



From Hillsborough to Rochdale - How the ECHR Has Helped Victims

Table of Contents

1 – Introduction	4
Bringing Human Rights Home	5
Helping Victims	6
2 - Victims of Crime and the Role of Public Authorities	8
When the State Fails to Protect Life	10
Helping Victims who are Disbelieved	14
Helping Victims who are treated like Criminals	18
Helping Victims when Harassment is Ignored	22
Helping Victims when Justice Must Be Revisited	24
Helping Victims When the State Causes Harm Itself	15
Giving Victims a Voice	30
3 - Victims of State Injustice	34
Article 2 Inquests	35
Jurisdictional Differences	37
Why Inquests are not enough	38
Article 3 and Public Inquiries	38
Correcting the Record: Article 2 and the Right to a Re-investigation	40
Helping Bereaved Families when the State has caused harm	43
Helping the bereaved families of vulnerable children and young people	45
Helping Families to reveal the truth about police failures to protect	48
Helping Victims and Bereaved families establish inquiries	49
Conclusion	55

Acknowledgements

JUSTICE is deeply grateful to the individuals and family members whose stories feature in this paper. Their strength and resilience enabled them to secure access to justice not only for themselves, but also to advance rights that continue to benefit countless others across the UK.

We also thank the lawyers, law firms and law centres who shared their experiences and expertise of using human rights to support their clients, including **Leigh Day, Bhatt Murphy, Southwell and Partners, Aamer Anwar & Co., Duncan Lewis Solicitors, Broudie Jackson Canter, Garden Court North, Matrix Chambers, and Doughty Street Chambers**. We are particularly grateful to **Reed Smith** for their generous support in finalising this report.

We are also grateful to the civil society organisations who supported this project and shared valuable perspectives on the role the ECHR has played in advancing victims' rights, including the **Centre for Women's Justice, End Violence Against Women Coalition, Centre for Military Justice, the Zahid Mubarek Trust, Police Spies Out of Lives, INQUEST, Hillsborough Law Now, Pat Finucane Centre, Victim Support Northern Ireland, Just Right Scotland, and the Committee on the Administration of Justice**.

We also thank the academics **Jamie Grace**, Sheffield Hallam University and **Eamon Keane**, University of Glasgow as well as **DS David Thomason** at the Cheshire Police Harm Reduction Unit.

This report is the product of collaboration across the JUSTICE community. We are grateful to the entire team for their work, support and enthusiasm throughout the project. We thank Legal Fellow **Elisabeth Jennings** for researching and drafting this paper and Senior Legal Policy Officers **Andrea Fraser** and **Philip Armitage** for bringing it to life. We are also grateful to Legal Director **Stephanie Needleman** and **Jessica Kaplan** and **Euan O'Byrne Milligan** for their thoughtful reviews. We also thank the **JUSTICE Board and Council**, whose expertise and commitment to justice make our work possible.



Introduction

The European Convention on Human Rights (“ECHR”) is an international treaty that sets out the basic rights and freedoms everyone should have, like the right to life, freedom of expression, and the right to a fair trial. The original text of the ECHR was drafted in 1949-1950 by the newly formed Council of Europe in response to the horrors of the Second World War, led by British MP and lawyer Sir David Maxwell-Fyfe and with input from Winston Churchill, amongst others.

There are 16 fundamental Convention rights incorporated into UK law. These are arranged into ‘articles’ and are referred to as follows:

Convention rights

- | | |
|---|---|
|  Right to life (Article 2) |  Freedom of expression (Article 10) |
|  Prohibition of torture and inhuman or degrading treatment or punishment (Article 3) |  Freedom of assembly and association (Article 11) |
|  Prohibition of slavery and forced labour (Article 4) |  Right to marry (Article 12) |
|  Right to liberty and security (Article 5) |  Right to an effective remedy (Article 13) |
|  Right to a fair trial (Article 6) |  Right to enjoy each of these rights without discrimination (Article 14) |
|  No punishment without law (Article 7) |  Right to the peaceful enjoyment of property (Article 1, Protocol 1) |
|  Right to respect for private and family life (Article 8) |  Right to education (Article 2, Protocol 1) |
|  Freedom of thought, conscience and religion (Article 9) |  Right to free elections (Article 3, Protocol 1) |

Bringing Human Rights Home

In 1998, Parliament passed the Human Rights Act (“HRA”), which brought the rights set out in the ECHR into UK law – giving ordinary people a way to enforce these rights in UK courts. The HRA requires public authorities to act in a way which respects rights, guided always by the limits set out elsewhere in UK law by Parliament.

It also places active duties on public authorities like the police and local authorities to proactively protect rights. For example, the right to life (Article 2) requires public authorities to take reasonable steps to safeguard lives, create laws that protect life, and take active steps to properly investigate any suspicious deaths and put in place a system to deter and punish those who have killed people unlawfully. These duties also apply to the prohibitions of torture and inhuman treatment (Article 3) and forced labour (Article 4).

Complying with Convention rights does not just mean taking action; it can also require public bodies to refrain from doing something. It requires the state to avoid unjust interference with an individual’s rights. For example, Article 6 (the right to a fair trial) places a duty on public authorities to refrain from interfering with the independence of the courts or undermining the fairness of legal proceedings. Similarly, Article 8 (the right to respect for private and family life) requires public bodies to avoid unlawful or disproportionate interference with a person’s private life, home or correspondence, unless such interference is justified, necessary and proportionate in pursuit of a legitimate aim.

It is because of the HRA and ECHR that individuals can challenge public authorities, whether that is the police, the government, or local authorities, when their rights have been breached. If a public body falls short, a claim can be considered by the courts, and a judge can overturn a decision by a public authority or direct them to stop acting unlawfully. Members of the public who have had their rights breached can also receive compensation under the HRA. These mechanisms empower victims to seek accountability and redress. They also encourage public bodies to improve their practices, because failing to address unlawful conduct leaves them open to further claims.

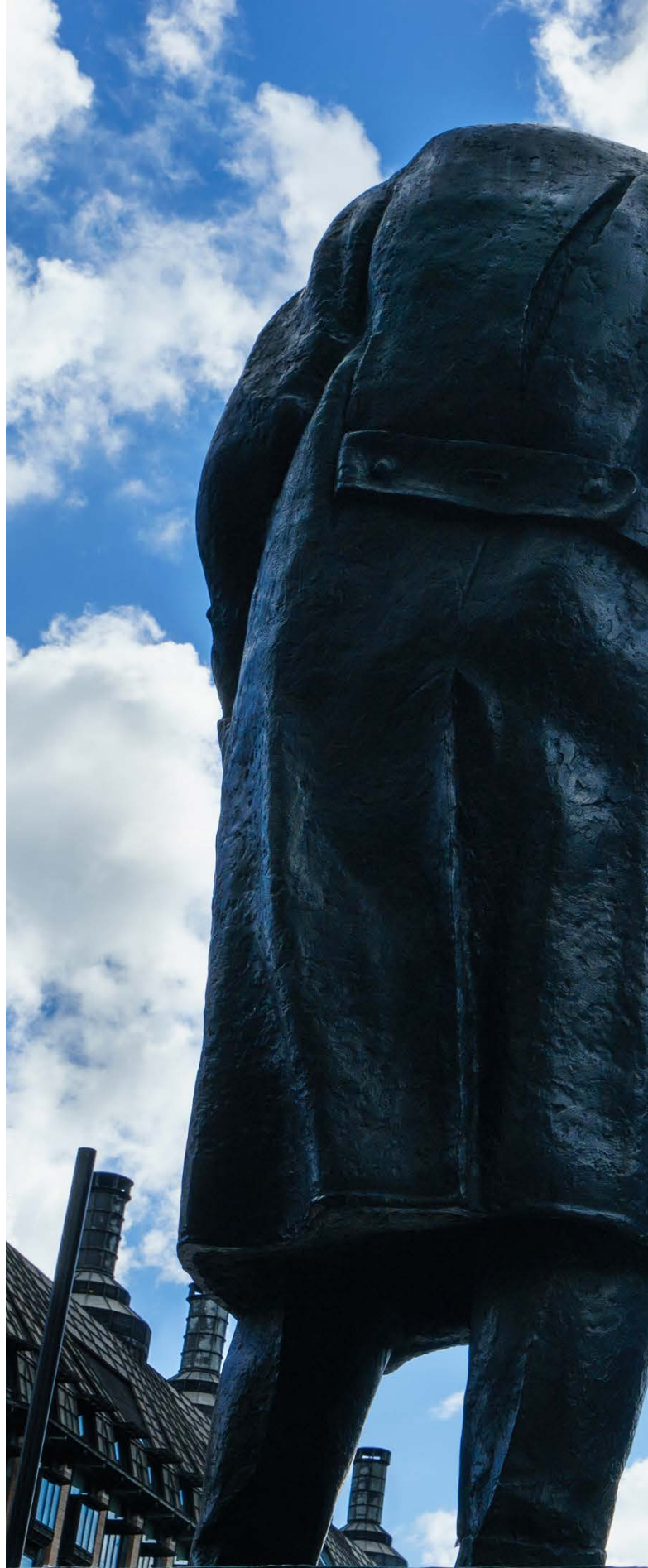
Claims are brought and determined by judges in the UK courts culminating in the Supreme Court—the highest court in the UK. The European Court of Human Rights (“ECtHR”) acts as a final backstop, on appeal from the Supreme Court, available only after all domestic remedies have been exhausted. Being able to enforce rights domestically helps people to avoid the cost and delay of going to the ECtHR in Strasbourg. The relationship between the UK and the Convention also means that UK judges, applying UK law, remain firmly in control of how Convention rights operate in this country. While UK courts must take into account ECtHR case law, they are not bound to follow their decisions unless they agree (unlike lower courts in the UK which must follow the rulings of the Supreme Court). UK judges are well-respected and influential in how the ECtHR approaches human rights.

Helping Victims

The HRA and ECHR protect ordinary people in concrete and practical ways: safeguarding the right to life, protecting privacy and family life, and prohibiting inhuman and degrading treatment. In recent years, these frameworks have significantly strengthened victims' rights, improving investigations into deaths, violence, and abuse, and obliging local authorities to take steps to protect vulnerable individuals from harm. They have also helped improve the behaviour of public authorities by encouraging greater accountability, more careful decision-making, and stronger safeguards for those at risk. Families have been able to challenge inadequate police investigations following the death of their loved ones, securing accountability where there previously was none.

The HRA and ECHR have also provided ordinary people with new and powerful routes to redress. Taking into consideration preventable tragedies such as Hillsborough and the Infected Blood scandal, human rights law has enhanced the scope of inquests and inquiries, while also improving standards of treatment. These mechanisms were not available in the same form before the incorporation of the Convention into domestic law.

Today, victims' rights are significantly stronger because of the HRA and the ECHR.





“[I]n the centre of our
movement stands a
charter of human rights,
guarded by freedom and
sustained by law.”

Winston Churchill, 1948



Victims of Crime and the Role of Public Authorities

Chapter

2

Victims of Crime and the Role of Public Authorities

2

Any victim of a crime can be let down by the state. Mistakes are made, warnings may be missed, and investigations can fall short. That is why a legal framework which holds the police and local authorities to account when things go wrong is so important. Empowering victims to bring human rights claims against public bodies, such as the police and local authorities, has helped drive meaningful improvements, including in police investigations into sexual assault and in local authority protections for children who need to be removed from their parents.

Several Convention rights place clear legal duties on the police and local authorities to take action in certain circumstances.

The right to life (Article 2), the prohibition of torture and degrading treatment (Article 3), and the right to be protected from slavery and forced labour (Article 4), impose core responsibilities on the police and local authorities:

First, a duty to protect people.

Where the police or local authority know, or ought to know, that an individual faces a real and immediate risk of serious harm, they must take reasonable steps to try to protect that person..

Second, a duty to investigate properly.

