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CORONER FOR NORTHERN IRELAND

MR JOSEPH McCRISKEN

INQUEST INTO THE DEATH OF

MR L

FACTUAL FINDINGS

1 June 2021

Introduction.

1. I was represented by Coroners Counsel Ms Marie-Claire McDermott. My solicitor was Mr O'Rawe. The Next of Kin ('NOK') were not legally represented. Mr Barclay, the Chairman of the Contact Centre assisted by Ms Donna Thompson, Solicitor appeared for the Contact Centre. I am indebted to all those who appeared, in particular my own counsel, for their assistance. I also want to thank my court clerk Claire for her assistance during both days of this hearing.

2. I have anonymised these findings to protect the identities of Mr L's children.

3. Although, as I will outline later, the cause of Mr L's death was neck suspension as a result of hanging this inquest raised issues concerning arrangements for child contact managed by the Family Proceedings Court ('FPC'). Accordingly, I consider that article 2 of the European Convention on Human Rights is engaged to the extent that these findings should consider "how and in what circumstances" Mr L came by his death. Mr L's family deserve to have the circumstances of his death properly investigated. This inquest is their only means of getting answers to some of the many questions they have regarding Mr L's death.

Background.

4. Mr L was 48 years old when he died. At the time of his death Mr L was married to Mrs AL but was separated. He has three children. Mr L was self-employed.

5. I was told at inquest that in January 2017 Mrs AL informed Mr L that she intended to leave the marriage, move out of the marital home and reside with the children. As it turned out this did not actually occur until August 2017 when Mrs AL moved out of the marital home with their three children, then aged 5, 4 and 2. Mr L's sister told the inquest that the removal of the children caused him a great deal of upset. Although contact with the children occurred initially regularly, over the next two years there were issues regarding Mr L's contact with the children that required private law court proceedings to be issued by him.

6. Mr L contacted his General Practitioner ('GP') on 11 October 2017 reporting that his marriage had broken down. He sought counselling prior to this and his counsellor advised him to contact his GP. His GP noted that Mr L was

experiencing thoughts that life was not worth living but had no active suicide plan or ideation. Mr L was commenced on an anti-depressant with a follow up appointment arranged for 2-3 weeks time. On 17 October 2017 the GP received a phone call from Mr L indicating that he was feeling suicidal and was thinking about hanging himself. The GP made contact with the Crisis Response Team. Mr L was assessed the same day and accepted by the Mental Health Home Treatment Team.

7. At this time Mr L was enjoying contact with his children on a regular basis. On 15 November 2017 Mr L attempted to take his own life using a hosepipe attached to a car exhaust as well as overdosing on medication. He sent some family members texts which as a result of which they became concerned for his welfare. He was found and rescued by a family member and spent 9 days as a voluntary patient at Holywell Hospital receiving treatment for depression and suicidal ideation. He was eventually discharged by the Community Mental Health Team on 30 April 2018. A Consultant Psychiatrist who treated Mr L diagnosed him as suffering from an adjustment disorder with depressive symptoms. The Psychiatrist thought that break-down of his marriage and the removal of his children had caused trauma which had adversely affected Mr L's mental health. According to his GP Mr L continued to take his medication up until his death.

8. When Mr L was discharged from hospital he could not work for a period of time. As a result I was told he was unable to pay Mrs AL maintenance payments that he had done previously. Apparently when he informed Mrs AL of this change in circumstances she refused to allow contact with the children and made an application for an ex parte non-molestation order. His family told me that Mr L was forced to seek the advice of a solicitor and initiated private law proceedings to secure contact with his children. The C1

application, lodged by Mr L on 8 January 2018, mentions Mr L's inpatient stay in Holywell Hospital.

9. FPC proceedings were commenced and included inter alia, reports from a health visitor, a Consultant Psychiatrist and Court Children's Officer (CCO). The papers disclose occasions when contact was arranged and agreed before Mrs AL unilaterally cancelled contact.

10. Mr L began using the Contact Centre on 21 July 2018 to facilitate contact with his children. Initially the FPC allowed Mr L one hour of contact per week which was increased to two hours.

11. On 3 September 2018 a Re L Hearing concluded that there were no safety issues regarding contact with Mr L and his three children – "they are not at risk in his care".

12. After input from a CCO a FPC made an interim order allowing Mr L contact with all three children in the Contact Centre for one hour followed by one hour of contact outside the centre. This was to commence on 16 March 2019 and was to take place at the Contact Centre. I was told at inquest that the CCO was trying to encourage Mrs AL to leave the Contact Centre during contact.

