 and 92). The Court of Appeal also held in that case that, where a death occurred in State custody, either at the hands of another prisoner or as a result of a suicide, the investigative obligation under Article 2 was engaged (§ 43).

Rule 43 of the Coroners Rules 1984 provides:

> "A coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held may announce at the inquest that he is reporting the matter in writing to the person or authority who may have power to take such action and he may report the matter accordingly."

A coroner's court does not have jurisdiction to award compensation in respect of a death.

2. Proceedings for death caused by negligence

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

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."

The statutory right of action is however for the deceased's dependants (section 1(2)) which allows the recovery of their pecuniary loss. If there is no dependency, there is no pecuniary loss to recover as damages. Bereavement damages (fixed at 7,500 pounds sterling) are only available to the parents of a deceased child under the age of 18 at the time of death or to the spouse of the deceased (section 1A(2)). Funeral expenses are recoverable (section 3(5)).

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

> "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."

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 it cannot be proved that the deceased experienced pain and suffering before death, damages are not

recoverable under the 1934 Act and the only amount recoverable would be funeral expenses.

3. Common law duty of care owed to those in detention

It was accepted in the House of Lords case of *Reeves v. Commissioner of the Police of the Metropolis* [2000] 1 A.C. 360 that there was a common law duty of care upon the police to take reasonable steps to prevent a person of sound mind who was known to be a suicide risk from taking his own life while in custody. The duty had been breached on the facts of the case when the deceased had been able to hang himself as a result of the officers having left the hatch of his cell door open. Liability for the death was shared equally with the deceased, as a result of his voluntary act.

In *Orange v. the Chief Constable of West Yorkshire* [2001] 3 WLR 736, the Court of Appeal addressed the question, left open by the House of Lords in *Reeves*, as to whether the duty under consideration in *Reeves* arose only where the authorities knew or ought to have known that the individual prisoner presented a suicide risk, or whether it was a duty owed to all prisoners in custody. The Court of Appeal held that suicide was not a foreseeable risk in relation to every prisoner and that the obligation to take reasonable care to prevent a prisoner from taking his own life deliberately only arose where the custodian knew or ought to have known that the individual prisoner presented a suicide risk. It further held that the increased risk of suicide amongst prisoners gave rise to an obligation, within the general duty of care of the custodian for the health and safety of the prisoner, to take reasonable steps to identify whether or not a prisoner presented a suicide risk. As, on the facts, the police had been justified in concluding that the deceased was not a suicide risk, no duty of care was owed to him to prevent him from taking his own life and therefore it was not a breach of any duty to permit the deceased to retain his belt or to have placed the deceased in a cell in which the gate on the door, from which the deceased had hanged himself using his belt as a ligature, did not comply with recommendations contained in Home Office circulars. As Mrs Orange elected not to petition the House of Lords for leave to appeal, the issue in *Orange* has not yet been addressed by the House of Lords.

In *Orange* the Court of Appeal referred to the Canadian case of *Funk v. Clapp* (1986) 68 DLR (4th) 229, in which the allegations were that, although the deceased, a prisoner who had hanged himself, was not known to be a suicide risk, the standard procedures in the police operating manual should have been followed. The British Columbia Court of Appeal stated the following principle (cited at page 747 of *Orange*):

> "Suicide being reasonably foreseeable for prisoners as a group, and the defendants not having time to examine each person to see whether or not he is likely to attempt suicide, the reasonable course is to adopt a minimum standard applicable to all

prisoners except those who require special attention. The steps outlined in an operating manual seem appropriate for that purpose."

4. The PER form

Home Office Circular No. 50/1998, dated 4 December 1998 and implemented on 25 January 1999, introduced the PER form and described its purpose as follows:

> "It is essential that those responsible for the custody and care of a detainee/prisoner are made **fully aware at all times** of any associated risks from the prisoner and/or of any medical or psychiatric conditions of the prisoner. To ensure that such information is recorded for each prisoner and therefore accessible to all police officers, prison officers or escort custody officers in whose custody the prisoner may be, a form has been introduced for national use by the police, prison, court and escort services. ...
>
> ... The PER form is designed for use by everyone who comes into custodial contact with prisoners and should help minimise the danger of relevant information about the prisoner not being passed on to receiving authorities and, importantly, to those officers who take over responsibility for prisoners from others. Correct use of the form should not only ensure that prisoners are given the correct level of care and attention at all stages but that those who have responsibility for custody and transfer are made aware of the risks or potential risks they may face."