When someone dies or suffers serious harm, especially in circumstances involving potential criminal conduct or state failure, the police and local authorities are required to carry out an effective investigation.

Third, a duty to operate adequate systems.

The police must have in place effective legal, operational, and administrative systems designed to prevent violations of these rights. This includes proper training, clear procedures, and safeguards.

The right to private and family life (Article 8) further requires public authorities to respect victims' dignity, privacy and family life in how they respond to harm and engage with those affected.

When the State Fails to Protect Victims:

Example: Article 2 and the Duty to Act

One important change introduced by ECHR and HRA is that the police can now be challenged in the UK courts when they fail to act. Before the HRA, the courts said the police did not owe a legal duty to individual victims when investigating or preventing crime. For example, the mother of the final victim of serial killer Peter Sutcliffe (the "Yorkshire Ripper") was unsuccessful in suing the police despite serious and ongoing failures in their investigation.¹ The court stated that there was insufficient proximity between the police and the victim to establish a duty of care. This left victims and families without an effective remedy, even in cases of grave police error. Human rights law has changed this. By imposing duties to protect and to investigate, the ECHR and the HRA ensure that serious policing failures are no longer automatically immune from legal scrutiny:

The case of *Osman v United Kingdom*² established, for the first time, that the police had a duty to prevent loss of life in certain circumstances, and could be held liable for a breach of Article 2 if they failed to do so.

In March 1988, Ahmet Osman was seriously injured when his teacher shot him and murdered his father. The shooting followed a prolonged period of escalating and highly concerning behaviour by the teacher, who had developed an obsessive fixation on Ahmet and his family.

Over time, there were numerous warning signs that the teacher posed a serious danger, including stalking, harassment, and repeated acts of criminal damage. These incidents were known to the authorities, yet the police did not take decisive steps to intervene or to protect the family from the growing risk. Although the Court did not ultimately find a breach of Article 2 on the specific facts, it articulated a landmark legal principle:

Victims can make claims against public authorities on human rights grounds where public authorities knew or ought to have known of a real and immediate risk to the victim's life, yet they failed to take reasonable measures within their powers to prevent it.

This legal threshold is known as the "Osman test".

1 Hill v Chief Constable of West Yorkshire [1989] AC 53 (HL).

2 Osman v United Kingdom (1998) 29 EHRR 245.

The Osman Test in Action

The impact of Osman extends far beyond the courtroom. The principles it established on human rights grounds now underpin police practices for warning individuals of serious risk, including the use of Threat-to-Life Notices, often known as Osman warnings. These are issued where intelligence indicates a credible and imminent threat to life, even when arrest is not possible, and are used in high-risk situations such as organised crime, serious violence, and witness intimidation. Many police forces have also developed their own notification systems to help keep victims safe.

Victim support organisations have highlighted the value of threat to life warnings – particularly in the context of domestic abuse and “honour” based violence.³ Other initiatives have also arisen in the Violence Against Women and Girls (“VAWG”) context which reflect the police’s duty to protect life:

- **Clare’s Law:** The Domestic Violence Disclosure Scheme was implemented nationally in 2014 after the murder of 36-year-old Clare Wood by a former partner with a known history of violence. The scheme enables police to share information about a partner’s past abusive behaviour where this is necessary to prevent harm. Legal / Statutory guidance on Clare’s Law makes it very clear that the ECHR duty should be considered by the police when deciding whether to share information with a partner, in an attempt to protect them from future abuse.

“ Clare’s Law draws a lot of its strengths from a connection with the rights of victims as interpreted in the ECHR”.

(Jamie Grace, Sheffield Hallam University, author of ‘Human rights in policing - the past, present and future.’)

- **Sarah’s Law:** The Child Sex Offender Disclosure Scheme was introduced nationally in 2011 following the abduction and murder of 8-year-old Sarah Payne by a convicted paedophile. It allows parents and carers to ask the police whether a person with access to their child has a relevant history of sexual offending, enabling pre-emptive safeguarding steps to be taken.

Taken together, these developments show how the ECHR has shaped practical measures designed to support earlier intervention and improve protection for individuals at risk of serious violence. It also highlights how the ECHR and HRA have helped drive improvements in policing standards. Knowing that failures to act, or inadequate investigations, may be examined by the courts encourages better decision-making, earlier intervention, and more thorough investigations.

Example: Article 3 and local authorities’ duty to act

Under Article 3, states have an obligation to protect individuals from serious ill-treatment, including by private actors. For children, this means that local authorities must actively intervene – including to remove a child from abusive parents - when they know or ought to know that a child is at risk of serious harm that reaches the Article 3 threshold. This is the case whether the child is still living with their parents or has been placed in the care of the authority.

This was not always the case. Prior to the ECHR and HRA, UK courts held that local authorities generally owed no duty of care to children in the context of child-protection decisions. This blanket immunity has changed thanks to the ECHR and HRA. Victims of parental abuse benefit directly from our human rights laws, including being able to take their cases to the ECtHR when the domestic legal protections (including the common law) did not go far enough - as the following case study demonstrates.

3 End Violence Against Women, ‘How the Bill of Rights harms the fight to end violence against women’, (2022), p.18.

Z and her siblings' Story⁴

The case of *Z v United Kingdom* established that a local authority's inaction to protect children from parental abuse and neglect can amount to a breach of their Article 3 rights.

The applicants were four siblings from Rotherham—two boys and two girls—who, at the start of the events giving rise to the legal challenge, were aged between one and five years old.

Over a five-year period, the children were subject to severe abuse at the hands of their parents. Social services were first alerted in 1987 after one child was caught stealing food and showed signs of neglect, including poor hygiene, hunger and developmental delays. Over the following five years, the local authority received numerous reports from professionals, schools, medical practitioners, neighbours, and police officers describing severe neglect and abuse. The children were frequently reported as arriving at school dirty and hungry and suffering from untreated medical conditions. Neighbours reported screaming and violence within the home.

Despite the evidence and at least 11 professional meetings and conferences, the local authority did not take protective action to remove the children from their parent's care. It was not until December 1992, that the children were placed into emergency foster care, after their mother threatened further violence if they were not taken away.

In 1993, the children brought a claim in the domestic courts alleging negligence and breach of statutory duty by the local authority, arguing that its failure to act had caused them serious psychological harm. The House of Lords dismissed their case, finding that local authorities generally owed no duty of care to children in the context of child-protection decisions, such as whether to begin care proceedings or remove a child from home.

The children subsequently applied to the ECtHR. It held that the local authority's prolonged inaction violated Article 3, finding that it had failed in its obligation to take reasonable steps to protect the children from inhuman and degrading treatment.

The Court also found a breach of Article 13 because, under UK law, the children could not bring a negligence claim - a civil claim alleging that a person or public body breached a duty of care - and were therefore deprived of an effective remedy. Each child was awarded £32,000 in damages.

This case, alongside the introduction of the HRA, means that even where children cannot succeed in negligence claims, they may still challenge a local authority's failure to protect them by relying on their Convention rights.

4 *Z v United Kingdom* (2001) 34 EHRR 3.



Victim's stories

The following case studies provide further examples of how victims have relied on their rights when the police or local authorities have ignored clear warning signs that someone is in danger; failed to respond properly to serious allegations; or carried out a poor quality or delayed investigation.

2

Helping Victims who are Disbelieved: Sexual Violence and Article 3

Human rights have helped victims of serious sexual violence – including the victims of Worboys - to hold the police to account for failing to take their police complaints seriously and conduct proper investigations.

DSD and NBV's Story⁵

DSD and NBV were among the many women sexually assaulted by London black cab driver John Worboys. He is believed to have committed more than 100 rapes and sexual assaults between 2003 and 2008. Both women reported their attacks to the police – DSD in 2003 and NBV in 2007, but each struggled to have her account taken seriously and felt that the police did not believe them.

DSD and NBV were among the many women sexually assaulted by London black cab driver John Worboys, who is believed to have committed over 100 serious sexual offences between 2003 and 2008. Both women reported their assaults to the police - DSD in 2003 and NBV in 2007 - but each felt that their complaints were not taken seriously.

DSD returned to the police at least four times to raise concerns about Worboys and the risk he posed, yet her case was closed in 2004 without a proper investigation. NBV's complaint was also closed in 2007 and was only reopened after an article in The Sun newspaper linked a series of similar attacks to a suspected "black cab rapist."

The two women brought a claim against the Metropolitan Police for their alleged failure to conduct an effective investigation into John Worboys' crimes. The Supreme Court examined how the police handled their reports and found serious investigative failures. The police had failed to record information in reports of crimes, failed to promptly interview witnesses, failed to collect CCTV evidence and failed to link complaints from multiple victims to one man.

The women brought a claim against the Metropolitan Police, arguing that the police had failed to carry out an effective investigation under Article 3 of the Convention. The Supreme Court identified serious investigative failings, including failures to record evidence properly, interview witnesses promptly, collect CCTV evidence, and link multiple complaints pointing to the same offender.

The Court held that these failures breached Article 3 of the Convention, which requires the police to carry out effective investigations into serious allegations of harm. DSD and NBV won their case, establishing that egregious investigative failures can amount to a breach of human rights.

This case makes clear that the police may be held accountable where serious failures in investigation expose others to a real risk of further harm. It has strengthened protections for victims and reinforced the importance of thorough and proactive policing in cases of serious violence and sexual abuse.

5 Commissioner of Police of the Metropolis v DSD and NBV [2018] UKSC 11.

“ The Human Rights Act is often the only legal tool we have to hold authorities accountable when they fail to tackle violence against women - leaving the ECHR would undermine that. In the Worboys case, we relied on the ECHR to establish a new legal precedent: police should be held responsible when they fail to investigate serious crimes - and victims who suffered as a result may be entitled to compensation. If we leave the ECHR, that principle disappears with it, letting the state off the hook and denying victims access to justice” (Harriet Wistrich, DSD and NBV’s lawyer, Centre for Women’s Justice.)

“ The experience of being disbelieved and failed by the police was as bad, if not worse, than being a victim of Worboys. I brought this case not just for myself but because the police should be held to account when they have failed so badly.”⁶ (DSD.)

“ The way I was treated by the police probably had a worse impact on me than the original rape. I brought the case because I did not want any other woman to go through what I did.”⁷ (NBV.)

DSD and NBV’s human rights challenge directly enabled many more victims, including those with additional support needs, to hold the police to account where they fail to investigate allegations of sexual assault:

C’s Story⁸

C, a young woman with Asperger’s syndrome, was raped by a stranger following a night out in Northern Ireland. She reported the assault to the police, but the investigation that followed was marked by serious and prolonged failures.

Despite being told that C’s belongings had been left at the location where the rape occurred, police failed to secure CCTV footage or recover potential evidence. No immediate statements were taken from people who had been with her that night, and opportunities to identify further witnesses were missed. C herself was not interviewed until six months after the incident, and forensic evidence was not submitted for analysis for over five months. The investigating officer also lacked specialist training in the investigation of serious sexual offences.

C brought a legal challenge against the Chief Constable of the Police Service of Northern Ireland, arguing that these failures amounted to a breach of her rights under Article 3. The High Court agreed. Applying the principles established in the DSD (Worboys) case, the Court held that the investigation fell far below the standard required for allegations of serious sexual violence and that the failures were so serious as to amount to a breach of C’s human rights.

C was awarded £16,500 in damages for the police’s “egregious” errors. Following the judgment, the Police Ombudsman recommended misconduct proceedings for two officers, who accepted that the investigation had been inadequate. Two more senior officers received advice and guidance due to failures in supervision.

6 H. Wistrich, ‘My clients were John Worboys’ victims. The bill of rights would undo their victory,’ (The Guardian, September 2022).

