Keoghs
a Davies business

Client Briefing Note

When the bereaved are unhappy with the Inquest outcome

In this briefing, Chloe Hopkins from the Healthcare and Sports team takes a closer look at recent requests for new Inquests.

A fresh Inquest can only be directed by the Divisional Court pursuant to s.13 Coroners Act 1998. There have been some recent examples which serve as useful guidance as to some of the circumstances that will give grounds for a successful application.

The particular grounds considered in the cases in this review are (a) where there was new evidence and (b) where there was alleged to have been inappropriate Coronial questioning.

Section 13 of the Act provides that in order to a hold a new Inquest, the Court must be satisfied that where an Inquest has been held, that it is necessary or desirable in the interests of justice that another investigation be held.

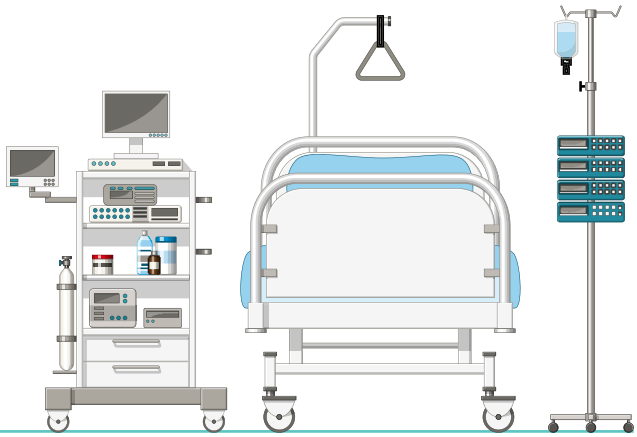
New Evidence - Factual

In the case of Mays v HM Senior Coroner for Kingston upon Hull & East Riding of Yorkshire [2021], an Inquest was opened into the death of 22 year old Sally Mays. Ms Mays was suffering from various mental health issues and had made numerous attempts to take her own life, and had attended A&E multiples times in the period preceding her death. Crucially, she attended hospital on the day of her death and asked to be admitted to hospital for an inpatient stay. This request was refused and hours later Ms Mays dialled 999 and was very sadly found dead when the ambulance service attended the scene. The Coroner identified a number of failings by the NHS Trust and specifically a failure to admit her to an acute inpatient psychiatric ward which fundamentally caused or contributed to her death.

After the Inquest concluded, the Coroner was made aware of a conversation that had taken place between a Community Psychiatric Nurse (CPN) and a Consultant Psychiatrist shortly after Ms Mays was refused inpatient admission to the psychiatric ward, where the CPN expressed concerns about the refusal to admit Ms May. The CPN did not document the conversation as she (and the Psychiatrist) deemed it to be informal, and this conversation had not been disclosed as part of the internal Trust investigation. It was determined that this information had been consciously withheld from the Coroner both before and during the Inquest following a discussion between the CPN and the Psychiatrist.

In view of the fact this was an Article 2 (ECHR) Inquest and the evidence had been withheld from the Coroner, and as such the significance of this conversation had not been scrutinised at the Inquest, meant that the Coroner's obligations in relation to Article 2 had not been discharged as the full facts of the death had not been explored, and consequently a fresh Inquest was ordered.

Further, this decision was made despite the fact the eventual conclusion about the cause of death was unlikely to change. The Court deemed that the evidence was material to the issues raised, which may result in additional new findings and therefore a fresh Inquest was necessary in the interests of justice.



New Evidence - Clinical

In the case of Nguyen -v- Assistant Coroner Inner West London [2021], the claimant's son, Hayden Nygen, had been suffering from a fever a few days following his birth. Hayden's parents took him to A&E however the paediatric team concluded that Hayden's blood results (which were indicative of sepsis) were inconsistent with his clinical presentation. As such, treatment for sepsis was not provided.

Unfortunately, Hayden's condition deteriorated rapidly and he was transferred to a Critical Care Unit where it was decided Hayden would require urgent ventilation. Before ventilation efforts commenced, Hayden suffered a cardiac arrest and despite efforts to resuscitate him, he sadly passed away.

The post-mortem report concluded that the cause of death was lymphocytic myocarditis and disseminated enterovirus infection.