5. Requests for a medical examination by detained persons

Paragraph 9.4 of Code C of the Police and Criminal Evidence Act 1984 provides:

> "If a detained person requests a medical examination the police surgeon must be called as soon as practicable. He may in addition be examined by a medical practitioner of his own choice at his own expense."

6. Home Office Guidance on hatches on cell doors

Home Office Circular No. 92/1968, dated 10 April 1968, provides in relevant part:

> "Police authorities and police officers are aware of the need to ensure that fittings in cells should not provide opportunity for a prisoner to do himself injury ... Chief Constables are requested to arrange for early inspection of all police cells to ensure that there are no projections or fittings which prisoners might use to cause themselves injury. ...
>
> ... where cell doors are fitted with a drop-down service hatch, the hatch should not be left open when the cell is occupied by a prisoner. With the hatch open it would be possible for a person inside the cell to secure a ligature on the handle of the hatch."

7. Statistical information contained in the PECS report

Paragraph 3.4 of the PECS report, headed "Area 4 East Anglia" stated, in relevant part, as follows:

> "The Court Escort Contract in East Anglia commenced on 1 July 1995 with a phased introduction over six months. It provides court escort and custody services across the eight counties of Bedfordshire, Buckinghamshire, Cambridgeshire, Essex, Hertfordshire, Norfolk, Northamptonshire and Suffolk.
>
> The contract in Area 4 has been fully operational for just over three years. The contractor is Group 4 Court Services Limited. In each year of the contract operation, Group 4 has undertaken an average of 74,850 prisoner movements and handled an average of 120,661 prisoners. During this period the contractor has been faced with numerous incidents, including attempted suicide and self-harm. The number of attempted suicides/self-harm incidents recorded in Area 4 is illustrated in the table below:

Year	Prisoners Escorted	Prisoners Handled	Self-Harm/ Attempted Suicide	Percentage of Prisoners Handled
1996	70,591	117,129	40	0.03
1997	76,159	121,540	46	0.04
1998	77,801	123,315	60	0.05

> The nature of these incidents varies considerably, ranging from a determined attempt where a prisoner swallowed medication which had previously been concealed about the person, to smaller incidents where individual prisoners have struck hard surfaces causing minor injuries to their hands or grazes to their heads. The contractor has, however, always taken each incident seriously. One has to be cautious given the vulnerable nature of some prisoners, particularly those on remand or appearing at court for the first time. Group 4 Court Services Limited has a very good record of prisoner care."

COMPLAINTS

The applicant complains under Article 2 of the Convention that the circumstances in which her son died in custody constituted a violation of the State's positive obligation to take adequate measures to safeguard his life. She alleges that the authorities failed to ensure that confidential medical attention was available to him and that they failed to ensure that he was detained in a safe custodial environment. In particular, the authorities failed to follow Home Office guidance which specifically warned that cell hatches should not be left open when the cell is occupied by a prisoner because they are so frequently used for the attachment of ligatures.

The applicant also complains under Article 13 of the Convention that there did not exist any effective remedy in domestic law in respect of her son's death in custody.

THE LAW

The applicant complains about the circumstances in which her son died in detention and the lack of an effective domestic remedy in respect of his death under Articles 2 and 13 of the Convention.

Article 2 of the Convention provides, in relevant part:

> "1. Everyone's right to life shall be protected by law."

Article 13 of the Convention provides:

> "Everyone whose rights and freedoms as set forth in this 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."

A. The six-month rule

The Government submit that the six month time limit imposed by Article 35 § 1 of the Convention began to run from the date of Stuart Gipp's act of hanging himself and/or the alleged failures of the authorities on 9 February 1999. Alternatively, the Government submit that, insofar as the applicant might contend that she was awaiting the outcome of the PECS investigation in order to see whether that in fact provided an effective remedy for her complaints, time began to run from the completion of that report on 6 August 1999. Finally, the Government submit that the applicant became, or ought to have become, aware that there would not be any realistic opportunity to bring civil proceedings once she received the PECS report, or shortly after that time if she needed to take legal advice upon it. The application was therefore lodged out of time on 21 March 2000.