7 Ibid

8 BBC News, ‘Alleged rape victim awarded £15k over PSNI failings,’ (13 January 2020).

Human rights challenges have led to the implementation of safeguards by the police to ensure that rape allegations are not dismissed:

Laura's story⁹

"Laura" was 17 years old when she was raped on a night out with friends by an unknown, older man. Her mother reported the assault to the police within hours. Laura told officers that the t-shirt she had been wearing during the attack might contain her attacker's DNA.

Despite this, the police did not take Laura seriously. They did not send her t-shirt for forensic testing and later closed the investigation without telling her. Rather than pursuing her attacker, the police began a covert investigation into Laura herself believing her to have perverted the course of justice by lying about the attack.

Laura was later asked to attend a police station, which she believed was to provide further evidence. Instead, she was arrested and told that it was because she had lied about being raped. The impact of this treatment was devastating. While the possibility of criminal charges against her remained, Laura attempted suicide on two occasions.

It was only later, when a new team of officers reviewed the case, that Laura's account was taken seriously. The t-shirt she had identified as potential evidence was properly tested for the first time. The results confirmed that she had been raped. Her attacker was charged and ultimately convicted - the outcome that should have followed from the original report.

Laura brought a claim against the police force responsible for the initial investigation, relying on the Human Rights Act. She argued that their failure to investigate her rape breached Article 3, which requires the state to protect individuals from inhuman and degrading treatment through effective investigation of serious violence. The police force settled the claim, admitting liability and apologising to Laura. They also introduced new safeguards requiring any decision to stop a rape investigation or release a suspect to be reviewed by an independent panel chaired by an assistant chief constable.

“ The only way victims of crime can seek justice for these sorts of issues is using the Human Rights Act, which imposes a duty on the police to properly investigate very serious offences.”

(Debaleena Dasgupta, Laura's lawyer)

9 End Violence Against Women, How the Bill of Rights harms the fight to end violence against women, (2022), p.17.

Human rights have helped to achieve justice for children following failures to prevent sexual assault taking place in school:

Joel's story

"Joel", a six-year-old boy, was sexually assaulted and threatened by a classmate outside of school. The abuse began with an incident outside school, which his mother reported to staff; however, the school assured her he would be safe and kept the boys in the same class.

Joel's behaviour deteriorated, prompting further meetings where his mother raised concerns about supervision and social services' involvement; the family later learned the incident was never reported. The local authority dismissed the off-site assault as normal exploration between children, while the school deemed monitoring sufficient. After counselling, Joel disclosed additional assaults by the same child on school premises, including in the bathrooms.

Joel's mother brought a claim against the school and the local authority, alleging that her son's Article 3 and 8 rights had been breached and that both bodies had acted negligently. She said that both the school and local authority had failed to properly investigate Joel's sexual abuse and failed to put measures in place to prevent further sexual assaults.

In August 2021, the school and local authority conceded that they had breached their duties to Joel, and he received a damages award in the tens of thousands of pounds.

“ Joel's case is a prime example of what authorities ought not to do once a disclosure of harmful sexual behaviour has been made. The claim, which was argued in both negligence and breach of his human rights, was brought as a result the failures to investigate and to prevent further assaults and eventually concluded with a payment of compensation to Joel” (Andrew Lord, Joel's Lawyer, Leigh Day)

Helping Victims who are treated like Criminals: Exploitation, Trafficking and Article 4

Human rights have empowered children to hold the police to account for failing to investigate forced labour:

Child A, B and C's Story

Four Nigerian girls were trafficked into the UK as children and forced to work as unpaid servants.¹⁰ They were just 11, 14 and 15 years old, and placed in private homes where they were forced to care of other people's children and work long hours doing demanding domestic labour.

All of the girls were physically abused in the homes where they worked. One girl was hit with shoes, rulers, and wooden ladles, and told she would be arrested if she spoke to the police. Another was stabbed in the head with a meat cleaver and beaten unconscious. A third was slapped and pinched and later cast out when she became too ill to work after surgery.

Even though these allegations were raised with the Metropolitan Police several times, no proper investigation took place. One of the girls even went to the police herself and told them she was being treated like a slave, but because her abusers denied the allegations, officers took no further action. With nowhere else to go, she had to return to the home where she was being abused.

The girls later challenged the inaction of the police in court using the HRA, saying that the police had breached their rights by failing to investigate their reports for over two and a half years. The police tried to argue that it had not been possible to start an investigation because the women had not cooperated, but the court rejected this. It found that the police had done "nothing to commence an effective investigation" and that they only acted when faced with the threat of legal proceedings.[1] The court also found that the police apparently did not believe the women because they thought they were exaggerating their accounts to achieve some kind of immigration benefit.

The court concluded that the young girls' rights under Article 4 ECHR, which protects individuals from slavery, servitude, and forced labour, had been breached. The girls received a formal declaration that the police had acted unlawfully and were awarded £5,000 each in damages.

10 Ibid, p.20.; O.O.O. and Others v Commissioner of Police for the Metropolis [2011] EWHC 1246.

Human rights have exposed and challenged police failures that allowed child sexual exploitation to continue unchecked:

Amber, BXW and Daisy's Story¹¹

"Amber", "BXW" and "Daisy" were among a group of girls groomed, trafficked and sexually abused in Rochdale in the early 2000s by organised groups targeting vulnerable children. They were subjected to rape, sexual assault, trafficking, physical violence, kidnapping, and forced prostitution over several years.

Amber was first groomed at 14 and subjected to repeated sexual abuse and trafficking. Despite being known to the police and registered as a child at risk on the Child Protection Register, no effective steps were taken to protect her. Instead, she was later arrested on suspicion of inciting prostitution, although not charged. Her younger sister, BXW, was first abused at 12. From 2008 onwards, the police received clear information about the abuse she was suffering but failed to intervene.

Both sisters later gave extensive evidence to the police during Operation Span, identifying multiple perpetrators. Despite this, very few prosecutions followed. Amber later discovered that none of the offences she reported had been formally recorded and none of her abusers charged.

Daisy's abuse also began when she was around 12. She made repeated attempts to report serious sexual violence, including an incident in which she was injured after refusing sex at a party. When the police arrived, they did not believe her, and when she became distressed, they arrested her, and she was later convicted of disorderly behaviour. This was one of several occasions over three years where Daisy tried to report abuse, and the police failed to act.

Across all three cases, the police repeatedly failed to respond to clear evidence of child sexual exploitation, allowing the men who abused these girls to continue harming them.

In 2019, Amber, BXW and Daisy brought claims under the HRA against Greater Manchester Police ("GMP"), arguing that repeated investigative failures breached their duties to protect victims of serious sexual exploitation and trafficking under Articles 3 and 4.

In 2022, the Chief Constable formally apologised and acknowledged the extent of the failures, and the women received a settlement of damages. This was the first time that the police formally recognised the extent of their failings. The girls also received damages.

11 Centre For Women's Justice, Rochdale Grooming Survivors Win Historic Victory, (April 2022.)

This case, taken together with reviews and investigations into grooming gangs in Greater Manchester, contributed to increased scrutiny of child sexual exploitation and a significant expansion of investigations by GMP, which by 2025 reported more than 1,000 suspects and over 700 victims linked to ongoing child sexual exploitation investigations.¹²

“ I feel like this is the first time I’ve really been seen and publicly recognised by authorities as an innocent child victim who needed protection. The way I was treated at the time had a terrible impact on my life, for years after the abuse ended. As a victim I should never have been treated the way I was, so it is a relief, after all these years, that the police have finally recognised that” (Amber.)

“ I don’t know if I believe that Greater Manchester Police have really changed their ways as they say they have, but I’m happy that they’ve taken into account their failings and there’s finally been some accountability. It’s been 10 years since Operation Span and until now, they’d never accepted what really happened. If we’d never found lawyers I don’t know if they ever would have apologised to us.” (Daisy.)

“ It is extraordinary what these three women have achieved after all they have been through. We hope that today’s outcome will serve as a reminder to Greater Manchester Police, and other police forces, that they will be held to account if they fail to protect vulnerable children from exploitation and abuse.”

(Kate Ellis, Amber, BXW and Daisy’s Lawyer, Centre for Women’s Justice)



12 Hannah Al-Otham, ‘Greater Manchester police investigating over 1,000 grooming gang suspects’, (The Guardian, 3 July 2025).

Human rights have shaped how the police and CPS respond to child trafficking, requiring them to check for signs of trafficking and guard against wrongful prosecution:

VCL and AN 's Story¹³

VCL and AN were Vietnamese children who were trafficked into the UK and forced to work in cannabis factories. When police discovered them at the sites where they were being exploited, both boys were arrested, charged with drug offences, and prosecuted as offenders.

VCL told police he was 15 years old and had been smuggled into the UK before being forced to work by traffickers. AN, aged 17, explained that he had been taken to a cannabis farm and pressured to work without pay. These accounts gave rise to clear indicators of trafficking from the outset. Despite this, both boys pleaded guilty on legal advice and were sentenced to detention in young offenders' institutions.

The Home Office later formally recognised both boys as victims of trafficking. However, the CPS reviewed the cases and chose to continue the prosecutions, rejecting the trafficking findings without giving adequate reasons.

The boys challenged their convictions, arguing that the authorities had failed to investigate whether they were victims of trafficking and had therefore failed to protect them. The ECtHR ultimately agreed. It held that there was a credible suspicion of trafficking from the moment of arrest, which triggered a duty under Article 4 ECHR (the prohibition of forced labour) to carry out a prompt and effective assessment before decisions to prosecute were taken. Proceeding with the prosecutions without doing so breached Article 4. The Court also found a breach of Article 6 because the criminal proceedings were unfair.

The Court made clear that prosecuting individuals who are known, or ought to be known, to be victims of trafficking may be incompatible with a state's duty to protect them. The judgment has had important practical effects, requiring police to investigate credible signs of trafficking at an early stage and requiring the CPS to provide clear, reasoned justification where it disagrees with a formal trafficking decision.

“ VCL is a ground-breaking judgment for victims delivered by the ECtHR, in which Article 4 ECHR was pivotal in securing protection for victims of forced criminal exploitation, by imposing a duty on authorities to identify and assess trafficking indicators before prosecution, and has since had a positive, wide-reaching and significant impact on subsequent cases in this area.”

(Philippa Southwell, VCL's Lawyer, Southwell & Partners.)

13 V.C.L and A.N v. United Kingdom (2021) ECHR..

Helping Victims when Harassment is Ignored: Coercive Control, Stalking, State Responsibility and Articles 3 and 8:

Human rights have helped stalking victims to secure police investigations:

Claire's Story

Claire Waxman, now the Victims' Commissioner for England and Wales, was subjected to serious and persistent stalking and harassment by a man she met while at college. The harassment continued for more than a decade and had a profound impact on her safety, wellbeing, and daily life.

Over the years, the perpetrator was convicted of harassing Claire and received suspended and custodial sentences as a result. He was also subject to a restraining order. Despite this, the behaviour continued. He repeatedly attempted to misuse the legal system to harass her further and breach his restraining order, issuing civil proceedings against Claire in 2006 and again in 2010. The restraining order was in place to prevent her stalker from making direct or indirect contact with her and storing or retrieving information about her. Both claims were struck out as having no merit, and he was eventually made subject to a civil restraint order, preventing him from bringing further claims without a judge's permission.

After one complaint to the police, the CPS charged the perpetrator with breaching the restraining order by attempting to issue new legal proceedings. However, the CPS later decided to drop the case, expressing concern that prosecuting him might interfere with his right of access to the courts. The case also involved attempts by the perpetrator to rely on personal information about Claire in order to bring the vexatious claims

Claire challenged that decision under the HRA. The High Court found that the CPS had failed to properly protect her rights, given that, in certain circumstances, Article 8 - the right to respect for private and family life-can impose a positive obligation on the state to provide an effective criminal remedy. The Court emphasised that vulnerable individuals who are subject to persistent harassment are particularly entitled to effective protection.