13. Mr L's family told me at inquest that he was really excited to be finally able to enjoy time with all three children outside of the contact centre. He went to a local shop and purchased sufficient car safety seats to be able to take all three children out. His sister-in-law, Mrs BL, was to be with him. She told me at

inquest that in March 2019 she had not seen the children in well over a year as she had not been permitted to see them by Mrs AL.

14. The day before contact was to take place the Contact Centre co-ordinator spoke on the telephone to Mr L and Mrs AL separately to go through arrangements. The co-ordinator told me at inquest that it was agreed with Mrs AL that she would drop all three children off at the Contact Centre and then leave, thus allowing time for them to settle with staff before the arrival of Mr L. This information was also passed to Mr L and Mrs BL. This arrangement was reached purely by consent. The Court Order made no mention of the arrangements since the FPC was never made aware that the parties required any specific direction regarding contact.

15. A volunteer at the centre told the inquest he had no knowledge of this agreement. He said he expected Mrs AL to remain at the centre in the parent's room while contact took place. He could recall no conversation with the co-ordinator regarding this issue. Indeed, I got the impression from his evidence that he assumed all resident parents would stay at the centre while contact was facilitated. The same volunteer told me that he had very little information regarding any users of the Contact Centre prior to their arrival at the centre. He would not receive copies of court orders, judicial directions or the contact centre application form completed by both parties.

16. Mrs AL told me that she did not agree with contact being extended by the FPC to include contact outside the Contact Centre. She said that she intended to stay at the centre for the first 30-45 minutes on 16 March 2019 as the Court Order did not specify that she had to leave despite reaching an agreement with the co-ordinator the day before. I am of the view that Mrs AL staying at

the centre was a deliberate act designed to adversely affect and frustrate contact.

17. What was allowed to occur on 16 March 2019 at contact was, in my view, wholly preventable. Firstly, if problems were expected to occur between the parties this issue should have been raised specifically in court and a direction issued by the FPC. This direction could then have been explained to the parties in Court. Further, serious problems with communication between staff at the contact centre meant that when Mrs AL arrived at the centre, having agreed to leave, she was not expected to leave. In these circumstances she sought to remain and was allowed to do so. I believe a Court Order specifying contact arrangements would have assisted all involved and meant that contact was more likely to be successful. A copy of the order could have been sent to the Contact Centre. I was told that presently it may take some weeks for a copy of the court order to issue and the Contact Centre may never receive a copy in some cases.

18. I was told at inquest by Mrs BL that she expected Mrs AL to have left the contact centre prior to their arrival since that is what she had been told would occur. Indeed, Mrs BL noted that Mrs AL had not left when she arrived at the centre and she delayed her own entrance to see if Mrs AL would leave. Mrs BL told the inquest that initially Mr L was enjoying contact within the centre. Then the supervisor called all three children so that they could spend time outside the centre with Mr L. At some point prior to leaving the centre to spend some time with Mr L, his daughter indicated that she did not wish to leave and asked to remain with her mother. The child ran out of the room where she had been with her father to the room where her mother was located. Mr L, it seems, thought that this had been a pre-arranged action instigated by Mrs AL to frustrate contact. He became very upset and was seen to shout and

curse in front of his two boys. He was warned by a member of staff and spoken to by another parent. He eventually calmed down and enjoyed some contact with his two sons outside of the contact centre. While he was with the boys apparently one of them said he was "cheeky" and "bad L". He also heard one of the boys say that they had a new daddy.

19. The volunteer who witnessed Mr L's behaviour then forwarded a report of the incident to the Contact Centre co-ordinator. In his report he recommended that Mr L be warned about his behaviour but that contact should continue to be facilitated within the centre. Contact Centre staff were not aware that Mr L had attempted to end his life in November 2017 on the background of an adjustment disorder specifically linked to the loss of contact with his children. The information they possessed originated from a form completed by lawyers for both parties prior to contact being permitted in the Contact Centre. This form was not available to be viewed at inquest as it was destroyed in July 2019 I was told in line with General Data Protection Regulations (GDPR). Accordingly I am not able to say exactly what information was provided. At inquest the co-ordinator told me she could recall the form and it did not mention any mental health issues with either party. She said she relied on the parties to inform her of any relevant issues. The co-ordinator said that the Contact Centre did not have any direct communication with the court and thought that a direct line of communication through, for example, a liaison officer would be very useful.

20. In terms of the events of 16 March 2019 the Contact Centre co-ordinator took a different view to that of the volunteer. On 20 March 2019 she sent a short letter to Mr L informing him that his use of the contact centre would be suspended and the CCO would be informed. The letter was addressed to Mr L directly and not to his legal representatives. The letter indicated that a final decision

had yet to be taken and a review was to take place. No further explanation was provided regarding the nature of the review and no mention was made of the FPC or recourse to a court. A similar letter was sent to Mrs AL but this letter made no mention of her contribution to the events of 16 March 2019 when she breached her agreement to leave the centre.