The applicant responds that Stuart Gipp died in custody and, until the disclosure to her solicitors of the PECS investigation report on 18 November 1999, she did not have any detailed understanding of the circumstances in which her son had died or the potential liability of any State agent or body for his death. Time cannot therefore run from the date of Stuart Gipp's death on 9 February 1999. Equally, time could only run from the date on which the PECS report was disclosed to the applicant, not the date on which that report was completed. The applicant submits that whether time began to run from the date on which she was first advised that she did not have any civil claim on 23 September 1999 or from the receipt of the PECS report on 18 November 1999, the application was clearly

lodged within the six month time limit imposed by Article 35 § 1 of the Convention.

The Court recalls that Article 35 § 1 of the Convention provides that the Court may only deal with a matter where it has been introduced within six months from date of the final decision in the process of exhaustion of domestic remedies. Where no effective remedy is available to the applicant, the period runs from the date of the acts or measures complained of, or from the date of knowledge of that act or its effect or prejudice on the applicant (see e.g. *Hilton v. the United Kingdom*, no. 12015/86, Commission decision of 6 July 1988, DR 57, p. 108, in which the Commission considered that the absence of knowledge on the part of the applicant of the matters which formed the subject of the complaint constituted special circumstances which interrupted the running of the six months period).

The Court further recalls that it may be appropriate for the purposes of Article 35 § 1 of the Convention to take the start of the six month period from the date when the applicant first became or ought to have become aware of the circumstances which rendered the remedy ineffective (see no. 27229/95, *Keenan v. the United Kingdom*, decision on admissibility of 22 May 1998).

In the present case, insofar as it could be argued that the initial legal advice given to the applicant on 23 September 1999 that neither she nor Stuart Gipp's estate had a viable cause of action for damages which would justify the grant of a legal aid certificate on a cost-benefit analysis demonstrates that the applicant never had an effective domestic remedy, the Court observes that the applicant potentially had a remedy in respect of the death of her son under the Fatal Accidents Act 1976 and/or the Law Reform (Miscellaneous Provisions) Act 1934. It was not, however, until she received the aforementioned legal advice that the applicant could reasonably have known that any potential remedy under those Acts would be ineffective in the circumstances of her case. The Court notes that the applicant sought and received legal advice within a few months of the death of her son and that there is no evidence of dilatoriness on her part. In those circumstances the Court finds that the six-month time period cannot be deemed to have started prior to 23 September 1999.

Moreover, the Court accepts that it was not until the PECS report was disclosed to the applicant that she would have had any detailed understanding of the circumstances in which her son had died or the potential liability of the State for his death. The facts upon which the applicant bases her Convention complaint are all matters which were the subject of investigation by the PECS investigators, leading to the eventual report. The Court considers that it cannot be regarded as unreasonable for the applicant to have waited until she had received the report, which had been specifically commissioned to investigate the circumstances of Stuart Gipp's death in custody, before introducing her application to Strasbourg.

The Court notes that the report was only disclosed to the applicant on 18 November 1999 and that she would not therefore have had any knowledge of its contents before that date.

The Court recalls that the application was introduced on 21 March 2000. In the above circumstances, whether the six month time period is deemed to have commenced from the initial legal advice of 23 September 1999 or from the disclosure to the applicant of the PECS report on 18 November 1999, the Court finds that the application satisfies the six months' requirement imposed by Article 35 § 1 of the Convention.

B. Article 2 of the Convention

1. The parties' submissions

(a) The Government

The Government refer to the Court's jurisprudence in the *Osman v. the United Kingdom* judgment of 28 October 1998 (*Reports of Judgments and Decisions* 1998-VIII, § 116), and *Keenan v. the United Kingdom* (no. 27229/95, ECHR 2001-III, § 89), to submit that, where there is an allegation that the authorities have violated their positive obligation under Article 2, it must be established that they knew or ought to have known at the time of the existence of a real and immediate danger to life and that they failed to take measures within the scope of their powers which, judged reasonably, they might have been expected to take to avoid that risk. They submit that the present case is analogous to *Douglas-Williams v. the United Kingdom* (decision, no. 56413/00, 8 January 2002, unreported), which was declared inadmissible by the Court on the basis that the police officers in that case were not found to have had any reason to suspect that the deceased was about to suffer a life-threatening seizure. In the present case, the Government submit that the suicide of Stuart Gipp was also unexpected.