The Court held that the CPS had breached that duty by failing to pursue the prosecution and awarded Claire damages. The judgment confirmed that public authorities must take effective and practical measures to protect victims of long term stalking, even where doing so limits a perpetrator's claimed rights. The Court awarded damages, recognising the alarm and distress caused by the CPS's failure to act.

“ This was a landmark judgment for stalking victims. By applying the Human Rights Act, the court made clear that stalkers do not have a right to use the courts as a tool to continue their abuse. Thanks to this case law, I have seen first-hand how other stalking victims have been protected as a result” (Claire Waxman, now Victim's Commissioner.)

Lewis' Story

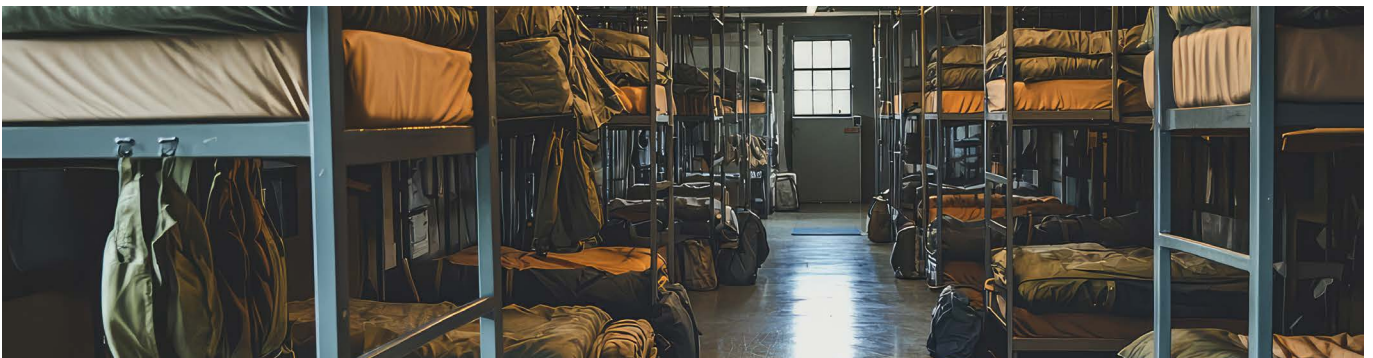
"Lewis", a 36-year-old British Army veteran, was subjected to a prolonged campaign of stalking and harassment by his ex-girlfriend. After their breakup in 2022, she targeted him both directly and indirectly for several years. She contacted his family, colleagues, and friends with false stories about him – setting up groups online to share the information further. She also impersonated him online, stole money from his bank account, and gave away his dog without permission. The harassment left Lewis increasingly isolated, as he changed his phone number, stopped contact with his children and eventually left the UK to escape the abuse.

Between 2022 and 2025, Lewis reported the stalking to the police many times, providing over 100 pieces of evidence, including photographs, letters, phone recordings and transcripts of messages, testimony from witnesses and detailed timelines. Despite this, no investigation was opened – a witness statement was never taken. On one occasion, officers suggested that, as a man, he could not genuinely feel at risk and that his ex-girlfriend had a right to "voice her opinion" online.

Believing he was treated differently because he was male, Lewis continued to press for action. After researching human rights law, he explicitly notified the police of their positive investigative duties under Articles 2 and 3, and that continued inaction risked breaching those obligations. Only then did officers take a witness statement and begin an investigation - four years after the harassment began.

While long overdue and not erasing the harm or displacement Lewis endured, it was the first time his case was taken seriously and showed how invoking human rights duties can prompt a proper policing response.

“ I knew nothing really about human rights until I started looking into it and reading about them. I saw that other people had had their domestic violence cases re-opened because of them. When I read about the right to life and the right to private life, it felt like a lightbulb moment. It gave me a way to communicate with the police to make them understand what I was going through and take me seriously.” (Lewis.)



Helping Victims when Justice Must Be Revisited: Re-opening Investigations, Accountability, and Article 2:

Human rights prevent historic killings from being exempt from further scrutiny when credible new information emerges:

Trevor's Story¹⁴

Trevor Brecknell was killed in December 1975 when loyalist gunmen attacked Donnelly's Bar in County Armagh, firing automatic weapons and throwing a bomb into the building. Trevor Brecknell and two others were killed.

Trevor's widow, Ann Brecknell, was contacted by police shortly after the attack and told that the suspects were known but could not be prosecuted. For many years, the family believed that the investigation had been inadequate, particularly amid concerns about possible collusion between security forces and paramilitaries.

In 1999, significant new information emerged from John Weir, a former RUC sergeant and convicted murderer, who made detailed allegations about security force involvement in a series of killings, including the attack that killed Trevor Brecknell. Despite the seriousness of these allegations, the authorities did not reopen the investigation or take operational steps to pursue the new evidence.

Ann Brecknell brought a claim to the ECtHR, arguing that the United Kingdom had breached its obligations under Article 2 ECHR by failing to investigate her husband's death in light of the new material. The Court agreed. It held that where credible and relevant new evidence comes to light, the authorities may be required to reopen or pursue further investigative steps, even many years after the original death.

This judgment established what has become known as the "Brecknell test": if new information emerges which could materially advance an investigation, the state's investigative duty under Article 2 may be revived. It has often been relied upon in appeals in Northern Ireland and at the Supreme Court to re-open former investigations.

Although Brecknell arose from a historic killing in Northern Ireland, the principle it established -that the Article 2 investigative duty may be revived where credible new evidence emerges-has been applied more broadly in non-legacy cases involving deaths in custody, healthcare failures, and police omissions, even where courts do not expressly refer to it as the "Brecknell test."

14 Brecknell v United Kingdom (2007) ECHR.

“ I remember the day we heard that we had won our case against the UK government, it was an emotional day, there were lots of tears when I went to tell my mother. This was a vindication that our family’s fight for truth and acknowledgement was important. Acknowledgement of the wrong-doing not only by those who had carried out the act but also those that had not done enough and were continuing to not do enough to bring them to legal justice. As the implications of the judgement rolled out over the years and the significance the case has had in relation to legacy cases here in Ireland and elsewhere we have a sense that taking the case was the right thing to do. It is important to hold the state to account and that is even more important in these turbulent and disturbing times. Hopefully this judgment can bring some level of truth, justice and acknowledgement to other victims and survivors and give people hope that the law can prevail even in the darkest of times.”

(Alan Brecknell, Son of Trevor.)

Allan’s Story

Allan Marshall was 30 years old when he died after being forcibly restrained by Scottish Prison Service prison officers in HMP Edinburgh in March 2015. His family spent years seeking answers about what happened to him, repeatedly let down by the very public bodies responsible for his safety and for investigating his death.

In 2019, a Fatal Accident Inquiry found his death was “entirely preventable” and that officers’ evidence was “mutually and consistently dishonest,” yet no individual prosecutions followed due to the broad immunity previously granted to the 17 officers involved in restraining Allan. Following the FAI and a review of the case, the Lord Advocate concluded there were grounds to investigate the Prison Service itself for potential corporate homicide, but still no charges have been brought.

Against this backdrop - no prosecutions, serious criticisms of the evidence, and a lack of accountability - Allan’s aunt brought a human rights claim to establish legal responsibility and force an effective, independent examination of what had happened. With the help of JustRight Scotland, the family overturned an initial refusal of legal aid and brought proceedings against the Scottish Prison Service, Police Scotland, and COPFS under Article 2.

At an unprecedented hearing in September 2025 at the Court of Session, the Scottish Prison Service admitted that it caused Allan Marshall’s death through unnecessary and excessive force used by prison officers. The Crown Office and Police Scotland likewise admitted that they had failed to adequately investigate his death, ensuring that those responsible were held accountable, in breach of Article 2.

The court has been asked to issue formal declarations recognising these breaches, along with a written Opinion setting out the factual and legal basis for its decision so that the reasoning is available in a published judgment.

In addition, the court will determine the level of damages to be paid by the Scottish Prison Service to Allan's aunt, Sharon McFadyen, who raised the HRA claim. Damages payable by Police Scotland and the Crown Office have already been agreed, and a final decision from the court is expected in the coming months.

“ We (myself and Alistair, Allan's brother) have been fighting for justice for Allan for over ten years, since the day he died.

We thought criminal charges would be brought against the prison officers after the FAI, but the Crown had granted immunity to all SPS staff for anything that happened the day Allan was restrained, so no criminal charges could be brought against them. That was shocking to us, and it felt as if they were treating us and Allan like we were not important and had no rights.

The only possibility left was raising a Human Rights case, to try to get some form of justice for Allan. When I first tried to do that, I was badly let down by the Scottish Legal Aid Board (SLAB), as they refused me legal aid to raise a Human Rights claim, even though I was eligible. They said the FAI was enough, even though it didn't change anything or hold anyone responsible.

When I found human rights lawyers at JustRight Scotland, they were able to challenge SLAB, I got legal aid and was finally able to raise this case. It should not have been that hard. The court's order means we finally have official acknowledgement that Allan's rights were breached by the Scottish Prison Service, and by Police Scotland and the Crown Office. It doesn't bring Allan back to us, and it doesn't give the accountability that criminal charges could, but it does give us some closure, and we hope it will help others.”

(Sharon MacFadyen, Allan's aunt.)

“ The Marshall family should not have had to fight for over ten years to obtain acknowledgment that Allan Marshall's rights were breached. Their determination has secured this outcome, which sets an important precedent, confirming the obligations on our public institutions, both those who hold people in their custody, and those who are responsible for investigating deaths.”

(Barbara Bolton, Legal Director and Partner at JustRight Scotland.)

Helping Victims When the State Causes Harm Itself: Abuse of Power and Articles 3 and 8

Human rights have held the police accountable for serious abuses of power in undercover operations:

Kate's Story¹⁵

Kate Wilson met Mark Kennedy in 2003 at a public meeting in a community centre in Nottingham. Kennedy was ten years older, personable and appeared to share Kate's political interests and values. The two became close and began a long-term romantic relationship lasting for more than a year, during which period they also spent time living together. Even after their relationship ended, Mark remained a significant part of Kate's life.

Yet in 2010, Kate learned that the man she had shared her life with had never really existed. "Mark Kennedy" was in fact an undercover Metropolitan Police officer, deployed for several years to infiltrate political groups, including the climate justice movement in which Kate was active. As part of this covert operation, Kennedy had deceived a number of women into intimate and sexual relationships. Kate was never told that she was under police surveillance, nor that her relationship formed part of a policing operation.

Kate brought legal proceedings against the Metropolitan Police, arguing that the undercover operation had breached multiple human rights. The case was heard by the Investigatory Powers Tribunal, which examined how the operation had been authorised, supervised and conducted, as well as the impact it had had on Kate's life.

The Tribunal found that the police had committed a "formidable list" of human rights breaches. It ruled that the sexual relationship itself amounted to inhuman and degrading treatment under Article 3; that Kate's right to respect for her private and family life had been violated (Article 8); that the operation involved sexist discrimination (Article 14); and that it unlawfully interfered with rights to freedom of expression and assembly (Articles 10 and 11). Crucially, the Tribunal also found that the Metropolitan Police had failed in their positive duty to protect women from the foreseeable risk posed by undercover officers forming sexual relationships with them. And that there had been a "lack of care about the impact on women" at senior levels of policing responsibility.

Kate was awarded £225,971.96 in damages for the multiple human rights breaches that she suffered, the largest ever awarded in the Tribunal, recognising the profound harm that she suffered and the systemic failings exposed by her case.

“ I needed answers and bringing this case against the police was a way of fighting back, taking back control of the story of my life.

The other reason we brought the case was to try and make sure it didn't happen again. In the beginning, that meant that no other women should be abused in the way that we were, but it's got a lot broader than that, over time.” (Kate.)

15 Police Spies Out of Lives, 'Kate's Story.'

Human rights have given people a way to challenge degrading treatment at the hands of the police and unjustified search and entry:

Duane's Story

In April 2021, Duane Binns was stopped by a Metropolitan Police officer who claimed that he could smell cannabis. As the encounter escalated, Duane was handcuffed, tasered, arrested, and taken into detention, where he was strip-searched. His home was also searched.

