Ferguson - the threshold for engaging Article 2 in inquests

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R (on the application of David Ferguson) v HMAC for Sefton Knowsley and St Helens [2025] EWHC 1901 (Admin) is an important judgment for any inquest and clinical negligence practitioner. Not only does it provide an erudite summary of the key authorities concerning breach of Article 2, but it importantly considers the threshold for whether an Article 2 duty exists in the first place.

What happened?

Mr Farley was an individual with a pre-existing history of psychosis and mental health difficulties. On 19th February 2023, approximately two months before his death, he was found on the roof of a car park reporting suicidal ideation. He was encouraged down by security staff.

On 11th April 2023, Mr Farley went to the fourteenth floor of a multi-story car park in Bootle, Liverpool. He was jumping up on to the railings and back down again. A member of the public was concerned about him and called the police. Three officers attended Mr Farley. At the time of their arrival, he was not sitting towards the edge of the car park, and he was compliant in responding to questions. Mr Farley told them that he was not intending to hurt himself and explained his mental health history to them. He was ultimately escorted down by the police officers. Police offer did not call for the assistance of a mental health triage car, which was a joint policing and mental health initiative to assist individuals who have contact with the police where there is a mental health component to their presentation. The police did complete a Vulnerable Personal Referral Form; a non-immediate referral to multi-agency safeguarding. The police were satisfied that Mr Farley did not pose a risk, and the officers returned to their duties. Less than twenty minutes later, Mr Farley re-entered the same car park, jumped over the side and tragically died.

An investigation by the Professional Standards Department of Merseyside police ('*PSD investigation*') found that there were missed opportunities to intervene. Had mental health been contacted, their advice likely would have been that they would have wanted to see Mr Farley, either in a mental health setting or in an accident and emergency setting.

The Inquest

The Coroner indicated that this was not an Article 2 inquest. His provisional scope was to examine the police involvement on 11th April 2023 and mental health service involvement between the 19th February 2023 and the 11th April 2023. Claimant's counsel submitted that the conduct of the officers arguably constituted a breach of the Article 2 operational duty, and the inadequate procedures in place arguably constituted a breach of the Article 2 systems duty.

The Coroner held that Article 2 was not engaged because (i) Mr Farley was not within the state's responsibility and (ii) the state had no knowledge of a particular risk to him. The operational duty to safeguard life did not exist, and it ought not be interpreted in a way that imposes an impossible burden on authorities. The Coroner considered that it did not appear that any of the substantive obligations under the European Convention on Human Rights (ECHR) had been breached, and that there was no credible evidential basis on which the state knew or ought to have known of a real and immediate risk to his life.

Judicial Review: The Key Points

It was agreed between the parties that the threshold of whether Article 2 was breached was a low one. It is trite that the threshold of whether there has been a breach is one where it can credibly be suggested / whether the same is arguable. The difference between the parties was whether that low arguability threshold also applied to the question of whether a positive operational duty existed in the first place.

When considering whether an Article 2 duty exists at the outset, it has now been clarified that the test is: has an

arguable duty arguably been breached? In other words, it is not necessary to establish that an Article 2 duty has arguably been breached when considering whether it existed in the first place.

The Coroner, as part of their written determination on the issue of Article 2, placed weight on Mr Farley's demeanour and explanations that he gave to the police when considering that there was no immediate risk to life. He was calm and compliant and he was not heavily under the influence of alcohol at the time he spoke to the police. He was not in any visible distress. This however was in the context of the Coroner being aware of the PSD investigation that was critical of the officers for being unduly reliant on Mr Farley's presentation. This included that the officers had been too easily swayed by his insistence that he was not going to self-harm.

It was held that the Coroner's reliance on Mr Farley's presentation posed a '*number of difficulties*', and particularly given the 'credible evidence' arising from the PSD investigation.

Mrs Justice Hill further rejected the Coroner's contention that the short period of time between the officers' contact with Mr Farley and his subsequent decision to jump, meant that there was no real and immediate risk to his life of which the officers did or should have had knowledge. It was held that the short time scale of that kind in fact militated in favour of there being a real and immediate risk and the officers having actual or constructive knowledge of it.

The Osman test requires that consideration is given to what state agents ought reasonably to have known of a real and immediate risk to an individual's life as well as what they actually knew. Had the officers taken the steps which the PSD investigation concluded that they should have done, namely contacting a triage car or professionals phone line, then that would have provided them with further details concerning his mental health background, and it would have assisted them with more informed decision making about safeguarding. This would have included the police officers being made aware of the recent incident in February 2023 when Mr Farley had attended a car park before.

It was held that it was plainly arguable that the incident in February 2023 was relevant to the officers assessment of risk that Mr Farley posed on 11th April 2023. It was clear that the two occasions had obvious parallels and that on both occasions Mr Farley had been found on the top floor of a car park experiencing hallucinations. The reasons given by the Coroner did not provide a sound basis for the conclusion that there was no arguable real immediate risk to his life of which the officers did or should have had knowledge.

Practical tips

Of immediate note to any practitioner that specialises in this work, Mrs Justice Hill highlighted the "*wisdom*" of the Coroner in providing a written determination of Article 2 on the basis of written submissions only. If submissions are going to be made as to whether Article 2 is likely going to be engaged, it is important that these are dealt with substantively during the pre-inquest review hearing.

In the author's opinion, the clarification concerning the threshold to be met when considering whether an Article 2 duty exists at the outset, will likely lead to greater instances of this being raised at the earliest possible opportunity at the inquest process. This is particularly in circumstances where disclosure is very often limited at the pre-inquest review hearing stage.

The particular feature of this case was the PSD investigation that made several findings suggestive that professional curiosity ought to have been carried out to allow for a greater understanding and assessments of mental health difficulty. In the author's opinion, there are clear connections to be drawn when considering whether a positive operational duty in the healthcare context arises where there is a critical internal investigation report by a healthcare provider.

Practitioners will want to consider whether, either in totality or a combination of those findings made in such reports give rise to a credible argument as to whether such a duty exists. This is not just applicable to mental health cases but is also applicable to physical health care cases.

The judgment, whilst primarily dealing with the threshold of engagement of Article 2, does highlight a notable development in the context of coronial causation. The Coroner's Bench Book summarises this pithily. The threshold for causation of death is answered by the following question and is ingrained into the minds of all practitioners doing this work: did the act or omission probably contribute to the death in a more than minimal way?

The analysis in *Ferguson* is somewhat different. It was held that the test for causation in cases involving Article 2 is whether the Deceased lost a "*substantial chance*" of survival because of the breach. It remains to be seen the extent to which this will be revisited in subsequent authority, or indeed whether the Bench Book will be modified in this regard.