The Government submit that the authorities were neither aware, nor should they have been aware, that Stuart Gipp was at risk of suicide. They submit first that he did not have a history of mental health problems or suicidal tendencies and, while it is true that his requests to see a doctor at the police station and at the Magistrates' Court were not complied with, neither Stuart Gipp himself nor his behaviour indicated at the time of his requests that he felt suicidal or was likely to harm himself; nor was there any indication that he was a drug user. The Government contend that there is no evidence that Stuart Gipp's suicidal tendencies would have been brought to the attention of the doctor and the authorities at an earlier stage had his requests for a doctor been complied with. The Goverment also submit that the first and only indication of Stuart Gipp's suicidal intention

was communicated by his solicitor, Mr Milsom, after which a F2052 self-harm form was initiated immediately and his cell was checked within three minutes of that communication, at which time he was found hanging.

The Government state that the authorities did all that they could reasonably have been expected to do to prevent the risk of Stuart Gipp's suicide, checking on him within three minutes of being informed that he might harm himself. They accept that his cell hatch was left open, which was contrary to Home Office Circular No. 92/1968 and the Group 4 internal memorandum dated 10 January 1999, and that Stuart Gipp took his own life by attaching a ligature to the open hatch. However, they point out that it is also possible to attach a ligature to a closed hatch or to a door handle in a cell and that the principal means of preventing suicide is by supervision of the prisoner.

The Government argue that it was neither the failure to call a doctor nor the failure to close the cell hatch, nor any other act of the authorities which caused Stuart Gipp's suicide. They submit that Stuart Gipp appears to have become particularly agitated once he knew that he was going to be detained on remand at Glen Parva and that it was that event which led him suddenly to threaten to take his life and, within minutes, to do so. In support of this submission the Government refer to the evidence that, at the police station, Stuart Gipp was compliant and calm when his detention was authorised, that he did not show any particular signs of physical or mental distress while he was there, that his request to see a doctor was not regarded as being urgent and that, according to his solicitor, at the time of his first legal visit he was anxious not to disclose to the authorities that he was a heroin addict or that he was suffering from withdrawal symptoms. They further refer to nothing having been said during Stuart Gipp's bail application at the Magistrates' Court to indicate that he was distressed, to his instant change in demeanour once he was remanded to Glen Parva at the end of that application, and to his statement to his solicitor immediately thereafter that he might kill himself. They also refer to the statement of one of the friends of Stuart Gipp that he had previously stated that he would kill himself if he ever had to return to Glen Parva.

The Government submit that the first PER form was properly completed and that it accompanied Stuart Gipp from Parkside police station to the Magistrates' Court on the morning of 9 February 1999.

In addition, the Government contend that they complied with the procedural element of Article 2 insofar as that Article required an effective official investigation into Stuart Gipp's death. They submit that there is no obligation to carry out an effective official investigation in situations where the death was due to suicide and, even if incorrect on that point, the internal PECS investigation and inquest complied with any such obligation.

(b) The applicant

The applicant accepts that Article 2 was not breached by reason of actual knowledge by the authorities of the risk of Stuart Gipp committing suicide and a consequent failure to do all that could reasonably be expected to avert that known risk, as they were only expressly told that he might try to take his own life a matter of minutes before he was checked and found hanging in his cell, after which they took immediate steps to try to revive him.

However, the applicant submits that had the authorities acted with reasonable care, there is a real possiblity that they would have been made aware of Stuart Gipp's vulnerability to the risk of suicide and would then have been in a position to take the necessary action to avert that risk. As such, the Government's reliance on *Douglas-Williams* (cited above) is inapt. She asserts that adopting such a "real possibility" test does not put an impossible or disproportionate burden on the authorities, but that it instead provides a meaningful vindication of the requirement that the right to life must be protected by law, in this case imposing a duty on the State to take reasonable care for the health, safety and well-being of persons in custody.