Duane challenged the police action in civil proceedings. A jury found that the officer had lied about smelling cannabis in order to justify the stop and search, and had misrepresented his reasons for the arrest. The jury concluded that Duane's detention and everything that followed - including the use of force, the strip search, and the search of his home - were unlawful.

Crucially, the jury also found that at every stage of his interaction with the police, Duane was treated differently because of his race. The actions taken against him were motivated by racial discrimination, and amounted to a serious abuse of police powers. Duane was awarded substantial damages.

Two aspects of the claim relied directly on the Human Rights Act. First, the decision to strip search Duane engaged Article 3, which protects individuals from inhuman and degrading treatment. The jury accepted that an unlawful strip search is not merely a physical intrusion, but a profoundly degrading experience that can cause lasting psychological harm.

Second, the unlawful search of Duane's home engaged Article 8, which protects the right to respect for private and family life and the home. Rather than relying solely on domestic common law, Duane's relied on Article 8 to reflect the deeper harm caused when the state arbitrarily intrudes into a person's home life.

This case demonstrates how the ECHR protects victims not only from failures to act, but also from active misconduct by the police. It shows the importance of the Human Rights Act in holding the police to account where misuse of power, racial discrimination, and degrading treatment occur during routine policing encounters.

“ The Human Rights Act added a dimension to this case which built on the domestic and common law in recognising and defending key individual rights to personal integrity and the protection of one's home. There is perhaps also an irony also in the fact that if a claim in trespass cannot be made out eg. if the police have raided a home on the basis of bad information rather than bad faith, the European Convention rights in Article 8 offer the only means of defending the principle that ‘an Englishman's home is his castle’”

(Carolynn Gallwey, Duane's Lawyer, Bhatt Murphy Solicitors.)

Human rights have exposed the mistreatment of adults with learning disabilities in state-funded care homes and given families a way to challenge it:

Ben's Story

Ben, a young adult with autism and learning difficulties, lived in a care home in Devon for 17 months from 2010 to 2011. During that time, Ben was mistreated by the staff there. He was forced into a "quiet room," a small, locked room without natural light, a bed, or toilet facilities, at least 117 times. Ben was sometimes left there overnight and would often cry, scream, self-harm and sometimes wet himself but staff did not come in or let him out.

The staff also repeatedly used physical restraints on him, and he was denied family visits or phone calls when he had not complied with staff orders. There was one occasion when Ben was not allowed to see his mother for 42 days and was told that she had died. He was later diagnosed with Post-Traumatic Stress Disorder stemming from his experiences in the care home.

Ben brought a claim under the HRA against Devon County Council, arguing that he was subjected to inhuman and degrading treatment at the care home and that his Article 8 right to family life had been breached. The care home admitted that Ben's Article 3 and 8 rights were breached. They also admitted that Ben's mother's right to a family and private life was breached due to her inability to see Ben while he was at the care home.

The care home agreed to pay compensation and make formal apologies to Ben and Claire.

“ People with learning disabilities and their families have the same human rights as everyone else to be free from harm and abuse, and to have a family life. Whilst this settlement is a landmark, we know sadly that the breaches of human rights underpinning it are far from rare, Ben is not the only person with learning disabilities, and we are not the only family, to have our human rights breached.

We hope that other families can benefit from this outcome, to champion their own rights and challenge human rights breaches.”

(Ben's sister, Emma)

“ It is a testament to the tenacity of Ben's family that the bodies responsible for his placement accept that his rights were breached by the cruel and inhumane regime of “care” at Veilstone.

Ben's mother Claire has fought tirelessly for recognition that she was unlawfully deprived of contact with her son, and it is right that the State bodies accept that this breached Claire's own human right to a family life.

The rights of learning disabled and autistic people like Ben to live good, fulfilled lives, must be upheld by the State. Ben's case is a stark reminder of the devastating consequences that occur when institutions fail to uphold human rights protections and ignore the concerns of families.”

(Catriona Rubens, Ben's Lawyer, Leigh Day.)

Giving Victims a Voice: Privacy, Dignity and Participation under Article 8

Human rights have encouraged courts to take greater account of victims' privacy when considering disclosure of personal records:

WF's Story¹⁶

This case arose from criminal proceedings in Scotland involving allegations of domestic abuse. During the case, the accused asked the court for permission to recover WF's medical, psychiatric and counselling records, held by the NHS and other third parties. These records covered many years and went far beyond the immediate issues in the case.

WF was deeply concerned about the impact that disclosure of such highly personal information would have on her privacy and dignity. At the time, however, the Scottish legal system did not clearly recognise a victim's right to be heard or legally represented when a request was made for access to their medical records. WF applied for legal aid so that she could oppose the request, but this was refused by the Scottish Ministers on the basis that she had no formal right to take part in that process.

WF challenged the refusal in the Court of Session. The judge found in her favour, holding that Article 8 ECHR was directly engaged whenever a court was asked to order the recovery of a victim's medical records. The Court confirmed that respect for private life meant WF had to be told about the request and given a real opportunity to be heard before any decision was made, including through legal representation where necessary. Excluding her from that process was incompatible with Article 8.

The Court also rejected the idea that a judge could adequately protect a victim's privacy without hearing directly from the person affected. It made clear that victims are rights-holders, not bystanders, when decisions are being made about access to their most sensitive information.

This judgment led directly to procedural change. In response, new regulations were introduced in 2017 to ensure that victims can access publicly funded legal assistance to oppose applications for the recovery of sensitive personal records, and that disclosure decisions must be approached in a way that actively respects victims' Article 8 rights. This marked a significant shift in Scottish practice around disclosure and victim participation.

The principles established in *WF v Scottish Ministers* have since been applied to other forms of highly personal information, including digital data. In *PF, Falkirk v BM* (2024) SLT (SAC) 7, the court extended the same Article 8 ECHR protections to applications seeking access to a victim's mobile phone records, recognising that messages, call logs and digital communications can be just as intrusive as medical records. The decision confirmed that victims must be properly informed, given an opportunity to be heard, and protected from unnecessary intrusion, demonstrating how the approach developed in *WF* continues to shape modern disclosure practice as new forms of personal evidence arise.

16 BBC News, 'Anti-rape groups hail legal aid ruling,' (12 February 2016).

“ The impact of the ECHR and the Human Rights Act on victim/survivor rights in Scotland has been profound, and in many ways, transformational. It is remarkable to think that for many years the Scottish legal system was content to consider the disclosure of people’s highly sensitive medical records without hearing from those to whom the records belonged, but that was the reality, and it was the ECHR that made the vital difference.

More generally, in the work that we do, it is fair to say, that the ECHR plays a pivotal role. On countless occasions, it forms the basis for submissions about what the Police and Crown can and should do when it comes to the recovery and disclosure of sensitive information. Article 8 is expressly mentioned in the policy which governs the Crown’s recovery of sensitive records by victims of crime. It has also been the mechanism by which failures by state agencies can be challenged and compensation obtained.”

(Eamon Keane, Principal Solicitor and Co-Director of the Emma Ritch Law Clinic, Representing Rape Crisis in PF, Falkirk.)



Stephen's Story

'Stephen' was the complainer in a prosecution concerning a serious sexual offence. During the pre-trial stage, the defence made a third-party disclosure application seeking access to personal records and information relating to aspects of his background which sat outside the scope of the issues in the case

The request was intrusive and bore no clear relevance to the issues in the case. There was a real risk that such material would be used to undermine Stephen's credibility by reference to aspects of his private life.

Stephen was supported by a Sexual Offences Legal Adviser (SOLA), who took detailed instructions and ensured his concerns were clearly articulated before the court. Stephen expressed significant anxiety about the proposed disclosure. He felt it would amount to a further invasion of his privacy and indicated that it could cause him to stop participating in the case.

On his behalf, the SOLA opposed the application, arguing that the request was irrelevant, disproportionate and constituted an unjustified interference with Stephen's right to respect for private life under Article 8 of the HRA.

The SOLA argued that Article 8 protects personal dignity and autonomy, and that any interference must be necessary and proportionate. The defence had failed to demonstrate any proper evidential basis for the request. The proposed disclosure would therefore represent an unnecessary intrusion into Stephen's private life and risk opening the door to inappropriate and prejudicial questioning

The judge found that the proposed disclosure was neither necessary nor proportionate. The case proceeded to trial without the inclusion of this material, and the defendant was convicted.

Stephen later reflected that this intervention had been critical. He felt protected and respected within the process. In particular, he stated that without the protection of Article 8, and the opportunity to have his views represented through the SOLA, he may have withdrawn from the case due to fears about unjustified intrusion into his private life.

“ In the work we do at Victim Support Northern Ireland, the European Convention on Human Rights is not an abstract set of principles but a foundational part of what good justice looks like in practice. For complainants in serious sexual offence cases, Article 8 provides a clear and principled framework for protecting dignity, privacy and personal autonomy, particularly where intrusive or speculative applications are made for access to highly sensitive material. Crucially, that protection operates alongside, not in opposition to, the accused’s right to a fair trial under Article 6.

The Convention requires a structured and fact-sensitive balancing exercise, helping to ensure that only material which is necessary and proportionate is brought before the court. It does not remove all the challenges and imperfections within the criminal justice system, but in my experience, the Convention strengthens the integrity of proceedings and underpins a system that is fairer and more capable of maintaining public confidence than it would be without those safeguards.”

(Peter Lockhart, Sexual Offence Legal Adviser Victim Support Northern Ireland.)





Victims of State Injustice

Chapter

3

Under Articles 2 and 3 ECHR, the state has a duty not only to avoid causing death or serious harm, but also a duty to properly investigate such serious incidents. Where an Article 2 investigation is required, for example because a person has died when under the care or control of the state whether in custody, mental health detention, healthcare settings, the armed forces, or in child protection environments, the ECHR requires an investigation capable of examining not just what happened, but why. Article 3 can trigger a similar duty where the issue is not a death but serious ill treatment (or a serious failure to protect someone from such treatment) in detention or other institutional settings.

In both circumstances, the ECHR strengthens accountability by requiring investigations that are independent, effective, open to scrutiny, and capable of involving bereaved families and victims in a meaningful way. In the UK, this investigative duty is typically fulfilled through coroners' inquests and, in some cases, public inquiries. These processes examine what went wrong after a death or serious ill-treatment, including failures to protect life, missed warning signs, poor safeguarding, and broader systemic issues. They also enable families and victims to challenge unclear or inaccurate accounts, participate meaningfully, and seek recognition of state responsibility where appropriate.

Article 2 Inquests

An inquest is an investigation into the circumstances of a death, which is usually carried out by a coroner and sometimes a jury. Its purpose is not to determine criminal or civil liability, but to establish who the deceased was and how, when and where the death occurred. In certain cases, an inquest also plays a crucial role in examining whether the actions or omissions of public authorities contributed to the death.

The ECHR and HRA has improved the quality of investigations in cases where the state may be responsible for a death, setting out core requirements that must be met under Article 2. Before the HRA, the scope of inquests was interpreted narrowly. Coroners were generally limited to determining how a person had died in a restricted sense. This meant focusing on the physical/medical cause of death rather than the broader circumstances or any underlying failings by public bodies that may have led to it. Families were frequently excluded from the process.¹⁷ The narrow scope of inquests, before the HRA, was confirmed in the case of Mark Jamieson:

R v HM Coroner for North Humberside and Scunthorpe, ex parte Jamieson

Mark Jamieson died by suicide while in prison custody in 1991. After the inquest into his death, his family argued that the coroner should have been permitted to examine potential negligence or failures by prison authorities, including how his suicide risk had been managed. The court rejected this argument, holding that an inquest was confined to fact-finding and should not investigate the wider surrounding circumstances beyond the immediate cause of death. Inquests conducted on this basis became known as "Jamieson inquests."