21. At inquest I was told that Mr L was very worried about what had occurred at the contact centre on 16 March 2019. He was concerned that Mrs AL was attempting to frustrate contact and also that his reaction may adversely affect his contact arrangements. He had very little contact with the children since he had separated from Mrs AL and was concerned that his contact would be revoked. Family members said he appeared despondent and almost resigned to losing his contact and having yet more time apart from his children. Mr L received the letter informing him of the suspension of his use of the contact centre on 21 March 2019.

22. Mr L's sister arranged to meet him on 21 March 2019 to discuss the letter. She told me she knew this would upset him and wanted to speak to him about this issue. Mr L left the letter at his solicitor's office. He was unable to speak to a solicitor because they were unavailable. Mr L then went to his sister's house for something to eat. She described him as quiet and subdued. He left his sister's house at 8.45pm.

23. On 22 March 2019 at approximately 5pm Mr L's sister went to visit him at his home address. She noted that his front door was closed but unlocked. She found Mr L hanging from a ligature within a bathroom. A wooden beam of wood had been attached to a roof space opening and a blue rope had been attached. Mr L was found hanging with the blue rope around his neck. Other family members came to assist and Mr L was cut down but it was apparent

that he was dead. A post-mortem examination found that Mr L died as a result of neck suspension from a ligature. He had not consumed any drugs or alcohol before his death. Some notes were found close to his body.

24. Along with a picture of his three children was a lengthy hand written note from Mr L. With the permission of his family I read the entirety of this note at inquest. It is one of the most heart-breaking and upsetting documents I have ever read at an inquest. Mr L outlined his reasons for taking his life. He said that he did not want his children to have to continue to go through the courts and be involved with contact centres. He thought his death would free them from this. Mr L also said that he "just wanted the whole thing sorted out legally. I don't get why one parent can get to keep the children of(sic) the other parent".

25. As part of this inquest process I have examined the entire FPC file. It is my view that Mr L posed no risk to his children. Those issues complained about by Mrs AL during the course of the family proceedings were of a trivial nature. The FPC dismissed her application for a non-molestation order and considered Mr L to be no risk to his children.

Decision regarding suicide.

26. To return a conclusion of suicide the act and the intent must be established on the balance of probabilities. I must be more satisfied than not so that that Mr L deliberately and voluntarily did the act which caused his death and did so with the intent of taking his own life. Suicide can only be the conclusion after other possible alternatives have been excluded. It must not be presumed simply because it seems a likely or the most likely explanation. A Coroner must exclude the possibility that the death was a result of some unexplained accident. Per *Lord Widgery* in ex Parte Barber [1975] 1 WLR 1310

> *"If a person dies a violent death, the possibility of suicide may be there for all to see, but it must not be presumed because it seems on the face of it to be a likely explanation. Suicide must be proved by evidence and, if it is not proved by evidence, it is the duty of the coroner not to find suicide…."*

27. Although intent to die must be established to the required standard there is no requirement for a coroner to determine 'why' a person killed themselves. Evidence of motive (in particular where notes are left) might assist in determining intent, but the coroner is not obliged to discern (still less be sure of) reason or motive for the deceased's action and intention. A coroner can be sure the death was self-inflicted and sure the deceased intended to take his life, but less than sure what had led him to do so.

28. Evidence of intention to die can lie within the circumstances of and leading up to the death as well as by the means of achieving it, the more obviously lethal the means, the more the circumstances may support the inference of an intention to take life.

29. Mr L had received treatment in the past following an attempt to end his life. Based upon what I was told at inquest I am satisfied that this previous attempt was a serious attempt. Indeed, had a family member not attended it seems likely that Mr L would have died from carbon monoxide poisoning. Mr L was being treated for an adjustment disorder and depressive illness approximately 17 months prior to his death. He did not have a recognised mental illness and had not expressed any suicidal ideation in the days or even weeks before his death.

30. There is no evidence that Mr L attempted to tell anyone about his attempt to end his life. No texts were sent to any family members. The letter that he left along with a picture of his children constitutes in my view what is known as a 'suicide note'.