In averring that the authorities ought to have been aware that Stuart Gipp was a suicide risk, the applicant refers to the fact that neither the police nor Group 4 summoned a doctor to see Stuart Gipp despite his two requests for one to be called; nor was he seen by the community psychiatric nurse who was on duty in the Magistrates' Court in the hours before he hanged himself. The authorities were also aware that Stuart Gipp was a drug user, as he had admitted this to PCO Stevens, who stated that he was concerned about Stuart Gipp's health. The applicant submits that none of these facts were recorded on Stuart Gipp's PER, nor was SCO Davis aware of them, as a result of gross failures of communication between the relevant staff. As such, no one with overall responsibility was able to make appropriate decisions about his welfare. Similarly, PCO Moore neither recorded on the PER, nor informed SCO Davis about, Stuart Gipp's change in demeanour following his remand in custody to Glen Parva, nor took any action to ensure that the cell hatch was closed.

Additionally, the applicant points out that relevant staff were unaware, even at the date of the inquest which took place nearly a year after Stuart Gipp's death, that the purpose of the Home Office guidance which stated that a cell hatch should be closed was directly related to the risk of suicide in custody.

The applicant submits that the above facts constituted a "lamentable sequence of omissions" which led to Stuart Gipp never being seen by any medically qualified person in custody and being left alone in a cell with an open cell door hatch, from which he was able to, and did, hang himself.

The applicant submits that the need for prisoners to have confidential access to a doctor is plainly of vital importance. They may be willing to disclose to a doctor important information affecting the assessment of their

potential suicide risk which they might not be willing to disclose to a custodian. Equally, a doctor may prescribe medication to a person experiencing feelings of despair as a result of drug withdrawal. She argues that Stuart Gipp's request to see a doctor was related to his fear, as a drug addict, of being remanded into custody for a lengthy period and that the failure to call a doctor constituted a serious breach of duty of care to him.

The applicant further points out that the evidence of Mr Miller reveals a concern that the reluctance of Group 4, a private company financing medical services from its own budget, to summon medical assistance for detainees in their custody stemmed from purely financial considerations, and that Group 4's policy of not summoning medical help without something specific to report, as described by PCO Banks, directly conflicted with the provisions of paragraph 9.4 of Code C of PACE (set out under "relevant domestic law and practice" above). The applicant submits that these factors made the breach of duty to Stuart Gipp even more serious.

The applicant argues that the authorities should not effectively be allowed to aver that, as a consequence of their breaches of the duty of care, they did not have any reason to be aware of the risk of suicide. Such an approach would be inconsistent with both the practical and effective enforcement of the right to life and the Court's above-cited judgments in *Keenan* (§§ 88-92) and *Osman* (§ 115) and would reward systemic negligence by placing a wholly unrealistic burden on the applicant to prove that, if the State had acted with due care, a real and immediate risk of suicide would inevitably have been identified and averted by reasonable preventative action.

The applicant also avers that it is self-evident that the vulnerability inherent in imprisonment is heightened where a detainee with a problem of drug addiction is denied access to confidential medical advice. She argues that, as an enhanced risk of suicide is a well known feature of the custodial situation and diagnosing who is and who is not at particular risk of suicide is not an exact science, the safest course is to adopt a minimum standard of care applicable to all prisoners, which would not depend upon the custodian having specifically identified a particular prisoner as presenting a specially enhanced risk of suicide. That minimum standard would, in the present case, encompass the policy set out in Home Office Circular No. 92/1968 requiring that cell hatches should not be left open when the cell is occupied.

The applicant further submits that the Government cannot seek to avoid responsibility for the breach of that Circular by asking the Court to speculate on the supposed availability of other possible mechanisms of death for which the Government may also have responsibility.

The applicant notes the untimed and unsigned entries on the front sheet of the first PER and questions the legitimacy of creating a second PER after Stuart Gipp had hanged himself. She does not accept that the Court is in any position to find as a fact that the first PER had been properly filled out.

The applicant accepts that, on the facts of this case, the investigative obligation inherent in Article 2 of the Convention was satisfied by the inquest into Stuart Gipp's death.

2. The Court's assessment

(a) General principles

Article 2, which safeguards the right to life and sets out the circumstances when deprivation of life may be justified, ranks as one of the most fundamental provisions in the Convention, to which in peacetime no derogation is permitted under Article 15. Together with Article 3, it also enshrines one of the basic values of the democratic societies making up the Council of Europe. The circumstances in which deprivation of life may be justified must therefore be strictly construed. The object and purpose of the Convention as an instrument for the protection of individual human beings also requires that Article 2 be interpreted and applied so as to make its safeguards practical and effective (see *McCann and Others v. the United Kingdom*, judgment of 27 September 1995, Series A no. 324, pp. 45-46, §§ 146-147).