¹⁷ This position was set out in the case of *R (Jamieson) v Coroner for North Humberside and Scunthorpe*.

A similar case brought less than a decade later but *after* the incorporation of the HRA produced a very different outcome:

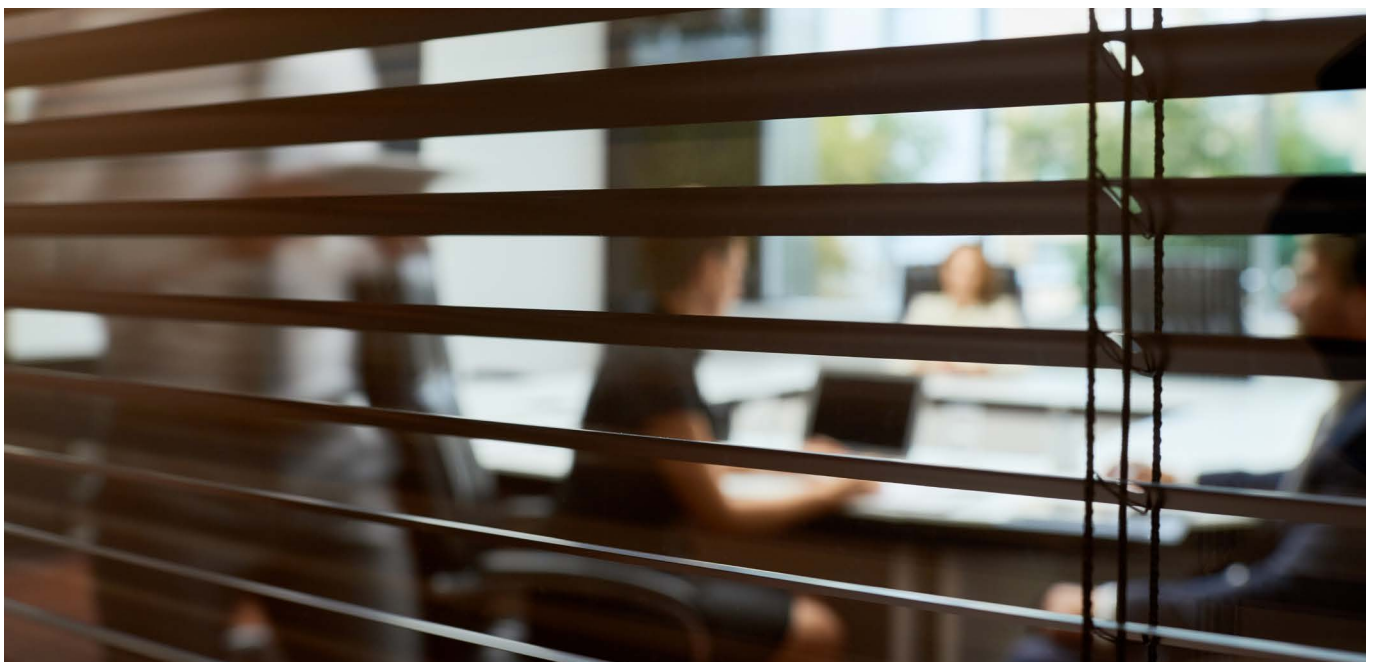
R (on the application of Middleton) v West Somerset Coroner 2004

Joseph Middleton died by suicide while in prison in 1999. At the first inquest, the coroner followed the traditional Jamieson approach and limited the jury to determining the immediate cause of death, returning a verdict of suicide. Joseph's widow challenged this, arguing that the inquest should also examine whether prison authorities had failed to manage her husband's known suicide risk, relying on Article 2.

The House of Lords agreed. It held that where a death involves potential responsibility on the part of public authorities, an inquest must comply with Article 2. This means that the coroner's task cannot be confined to the medical cause of death; it must extend to examining the full circumstances, including whether systemic failures, omissions, or flaws in policy or practice contributed to the death.

To this day, inquests involving Article 2 are referred to as "Middleton inquests" and must operate in line with the criteria set out in that case by the House of Lords. It held that where deaths involve an element of state responsibility, an inquest must operate to:

1. **Be independent** – conducted separately from any individuals or bodies who may be implicated in the death.
2. **Be effective** – capable of establishing how the death occurred, whether state involvement played a role, and whether broader systemic failings contributed.
3. **Be open to public scrutiny** – usually through public hearings, so that the process is transparent and capable of maintaining public confidence.
4. **Involve the family** – ensuring that the bereaved can participate in a meaningful way, including through access to information and legal representation where appropriate.
5. **Be carried out without unnecessary delay** – so that evidence is not lost and families are not denied answers for extended periods.



Article 2, Preventable Death Reports and Lesson Learning

In certain circumstances, coroners also have a duty to issue Prevention of Future Death (PFD) reports. Prior to the HRA, coroners had a largely discretionary power to raise concerns about future risks. That position was later strengthened by Parliament through the Coroners and Justice Act 2009 and subsequent regulations in 2013, which placed coroners under a statutory duty to issue a report where an investigation reveals a continuing risk of future deaths and action should be taken to address it.

These reports set out concerns identified during an inquest and explain why, in the coroner's view, there is a continuing risk of further deaths unless action is taken. Public bodies and organisations receiving a PFD report are required to respond, explaining what steps they will take, or why no action is proposed.

PFD reports are a direct expression of the procedural obligation under Article 2. They reflect the Convention's insistence that investigations into deaths must be capable not only of establishing what happened, but of learning lessons and preventing repetition.

In this way, Article 2 helps inquests look beyond the lives of those immediately affected and instead to all members of the public so that future harms can be avoided.

Jurisdictional Differences: Fatal Accident Inquiries in Scotland

In Scotland, the state's investigative obligations under Article 2 are discharged through Fatal Accident Inquiries (FAIs). Article 2 has had a significant impact on providing rights of redress via FAI's and Inquiries that might not exist otherwise.

“ The practical effect of article 2 may therefore be that it requires there to be a fatal accident inquiry or even a public inquiry in circumstances where none would otherwise be required.”

(Lord Hope of Craighead, *Kennedy and Black v Lord Advocate* [2006] UKHL 36, para 48.)

When Inquests are not enough: the Duty to Establish Public Inquiries

In some cases, an inquest (or FAI) is not sufficient to discharge the state's investigative obligations under Article 2. This may be because the issues raised are too complex, too sensitive, or too systemic to be properly examined within the limits of a coronial process. In those circumstances, the state may be required to establish a public inquiry.

A public inquiry is a formal investigation set up by the government to examine matters of serious public concern. Unlike inquests, inquiries are not limited to individual deaths and are not constrained by the statutory powers of coroners. They are designed to investigate what went wrong, why it went wrong, and whether wider institutional, regulatory, or cultural failures were involved, with the aim of preventing similar harm in the future.

In many cases, inquiries have broader powers than inquests, including the ability to review sensitive material and scrutinise senior decision-making across multiple public bodies. The decision to hold, or not hold, an inquiry must itself be compatible with the state's investigative obligations under the ECHR.

“ For bereaved families whose loved ones have died at the hands of the state, the Human Rights Act has been transformative. It has driven improvements to the quality of investigations and ensured families can meaningfully participate in inquests and inquiries, often in the face of institutional power and resistance. This has helped expose widespread failings and patterns of state violence, neglect and abuse of power that would otherwise remain hidden. This scrutiny is essential, not only for accountability after a death but for learning, prevention and systemic change.”

(Deborah Coles, Executive Director, INQUEST)

Article 3 and Public Inquiries: Serious Ill Treatment

Where the issue is not death but inhuman or degrading treatment, Article 3 can be engaged. In cases involving credible allegations of serious ill treatment by state agents, or serious failures to protect people from abuse in detention or other institutional settings, Article 3 also requires an investigation that is independent, effective, and open to public scrutiny. If the available processes are too limited, lack transparency, or cannot compel key evidence, a public inquiry may be the only mechanism capable of meeting these Article 3 standards and providing victims with meaningful participation and public accountability.



Victim's stories

The following case studies show how bereaved families and victims have relied on the ECHR and the Human Rights Act to secure justice, truth, and accountability through inquests and inquiries.

2

Correcting the Record: Article 2 and the Right to a Re-investigation

Article 2 enables families to correct false or incomplete official narratives:

Hillsborough Inquests

Following the events at Hillsborough Stadium during the FA Cup semi-final, 97 Liverpool supporters lost their lives. The original inquests, held between 1989 and 1991, were tightly restricted by the coroner to events occurring before 3.15 pm on 15 April 1989. This cut-off point was based on an assumption that all victims were beyond rescue by that time. As a result, the jury could not consider the response of the police and emergency services after the crush, could not examine whether failures in emergency response contributed to the deaths, and could not scrutinise broader systemic and operational failings.

On that basis, the jury returned verdicts of accidental death. These inquests were widely criticised for their narrow scope, which prevented proper examination of the actions of the police and other authorities once the crush had begun.

The proceedings were also criticised for allowing false allegations originally shared by South Yorkshire Police and the Sun newspaper to circulate that supporters had been drinking heavily or attending the match without tickets. Those claims, later shown to be unfounded, shifted responsibility onto the victims and away from institutional and operational failures.

After decades of campaigning by bereaved families, the original verdicts were eventually quashed and new inquests ordered. A key turning point came in 2012, when the Hillsborough Independent Panel published previously undisclosed material, including evidence that some victims may have been alive at or after 3.15 pm – undermining the original time cut-off by the first inquest. This evidence, coupled with sustained campaigning from families, was central to the decision to hold fresh, wider-ranging inquests.

The second inquests, which began in March 2014, reflected the state's investigative obligations under Article 2 ECHR. The jury was able to examine the full circumstances of the deaths, including stadium safety, police planning and crowd control, the emergency response, and the amendment of police witness statements after the disaster. Families were given full disclosure and were able to participate meaningfully through their legal representatives.

On 26 April 2016, the jury concluded that the victims were unlawfully killed, and that serious failures by the police and other authorities had caused or contributed to the disaster. This verdict overturned the narrative created by the original inquests and formally recognised that the deaths resulted from gross negligence and systemic failure, rather than the actions of the supporters. It marked a long-overdue acknowledgement of responsibility and vindicated the families' campaign for truth and justice.

“ And it was that article in the Human Rights Act – the Right to Life – without that we’d have been nowhere. And we need that for future reference. Because Hillsborough will happen again. Events like this will happen again and people will try to cover it up. So, we need the Human Rights Act to support any other individual in their quest for justice.”

(Steve Kelly, Brother of Hillsborough Victim Michael David Kelly)

“ Without Art 2 of ECHR we would not have been able to get a narrative verdict which confirmed that the fans bore no blame for the disaster and answered many more questions which would otherwise have been left hanging.” (Elkan Abrahamson, Director of Hillsborough Law Now)



Gosport War Memorial Hospital Inquests

Between 1987 and 2001, hundreds of elderly patients at Gosport War Memorial Hospital died after being prescribed opioids in circumstances later found to be unsafe. The original inquests – 10 of which were conducted in 2010 and 1 in 2013 - examined the deaths on an individual basis and generally returned conclusions of natural causes.

In those inquests, the coroner determined that Article 2 of the European Convention on Human Rights was not engaged. As a result, the scope of the investigations was narrowly confined to the medical cause of each individual death. This approach excluded examination of the wider circumstances, including clinical practices on the wards, potential systemic failures in patient care, and the role of institutional decision making in exposing patients to risk.

Although the police conducted criminal investigations, these did not result in prosecutions. Regulatory proceedings by the General Medical Council did, however, find that Dr Jane Barton – the GP responsible for prescribing practices at the hospital - had committed serious professional misconduct. She was not struck off the medical register. These outcomes, or lack thereof, contributed to growing concern among families that accountability had not been achieved.