31. Method of death – As I indicated above in certain circumstances the method of death can indicate intention. The more likely that death is going to occur, the higher the intention. Mr L died by placing a ligature around his neck. I am satisfied that he did this himself without assistance. Some degree of planning was required to find a suitable sturdy ligature point within the room and to either purchase or find a suitable ligature. This indicates high intent in my view. I have heard evidence in other inquests to the effect that it is possible for a person to tie a ligature around their neck with no intent to die but for the person to accidently become unconscious due to ischaemia (lack of blood supply to the brain). If the blood supply to head is cut off by a ligature around the neck, unconsciousness might occur within 10 seconds. Once a person is unconscious they are likely to die without assistance in a matter of minutes. I have considered the possibility that Mr L placed the ligature around his neck not intending to die but with the intention of self-harming or for some other reason - what is known as a 'cry for help'. I do not believe this was his intention.

32. Family and future plans can be protective factors for suicide. Mr L had a supportive and loving extended family who were concerned about him. However, at the time of his death he was not in a steady or loving relationship and was embroiled in a court supervised 'custody battle' involving his children. I am satisfied that Mr L felt let down by the Family Justice System and felt an acute sense of injustice especially following the events of 16 March 2019. This, in my view, provided a significant stressor in the days before his death.

33. I have considered all of the evidence and the factors above and I am satisfied to the required standard, that is, on the balance of probabilities that Mr L intended to end his life when he placed the ligature around his neck. I consider that he had experienced suicidal thoughts before. The main stressor leading Mr L to take his own life was the family proceedings and the lack of contact with his children, who he loved very dearly. His letter indicates that he did not see any positive outcome to the family proceedings for him or for the children. I am satisfied, on balance, that Mr L died on the evening of 21 March 2019 not long after returning home.

Conclusions.

34. I decided to hold an inquest into Mr L's death after being contacted by a member of staff from the Contact Centre who was concerned about certain decisions that had been taken, particularly the decision to effectively suspend contact when a volunteer at the centre had expressed a desire to work with Mr L notwithstanding his behaviour.

35. Mr L's family also told me that they feel let down by the Family Justice System. They feel that Mr L's involvement with the FPC played a part in his decision to take his own life.

36. Some of his family members told me at inquest that Mr L informed them that he had been advised he should not be seeking help for mental health issues because this might be used against him in the family proceedings. I heard no direct evidence that this advice had been given to him by his legal representatives. I find it difficult to accept that any lawyer would advise a client not to seek help for mental ill health and I have no evidence that this

occurred in Mr L's case. Nonetheless it could be the case that Mr L himself decided not to seek further help because disclosure of this might affect his application for contact. His family told me at inquest they, and Mr L, felt the court proceedings did not treat him fairly because he was a father. It is possible, therefore, that Mr L concealed issues with his mental health for fear that disclosure would affect his application for further contact.

37. Mr L could not understand how Mrs AL could take the children from him leaving him to fight for contact through the courts. His family feel there should be a presumption in favour of contact for fathers unless something is proven to limit contact. A court found that Mr L's children were not at risk in his care yet he still was only permitted to see them in a contact centre while supervised for a maximum of two hours per week. They cannot understand this. I feel a great deal of sympathy for the family. I can understand why Mr L felt frustrated with the Family Justice System. I can see how it was possible for Mrs AL to frustrate contact leading to feelings of helplessness by Mr L.

38. As I outlined above my role as a Coroner is to inquire as to "how" Mr L came by his death rather than asking "why" he died. However, one of the most important roles of the modern Coroner is to try, where possible, to prevent future deaths. In R v Secretary of State for the Home Department ex Parte Amin, *Lord Bingham* of Cornhill accurately described the function and duty of a modern inquest when discussing the State's obligation to investigate a death in accordance with art 2 of the European Convention on Human Rights. He said;

> *"The state's duty to investigate is secondary to the duties not to take life unlawfully and to protect life…It can fairly be described as procedural… such deaths (are) to be publicly investigated before an independent judicial tribunal*

with an opportunity for relatives of the deceased to participate. The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others."

39. Mr L could be described as a vulnerable individual and someone who, based upon his background, was potentially at risk of self-harm or suicide. I am satisfied that his contact with the Family Justice System and the incident at the contact centre which lead to a decision to suspend his use of the centre acted as significant stressors in the lead up to his decision to end his life.

40. I intend to provide a copy of these findings with a copy of a letter written by Mr L to the Senior Family Judge. I consider that these findings and a copy of the suicide note should be provided to all Family Judges in Northern Ireland to consider. Mr L was a user of the Family Justice System and died by suicide during the course of those proceedings having had no hope that those proceedings were benefiting him or his children. The Family Courts have a focus on the welfare of the child. Mr L's three children will now grow up without a father. His death is a tragedy for his family and for his children. I hope that lessons can be learnt from Mr L's death.

Coroner J McCrisken