The Court recalls 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 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 the above-cited *Osman* judgment, § 115).

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 in the context of where the risk to a person derives from self-harm, such as a suicide in custody, 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 and, if so, that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk (see the above-cited *Keenan* judgment, §§ 89 and 92).

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, ECHR 2000-VII, § 99). 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 those detained in their custody.

The Court has recognised that the prison authorities must discharge their duties in a manner compatible with the rights and freedoms of the individual prisoner concerned. There are general measures and precautions which will be available to diminish the opportunities for self-harm, without infringing personal autonomy. Whether any more stringent measures are necessary in respect of a prisoner and whether it is reasonable to apply them will depend on the circumstances of the case (the above-cited *Keenan* judgment, § 91).

(b) Application of the general principles to the present case

In the light of the above, the Court has examined whether the authorities knew or ought to have known that Stuart Gipp posed a real and immediate risk of suicide and, if so, whether they did all that reasonably could have been expected of them to prevent that risk.

The applicant accepts that Article 2 was not breached in this case on the basis of actual knowledge by the authorities of the risk of Stuart Gipp committing suicide and a consequent failure to do all that could reasonably be expected to avert that known risk. The Court agrees. The first time that the authorities were made expressly aware that Stuart Gipp was a suicide risk was when that fact was communicated by Mr Milsom to SCO Davis at about 3.50 p.m. on 9 February 1999. Thereafter, the authorities did all that could reasonably have been expected of them in initiating a self-harm form immediately and checking Stuart Gipp's cell within three minutes, by about 3.53 p.m. Tragically, Stuart Gipp was found hanging at about the same time. Thereafter, the PECS report specifically concluded that the staff dealing with the situation worked with speed and skill and did all that they could to revive him.

The question therefore arises as to whether the authorities ought to have known that Stuart Gipp was a suicide risk. The Court recalls that Stuart Gipp asked to see a doctor on two occasions on the morning of the day on which he hanged himself. Neither request was ultimately fulfilled and he did not see a doctor while he was in custody. In addition, Stuart Gipp told PCO Stevens that morning that he was a drug user and PCO Stevens stated that he was, for that reason, concerned about Stuart Gipp's health, but not his safety. While the Court is greatly concerned that the above information was not recorded on Stuart Gipp's PER, which it clearly should have been, and that no one with overall responsibility for his welfare admits to being aware of each of the above facts, it cannot conclude that, in the circumstances of

this case, the two requests to see a doctor and a knowledge that Stuart Gipp was a drug user ought, in themselves, to have been sufficient to put the authorities on notice that Stuart Gipp was a suicide risk.

In reaching the above conclusion, the Court has also taken into account the available evidence about Stuart Gipp's demeanour that morning and the circumstances surrounding his requests to see a doctor and the revelation that he was a drug user. The Court notes that Stuart Gipp did not have any known history of mental health problems or suicidal tendencies. At the time at which he first asked for a doctor at about 8.15 a.m. he stated that it was for a personal reason and that, while he would have waited to see one until he got to prison, he preferred to see a doctor beforehand as he believed that it would be more difficult once he was in prison. Up until that point, Stuart Gipp had acted at all times in a normal fashion, showing no particular signs of physical or mental distress. In those circumstances, both PS Sterne and Dr Gwynn concluded that Stuart Gipp's request to see a doctor was not urgent and left the matter to be dealt with by Group 4, whose staff were shortly thereafter due to transfer Stuart Gipp to court. At the time of his later request to PCO Banks to see a doctor, there is no evidence to suggest that Stuart Gipp appeared to Group 4 staff to be unwell. Although PCO Stevens reported that Stuart Gipp had initially not responded to his questions at about that time, he also stated that Stuart Gipp had perked up a little after he had continued to talk to PCO Stevens following his admission of being a drug user. During his visit at 11.15 a.m., Mr Milsom reported that Stuart Gipp appeared to him to be rather unwell, but not dramatically so. His demeanour was calm, rational and responsive.

In the above circumstances, the Court concludes that there is no evidence of anything about Stuart Gipp's actions or behaviour that ought to have put the authorities on notice that he was at a real and immediate risk of suicide either at the times at which he requested a doctor or when he revealed that he was a drug user.