Following sustained campaigning by families, the Gosport Independent Panel published its report in 2018. After reviewing extensive documentation that had not previously been disclosed, the Panel concluded that the lives of at least 456 patients were shortened by dangerous doses of opioids. It identified a pervasive culture in which the use of opioids was routine and not clinically justified, and where concerns raised by families and staff were not adequately addressed. However, the panel investigation was limited as it was only paper based, did not have the power to compel witnesses, and did not interview the family members of the deceased.

Relying on the Panel's findings, the families of Robert Wilson, Gladys Richards and Arthur Cunningham asked the Attorney General to apply to the High Court to quash the original inquests and order fresh investigations. They argued that the original inquests were fundamentally flawed and that significant new evidence demonstrated arguable breaches of the state's obligations under Article 2 ECHR, including the unlawful taking of life, exposure of vulnerable patients to known risks, and systemic failures in the provision of care.

In 2023, the High Court quashed the original inquest conclusions and ordered new inquests to be conducted in compliance with Article 2. The new inquests are intended to provide a full and robust examination of the deaths and the circumstances surrounding them at Gosport.

The Gosport case demonstrates how initial inquests may be challenged where they are too narrowly framed and fail to identify wider patterns of wrongdoing. The case also illustrates the central role of Article 2, which has underpinned both the families' long-running campaign and the legal basis for reopening the inquests.

“ As a lay person the workings of Article 2 are mostly beyond me, but I do understand how Article 2 was the lever used by Emma Jones and her outstanding team to right the injustice of the original Inquests, an argument accepted by the High Court in ordering fresh inquests.”

(Robert Logan, Son of Gosport Victim Robert Wilson.)

Helping Bereaved Families when the State has caused harm

Article 2 requires independent investigations into police failures and abuse within the military:

Anne-Marie Ellement's Inquest

Corporal Anne-Marie Ellement was 30 years old when she took her own life on 9 October 2011, while serving in the British Army. Prior to her death, Anne-Marie had reported that she had been raped by two fellow soldiers. Following her disclosure, she was subjected to severe bullying and mistreatment within her unit and received inadequate welfare and mental-health support from her chain of command.

The initial inquest into Anne-Marie's death adopted a narrow approach. The coroner refused to hear evidence relating to the rape allegation or the bullying that followed, limiting the investigation to the immediate cause of death and returning a conclusion of suicide. As a result, there was no public scrutiny of the Army's response or its role in the circumstances leading to her death.

Several years later, Anne-Marie's sisters relied on the Human Rights Act, and in particular Article 2 ECHR, to challenge the adequacy of the first inquest. The case was resolved without a contested judgment, with the coroner accepting that the original inquest had failed to examine the wider circumstances of Anne-Marie's death as required by Article 2. A second, Article 2-compliant inquest was subsequently ordered.

The renewed inquest examined Anne-Marie's report of rape, the bullying and mistreatment she experienced after disclosure, and the failures in care, support, and leadership within the Army. The jury returned a highly critical verdict, identifying systemic failings in how the Armed Forces respond to sexual violence and mental ill health among service personnel. It made a number of recommendations aimed at improving accountability and welfare protections.

The impact of the inquest was immediate. On the day the verdict was delivered, the Defence Secretary announced the creation of the first-ever Service Complaints Ombudsman for the Armed Forces, a reform directly influenced by the findings. Anne-Marie's case demonstrated how Article 2 of the ECHR can lead to practical changes in policy and redress.

“ Accountability. Justice. Reform. These things do not happen overnight. They are the product of years of hard work by the devastated victims of state abuse – or, where the victim has not survived, their loved ones. And the HRA enabled us to do it. Without it, we would have achieved absolutely nothing.”¹⁸ (Sharon Hardy, Sister of Anne-Marie.)

“ The Human Rights Act has had a transformative effect on the lives of many Service Personnel or their families, as this small snapshot shows.¹⁹ Women that have experienced sexual violence in the military, bereaved military families, LGBT service personnel, military whistleblowers - these are all groups connected to the military that have profoundly benefitted from the HRA. The only beneficiaries of repeal would be those that prefer we should turn a blind eye to allegations of abuse or serious unacceptable conduct in our armed forces. That must never be allowed to happen.”

(Emma Norton, Director and Solicitor, Centre for Military Justice)



18 End Violence Against Women, 'How the Bill of Rights harms the fight to end violence against women', (2022), p.22.

19 Centre for Military Justice, Military Human Rights Stories.

Helping the bereaved families of vulnerable children and young people: When the State Fails to Safeguard

Grant Lowry's Inquest

Grant Lowry was 20 years old when he was found dead on 3 June 2022 following a prolonged multi-agency search after he was reported missing the previous evening. At the time of his death, he was experiencing significant mental health difficulties, including ADHD, anxiety, and depression, and had previously expressed suicidal ideation. He was known to mental health services and had recent contact with healthcare providers.

On 1 June 2022, Grant sent a message to his mother indicating his intention to end his life. Police were alerted shortly thereafter, but his risk was initially assessed as "medium", with a delay in escalation to "high-risk". Due to a rota error, no Police Search Advisor was available during the critical early stages, resulting in the loss of the "golden hour".

The search was found to be poorly coordinated, with missed opportunities including delays in deploying specialist resources and failures to properly record and act on key information, such as an identified heat source. Grant's body was located approximately 30 hours after he was reported missing.

An inquest concluded in March 2026 that Grant died by suicide whilst the balance of his mind was disturbed. The jury found that an "unsatisfactory, uncoordinated" search, marked by poor communication and inadequate record-keeping, contributed to the delay in locating him. The inquest also identified missed opportunities by mental health services, including failures to record and follow up concerns raised by his family.

The inquest engaged Article 2 given the involvement of public authorities and the known risk to Grant's life. This required a broader examination of systemic failings in both healthcare provision and the emergency response that would otherwise not have been examined. A Prevention of Future Deaths report was issued, highlighting the need for improvements in risk assessment, communication, and multi-agency coordination.

“ Grant’s case engaged Article 2 and involved a rigorous investigation of the facts. In both cases, without Article 2 engagement and the subsequent linked award of legal aid, the questions would have gone unanswered, and the actions of state bodies would have been unscrutinised.”

(Leanne Devine, Lawyer for Grant's family, Leigh Day)

Matthew Caseby's Inquest

Matthew Caseby was 23 years old when he died in September 2020, shortly after being detained under section 2 of the Mental Health Act and transferred as an NHS-funded patient to Priory Hospital Woodbourne in Birmingham. Matthew was experiencing an acute psychotic episode and was under the care and control of the state when he was admitted to the private hospital commissioned to provide mental-health treatment on the NHS's behalf.

Within days of his admission, Matthew was left unsupervised in a hospital courtyard and was able to climb over a dangerously low perimeter fence, despite being deemed at risk of absconding. Matthew left the hospital and was killed by a train approximately 14 hours later. An inquest concluded in April 2022 found that his death was contributed to by neglect, identifying serious failures in risk assessment, observation levels, staff communication, and physical security.

The inquest proceeded as an Article 2-compliant inquest. The HRA and ECHR enabled Matthew's father, Richard Caseby, to secure publicly funded legal representation to ensure that Matthew's family could effectively participate in the inquest. He was granted legal aid on the basis that procedural requirements of Article 2 - particularly full scrutiny, testing of evidence, and accountability - could not be met without legal representation.

In written evidence to the House of Commons Justice Committee, Richard Caseby described himself as "*one of the very first beneficiaries*" of changes in the approach to funding for legal representation in Article 2 inquests, explaining that legal aid was essential in enabling him to challenge official accounts, obtain disclosure, and expose the full extent of institutional failings surrounding his son's death.

The enhanced scrutiny of an Article 2 inquest in this case led the coroner to issue multiple Prevention of Future Death reports, and following an investigation by the Care Quality Commission, Priory Healthcare Ltd admitted criminal failings for exposing Matthew to serious risk of harm.

In March 2024, the Priory was fined £650,000, the largest fine in its history following a death, reflecting the gravity and persistence of the failures identified through the inquest process. The Priory confirmed after the verdict that it had implemented all the recommendations identified during the investigation process and inquest into Matthew's death, including raising the height of the courtyard fencing at Woodbourne and other facilities to 3.2m.

“ An Article 2 inquest probes much deeper than a normal hearing. It must establish not only the cause of death but also attempt to identify anyone responsible and hold them to account.

This is a vital distinction and made a huge difference to the inquest into my son Matthew’s death. Nothing was brushed under the carpet during the three-week hearing before a jury.

There have been two significant recent reforms. In January 2022 the rules for Exceptional Case Funding for inquests were changed to remove the means test and in May 2023 the government said it would remove the means test for inquests involving a potential breach of rights under the European Convention on Human Rights.

I was one of the very first beneficiaries of the change in rules in 2022. Without legal-aid representation at Matthew’s inquest, I would never have been able to hold those to account whose neglect contributed to his death. And it was only because I won such a damning inquest conclusion that I was then able to secure the criminal conviction of the Priory Group, the company that was supposed to have been caring for my son.”

(Richard Caseby, Father of Matthew Caseby)



Helping Families to reveal the truth about police failures to protect

Article 2 requires inquests to examine whether repeated domestic abuse and known risk indicators were properly acted upon by police to protect life:

Katrina Makunova's Inquest

Katrina Makunova was murdered by her former partner on 12 July 2018. She was 17 years old. In the months leading up to her death, Katrina was subjected to a sustained pattern of abuse, harassment and controlling behaviour. Katrina and her family made multiple reports to the police, raising concerns about her safety and the risk posed by her former partner.

Despite these warnings, opportunities to protect Katrina were repeatedly missed. Officers failed to carry out consistent and effective risk assessments, and safeguarding responses were not coordinated in a way that reflected the seriousness of the threat she faced. The abuse occurred both at Katrina's home and at her workplace, demonstrating a known and escalating pattern of risk.

The inquest into Katrina's death was conducted as an Article 2 inquest, to investigate potential failures to protect life. The jury concluded that Katrina had been unlawfully killed and identified significant shortcomings in the actions of the police and other statutory agencies involved in safeguarding her.

The inquest found that the authorities had failed to respond adequately to clear warning signs and to recognise the cumulative risk posed by the ongoing abuse. Importantly, the jury examined not only the immediate circumstances of Katrina's death but also the systemic safeguarding failures that allowed those risks to persist.

Following the inquest, the coroner issued reports to prevent future deaths, highlighting concerns about police workloads, domestic abuse case management, and barriers to effective multi-agency working. These reports formally recognised that Katrina's death raised wider issues of public protection requiring changes in policy and practice.

The Metropolitan Police responded to the coroner's report in December 2021, stating their intention to take forward the inquest's recommendation by working with university academics and supporting research into how factors such as knife carrying and gang membership should be incorporated into domestic abuse risk assessments. They further confirmed that Katrina's death and the circumstances surrounding it are being used as a case study to support training for staff in the Public Protection team, with the aim of improving future responses.

“ By engaging Article 2, the inquest was empowered to expose the systemic “safeguarding gap” that allowed Katrina to fall through the cracks. It ensured that the scope was wide enough to compel police witnesses to justify their repeated decisions to treat domestic violence as a “non-criminal” matter and their failure to initiate formal safeguarding referrals.

Without this human rights framework, the jury’s conclusions might have been limited to a simple verdict of unlawful killing; a record that identifies the killer but ignores the institutional failures. Instead, Article 2 provided the family with a “narrative conclusion” that publicly acknowledged the missed opportunities by both the Metropolitan Police and social services, directly leading to the Senior Coroner’s formal reports to prevent future deaths. ”

(Frederick Powell, Barrister for Katrina’s family, Doughty Street Chambers.)

Helping Victims and Bereaved families establish inquiries

These cases show how the ECHR has played a crucial role in establishing public inquiries when an inquest is insufficient to uncover the truth, as well as in situations where the state has caused serious harm, even where that harm does not result in death.