The applicant submits, however, that, had the authorities acted with reasonable care - in particular by ensuring that Stuart Gipp was seen by a doctor and/or by the community psychiatric nurse, who was on duty at the court that morning - there is a real possibility that they would have been made aware of Stuart Gipp's vulnerability to the risk of suicide. The Court finds this assertion to be too speculative. While the Court does not regard it as appropriate to apply a "real possibility" test, which it finds puts the threshold far too low for the purposes of determining whether there has been a violation of Article 2, the Court would reach the same conclusion even on the basis of such a test. It cannot conclude on the available evidence that there was even a real possibility that, had Stuart Gipp been seen by a medical professional at a time prior to his bail application at about 2.50 p.m., the authorities would have become aware that he was at a real and immediate risk of suicide, nor that the calling of a doctor would have

made any difference to the tragic outcome of the case. The Court notes that, from 2.50 p.m. onwards, a doctor would have been unavailable, even if called, as SCO Davis had been trying to get one to attend another detainee since that time without success at the time at which she spoke to Mr Milsom at 3.50 p.m.

While the Court regards it as most unfortunate that Stuart Gipp was not seen by a medical practitioner in the circumstances of the case, it would be pure speculation to conclude that the summoning of a medical professional would have had the outcome for which the applicant contends.

Indeed, the Court observes that the available evidence points more strongly towards the suggestion that Stuart Gipp became a real and immediate suicide risk only after he had been remanded to Glen Parva, following his unsuccessful bail application. As set out above, up until that time Stuart Gipp's demeanour is variously described as normal, compliant, calm, rational and responsive, with no particular signs of mental or physical distress. However, once he was remanded to Glen Parva at about 3.20 p.m., his demeanour was said by PCO Moore to have changed almost instantly. His deflated and non-responsive demeanour was confirmed by PCO Cannon shortly after the bail hearing; and Mr Milsom describes Stuart Gipp's unhappiness about having been remanded to Glen Parva, talking of difficulties that he had experienced there in the past and that, during that conversation, he stated that he might kill himself. Mr Milsom saw Stuart Gipp on the evening of 8 February 1999, on the morning of 9 February 1999 and between about 3.35 and 3.45 p.m. on 9 February 1999. It was only on that last occasion, which followed the remand to Glen Parva, that Stuart Gipp mentioned that he might harm himself. Stuart Gipp's brother had not mentioned to any authority prior to the death that a friend of Stuart's had reported that he had previously said that he would kill himself if he ever had to go back to Glen Parva. While the Court has taken full account of the different description that Stuart Gipp's brother recounted in relation to his demeanour in court at his bail application that afternoon, this does not detract from the description of his behaviour prior to that hearing, nor from the inference that can be drawn from the evidence that his demeanour changed markedly after he had been remanded to Glen Parva.

The Court is critical of the failure of the relevant staff to note this change of demeanour on Stuart Gipp's PER. However, Stuart Gipp was seen by his solicitor, Mr Milsom, very shortly after the decision to remand him in custody and Mr Milsom communicated the threat that Stuart Gipp had made to kill himself immediately after that consultation. In all the circumstances, the Court cannot conclude that Stuart Gipp ought to have been known to the authorities as a real and immediate risk of suicide prior to Mr Milsom's communication of that information to SCO Davis at about 3.50 p.m.

In the above circumstances, the Court concludes that Stuart Gipp's act in hanging himself was not reasonably foreseeable. As the evidence does not

establish that he was, or ought to have been, known to the authorities as a real and immediate suicide risk, the authorities cannot be found, on the Court's established case-law, to have been in breach of Article 2 of the Convention on the basis that they failed in their positive obligation to protect his life.

However, the applicant further submits that, as an enhanced risk of suicide is a well-known feature of the custodial situation, the safest course is to adopt a minimum standard of care applicable to all prisoners, which, in the present case, would encompass the policy set out in Home Office Circular No. 92/1968 requiring that cell hatches should be closed when the cell is occupied because of the fact that they could otherwise be used for the attachment of ligatures. That minimum standard would not depend upon the custodian having specifically identified a particular prisoner as presenting a specially enhanced risk of suicide, but would apply to all prisoners in acknowledgment of the difficulties in making a precise assessment of suicide risk.