Article 2 has enabled families to challenge the inadequacy of the inquest process and secure a conversion to a full public inquiry with the powers needed to examine systemic issues in greater detail:

Zahid Mubarek Inquest

In January 2000, Zahid Mubarek, a 19-year-old man, was sentenced to 90 days’ imprisonment at Feltham Young Offender Institution after being convicted of shoplifting goods worth £6 from a supermarket. Zahid was a first-time offender.

In the early hours of 21 March 2000, just five hours before his release, Zahid was beaten to death by his cell-mate, Robert Stewart, a man with a known history of racism and violence. Stewart attacked Zahid with a broken table leg, inflicting catastrophic head injuries from which Zahid never recovered. After the assault, Stewart wrote on the wall of the cell, “Just killed me padmate”, followed by a swastika. Zahid died in hospital a week later.

In November 2000, Stewart was convicted of Zahid’s murder and sentenced to life imprisonment. However, following that conviction, the coroner refused to resume the inquest into Zahid’s death, stating that legal constraints prevented coroners from investigating the serious issues raised by the killing – although she did not explain why. As a result, no public forum examined how Zahid -a vulnerable young Asian man - had come to be placed for six weeks in a cell with a known violent racist, or whether prison authorities had failed to protect him.

Instead, the Prison Service carried out an internal review, and the Commission for Racial Equality conducted a separate investigation. Neither process involved Zahid's family in any meaningful way, nor did they provide a transparent or independent examination of the circumstances leading to his death.

Relying on Article 2 ECHR, Zahid's family brought legal proceedings to secure a public inquiry. Their challenge ultimately succeeded in the House of Lords, which held that the previous investigations had failed to meet the minimum requirements of an Article 2 compliant investigation. They lacked independence, public scrutiny, and effective participation by the family. The Court made clear that an investigation into Zahid's death required full disclosure, legal representation for the family, and the ability to question witnesses in order to establish the truth.

As a result, the Zahid Mubarek Public Inquiry was established in July 2004. It identified 186 separate failings that had contributed to Zahid's death and exposed a pervasive culture of complacency towards racism at Feltham YOI. Of its 88 recommendations, the Home Office accepted 55 in full.

For Zahid's family, the inquiry finally allowed them to see the evidence, hold those responsible to account, and understand the full circumstances of Zahid's death.

“ My family's pursuit for justice was led a single, fundamental question: why was Zahid's death allowed to happen?

This simple question remained unanswered despite several internal investigations, against a Home Secretary that resisted at every turn, calls for an investigation capable of delivering true accountability, transparency and meaningful family/ legal participation.

It became clear, that an inquiry into the circumstances leading to Zahid's death was essential for several reasons. Firstly, because the many of the issues which failed Zahid were as much systemic and widespread and because prisons, by their very nature are enclosed environments and often among the least transparent institutions this is in contrast to them being the most potentially 'controllable' of environments.

Through the provisions of the European Convention on Human Rights - five years later, my family was able to seek justice through appeal via the High Court, resulting in the landmark decision in ex parte Amin effectively compelling the Govt to establish a public inquiry.”

(Imtiaz Amin, Zahid's Uncle.)

Anthony Grainger Inquiry

On 3 March 2012, Anthony Grainger was shot and killed by a Greater Manchester Police officer during a planned police operation. He was sitting unarmed in a car when a single shot was fired through the windscreen. Although police suspected he was planning an armed robbery, no firearms were found.

An inquest into Anthony's death was first opened on 5 March 2012 but faced repeated delays due to investigations by the Independent Police Complaints Commission and consideration of criminal charges by the Crown Prosecution Service. The CPS ultimately decided not to bring charges against any police officer involved. The Chief Constable of GMP was prosecuted under health and safety laws, however, certain sensitive material could not be disclosed and as a result the judge ruled that the trial would not be fair and he was acquitted. This meant Anthony's partner and family could not see key evidence or fully understand what had happened.

At this point, it also became clear that an inquest would not sufficiently expose what had happened to Anthony because of the sensitive material that would not have been able to be disclosed. Therefore, any inquest would not have met the standards of investigation required by Article 2.

Anthony's partner and family and the coroner wrote to the Home Secretary to request that the inquest be converted into a public inquiry, as inquiries have stronger powers to access sensitive material and examine it properly. The duty placed on the state by Article 2 strengthened the right of Anthony's partner and family to know the truth about his death and to push for the inquiry.

In March 2016, the Home Secretary announced that the inquest into Anthony's death would be converted into a public inquiry with greater investigative powers. The conversion enabled all relevant evidence, including confidential and sensitive police documents, to be considered. In the Report, the Chair noted that the Article 2 compliant inquiry had uncovered facts and shortcomings which had not been apparent to the earlier processes.

Once the inquiry began in 2017, it uncovered repeated failures by GMP, including poor intelligence and briefings to the police officers on duty from superiors on the night of Anthony's death and evidence that an officer had amended his work log after Anthony had been shot to make it appear that the grounds for shooting him were stronger than they were. The inquiry concluded that there were catastrophic failings by the police officers managing the operation, and the Chair found expressly that the operation was not compliant with the standards required by Article 2 for the protection of life.

“ The catastrophic errors which led to the fatal police shooting of an unarmed man - Anthony Grainger - were only uncovered because of the investigatory obligations of Article 2, which required full disclosure and enabled the Chair to drill down into all relevant material, including that said to be sensitive. Several earlier processes had failed to do so because they did not have the legal powers to unpick the lack of candour and cover-up which occurred after the shooting.”

(Pete Wetherby KC, Barrister, Garden Court North Chambers.)

Sheku Bayoh Inquiry

On 3 May 2015, Sheku Bayoh, a 31-year-old black man and father of two, died after being restrained by multiple Police Scotland officers on a street in Kirkcaldy, Scotland.

The police received reports of a man behaving erratically in the street and responded. During the encounter, Sheku was handcuffed, beaten and restrained on the ground by multiple police officers, during which he became unresponsive. Officers called an ambulance, but Sheku was pronounced dead on arrival to the hospital, 90 minutes later. A post-mortem revealed that he had sustained facial injuries, bruises to his body and a fracture to his rib. Early police accounts characterised Sheku as violent and under the influence of drugs, a narrative strongly disputed by his family from the outset.

The Police Investigations and Review Commissioner ("PIRC") launched a years-long investigation into the use of restraint on Sheku and his resulting death. They found that the restraint was prolonged and raised serious concerns about officer conduct, communication, coordination, and adherence to policing guidelines. However, on 3 October 2018, the Lord Advocate ruled out criminal charges against the officers, citing PIRC findings and concluding that there was insufficient evidence to prosecute. This devastated Sheku's family, who met with the Lord Advocate that day and complained about the lack of accountability.

A Victim's Right to Review, a process allowing victims or their families to request a reconsideration of a decision not to prosecute, followed, but on 11 November 2019, the Lord Advocate maintained his decision not to prosecute. This ignited widespread public criticism about perceived investigative flaws and racial bias.

Sheku's family used the ECHR and HRA to campaign for a more thorough public inquiry, which was Article 2 compliant. The family argued that the initial investigation process did not meet the Article 2 standard, particularly given concerns about the early police narrative and decision-making. On 12 November 2019, the Scottish Government announced the inquiry, establishing an investigation that was broader than the standard Fatal Accidents Investigation process in Scotland.

The Sheku Bayoh Public Inquiry is tasked with investigating the circumstances leading to Sheku's death more fully than the PIRC, including, according to the inquiry's terms of reference, whether race was a factor in determining the actions of the officers. Whilst the Inquiry findings are outstanding, the establishment of the inquiry in itself is hugely important as it marks the first time that race as a potential factor in a police custody death has been considered in Scotland. The Inquiry hearings challenged the early police narrative, showing that initial reports may have overstated Sheku's aggression and misrepresented his condition. The Inquiry's report and recommendations are still outstanding.

“ When there is use of deadly force by State agents, Article 2 requires that, the investigation must be prompt, independent, adequate and effective in determining of whether the force used was justified. Article 2 ECHR also imposes a need for the state to engage and provide information to the family, yet for Sheku’s family (as in the case of many other bereaved families) this was tokenistic, with the authorities acting in comfort for years, as his family had no resources to challenge them.

The power imbalance between bereaved families and the state is the most significant injustice of the investigation process. That is why the Bayoh public inquiry for the family was so important, as adherence to rights under ECHR, might ensure accountability for a death that occurred under the state’s responsibility, but it also allowed previously unknown facts to become known to the public and in particular to Sheku’s relatives. central to that process was ensuring the family were at the heart of that inquiry, with effective participation- that was the very first time that had happened in the years that followed Sheku’s death.”

(Aamer Anwar, Lawyer for Sheku Bayoh’s family, Aamer Anwar & Co.)



Article 3 has enabled victims to challenge the inadequacy of proposed investigations and secure a full public inquiry into the abuse of individuals by those exercising state authority:

Brook House Inquiry

In 2017, a BBC Panorama documentary exposed serious abuse of detainees at Brook House Immigration Removal Centre near Gatwick. Undercover footage showed staff employed by G4S verbally abusing, threatening and physically mistreating vulnerable detainees. Initial investigations by official bodies were limited in scope, largely closed, and excluded those directly affected.

Former detainees brought a legal challenge against the Home Office, arguing that it had failed to carry out an effective investigation. In 2019, the High Court held that the Home Secretary's proposed investigations, including reviews by the Prisons and Probation Ombudsman and other administrative processes, were unlawful and inadequate under Article 3 and made clear that only a statutory inquiry with full powers could satisfy the state's investigative duty.

The Court made clear that a proper investigation would require the power to compel witnesses, particularly G4S staff who were unlikely to give evidence voluntarily, as well as public hearings and funded legal representation for detainees. The High Court's judgment directly led to the Government establishing the Brook House Public Inquiry.

The resulting Brook House Public Inquiry fundamentally changed the investigation. Detainees were able to give evidence, access disclosure, and challenge those responsible. When the Inquiry reported in 2023, it confirmed that detainees had been subjected to degrading - and in some cases violent - treatment within a culture that normalised abuse. It identified serious failures to protect vulnerable individuals, particularly those with mental health needs, alongside weak management and ineffective oversight by the Home Office.

“ Human rights, in particular Article 3, were crucial in shaping the Brook House Inquiry because the shocking violence, abuse, and mistreatment exposed at Brook House demanded a full investigation into how it was allowed to happen. Relying on it, those affected secured a High Court judgment that gave the inquiry the power to compel witnesses to attend, ensuring those involved could not avoid giving evidence.”

(Nicholas Hughes, Solicitor, Duncan Lewis Solicitors.)

Conclusion

This paper has shown that the ECHR, through the HRA, provides practical benefits to people living here in the UK, particularly to victims and their families when things go wrong. By imposing duties to protect, investigate and maintain adequate systems, ECHR rights have helped to close gaps in accountability that previously left victims and bereaved families without an effective remedy - whether the failure is a missed opportunity to prevent serious violence or death, an inadequate police investigation, or a safeguarding breakdown by local authorities.

The case studies also demonstrate how human rights obligations translate into better practice: earlier intervention, more rigorous investigation standards, improved victim participation, and stronger scrutiny through inquests and public inquiries.

Ultimately, the ECHR and the HRA provide important protections for ordinary people when public authorities fail. They help ensure that victims and bereaved families can demand answers, accountability and proper investigations, whether the failure involves policing, safeguarding or preventable deaths. By making public bodies responsible for respecting human rights in everyday decision-making, the ECHR and HRA help ensure that victims are heard, that truth is uncovered, and lessons are learned to reduce the risk of similar harms happening again.



JUSTICE Registered Charity in England & Wales No 1058580. In Scotland, JUSTICE is known as 'JUSTICE Scotland' Charity No SC043518.

A company limited by guarantee and registered in England No 3216897. Registered office address as above.