While the Court welcomes and encourages authorities to make the greatest efforts to ensure that all prisoners are kept in a safe custodial environment, the Court finds that the failure to follow Home Office Circular No. 92/1968 in the present case cannot, in itself, give rise to a violation of Article 2 of the Convention in the absence of actual or imputed knowledge, on the part of the authorities, that Stuart Gipp was a real and immediate suicide risk.

The Court rejects the logical effect of the applicant's above argument that every prisoner should be treated as a real and immediate suicide risk merely by virtue of being a prisoner. While the Court recognises the vulnerability of those in custody and could accept as a general proposition that the risk of suicide amongst those in custody may be higher than amongst those in the general population, there is no evidence before the Court to suggest that the occurrence of suicide in prison in the United Kingdom is anything other than rare. The Court refers to the statistical information contained in the PECS report, set out under the heading "relevant domestic law and practice" above, which, while relating only to one geographical area, shows the percentage of prisoners handled who attempted self-harm to be very low, ranging from 0.03% to 0.05% between 1996 and 1998. While no separate percentage is available for those who attempted suicide as opposed to other forms of self-inflicted injury, it would clearly be an even lower figure than that which includes all incidents of self-harm.

Furthermore, the Court considers that to regard all prisoners as suicide risks would impose not only a disproportionate burden upon the authorities in the unusual situation where they are under a positive obligation to prevent an individual from taking his or her own life, but also a potentially unnecessary and inappropriate restriction on the liberty of the individual

prisoner. The Court does not find that Article 2 imposes any such minimum standard upon the State in circumstances where there is no other evidence that an identified individual is a known suicide risk.

In relation to the criticisms that the applicant makes of the PER forms, the Court finds that the timings of the various events referred to in this decision accord not only with the entries on the second page of the first PER form, but also with the factual findings of the PECS report. As such, the Court does not have any reason to doubt their accuracy. Excepting the criticisms that it has already made above in relation to the failure to record significant information on Stuart Gipp's PERs, the Court does not find it necessary to make any further finding in relation to the manner in which the PERs were completed in the present case.

Finally, the Court notes that the applicant does not allege that Article 2 was breached by the failure of the State to satisfy the investigative procedural obligation inherent in Article 2, accepting that, on the facts of this case, the inquest into Stuart Gipp's death satisfied that requirement. The Court does not find any reason to disagree with that conclusion.

For the reasons stated above, the Court concludes that the applicant's complaints under Article 2 must be rejected as manifestly ill-founded within the meaning of Article 35 §§ 3 and 4 of the Convention.

Notwithstanding its above conclusion, the Court considers it appropriate to express its particular disquiet about the fact that the guidance contained in Home Office Circular No. 92/1968 and in Group 4's own internal memorandum of 10 January 1999, that cell door hatches should be kept closed when the cell is occupied, was not followed in the current case and that the Group 4 staff in the present case were apparently still not aware, at the time of the inquest almost one year after Stuart Gipp's death, that the purpose of the internal memorandum was that of suicide prevention.

C. Article 13 of the Convention

The Government submit that, as there has not been an arguable breach of Article 2, there has also not been any violation of Article 13 of the Convention. Alternatively, they argue that the PECS investigation and the inquest, viewed together, provided the applicant with an effective remedy.

The applicant submits that, if there has been a violation of Article 2 on the facts of the case, as averred by her, Article 13 of the Convention has also been breached because domestic law failed to provide an effective remedy therefor. As in the above-cited *Keenan* case, the applicant was not able to pursue any remedy which was capable of determining the liability of the State for the death of her son or which provided compensation in respect thereof.

The Court recalls that Article 13 applies only where an individual has an "arguable claim" to be the victim of a violation of a Convention right (see

Boyle and Rice v. the United Kingdom, judgment of 27 April 1988, Series A no. 131, § 52).

The Court has found above that the applicant's complaint under Article 2 is manifestly ill-founded. For similar reasons, the applicant did not have an "arguable claim" and Article 13 is therefore inapplicable to her case. It follows that this part of the application is also manifestly ill-founded within the meaning of Article 35 § 3 of the Convention and must be rejected pursuant to Article 35 § 4.

For these reasons, the Court by a majority

Declares the application inadmissible.

S. DOLLÉ
Registrar

J.-P. COSTA
President