The paediatric clinicians who treated Hayden suspected that the cause of death could have been sepsis, based on Hayden's rapid deterioration, both in terms of his blood results and clinical presentation. The Trust therefore prepared an SUI (Serious Untoward Investigation) report without having sight of the post-mortem report.

The SUI report highlighted a number of failings, all of which were based on the presumption that the cause of death was linked to sepsis. Specifically, these included failings to respond to the blood results and respond to the paediatric observation policy, and a lack of senior clinical input.

During the Inquest, the Trust admitted that the SUI should have been prepared with reference to the post-mortem report and the clinicians involved in Hayden's treatment should have been permitted to comment on the report. The treating clinicians made detailed written comments criticising the SUI report.

The Coroner had instructed a Court-appointed Consultant Paediatric Cardiologist who stated that whilst he could not comment in detail on the SUI report he had "some sympathy for the responses from the treating doctors". On causation, the expert concluded that in his opinion, taking into account the findings of the post-mortem report, the criticisms of the clinicians in the SUI report were unsound and concluded that neither the alleged failures of care nor any delay in referral to Intensive Care had caused or significantly contributed to Hayden's death.

The family decided to commission their own expert (who was a General Paediatrician) who disagreed with the conclusions of the Court-appointed expert. However, the Coroner decided not to call the family's expert to give evidence at the Inquest.

In their Application to quash the Inquest verdict and apply for a new Inquest, the family relied on grounds that (a) the Coroner had not heard evidence from the family's expert (whose report was available before the Inquest) and also (b) new evidence was now available confirming that over 50% of children with neonatal enterovirus myocarditis (as cited by the post-mortem report) would survive with Intensive Care treatment.

As to ground (a), the Divisional Court considered that the Coroner's decision not to call the family's expert as a witness was not on its own sufficient to cause the Court to direct that a new Inquest should be convened. The Court did acknowledge that the family's expert was "a potentially important witness and this Inquest would have proceeded in a fairer and more balanced fashion had he been called". However, the Court was satisfied with the Coroner's reasoning not to call the family's expert as this would only echo the conclusions of the SUI report and the family's expert was unable to comment on causation as a General Paediatrician.

Conversely, ground (b), that there was now new evidence confirming that 50% of children with neonatal enterovirus myocarditis would survive with intensive care treatment, was much more compelling, as this evidence would infer that, on the balance of probabilities, had Hayden received earlier intensivist treatment, he may have survived.

The Court noted that it was not a requirement under s.13 of the Senior Coroners Act 1998 that new evidence could not have been obtained at the first hearing and the Divisional Court accepted that the new evidence was sufficient grounds to direct that a new Inquest be convened.

Inappropriate Coronial questioning

Another ground of the family's Application to grant a new Inquest in Nguyen -v- Assistant Coroner Inner West London [2021], was on the basis of inappropriate Coronial questioning and an 'apparent bias' by the Coroner.

The claimant argued that the Coroner had asked unduly pressurising questions in an assertive manner of the author of the SUI report, who was a key witness in this case, such that this revealed the Coroner had a clear 'pro-doctor' bias.

On analysis of the oral evidence at the Inquest, the Court identified that the Coroner had asked a mixture of non-leading and leading questions of the clinical witnesses which were unobjectionable. However, the Court did conclude that the Coroner's questioning of the SUI author was in the style of cross-examination and the questions were also put to the witness in a convoluted manner, within long paragraphs which asked multiple questions. For example, the Coroner asked of the SUI witness:

"Have you taken any consideration of the fact that all the clinicians and to some extent the nursing staff have said that this didn't look like a baby with a lactate of 4? That this baby handled well, that clinically, this baby did not look as if it was in septic shock? Which indeed it wasn't, we know. So, what about the fact that the clinician with the child on the day, having seen the child, has some flexibility or some decision-making as to whether it would be appropriate to fluid resuscitate a child who looks as well as they did, despite the fact … yes, the boxes had been ticked and it should day, the result ticked the box, how do you factor that in?"

Although the transcript of the Inquest could not show the manner or tone in which the Coroner's questions were being asked, the Court observed that elements of the questioning "came close to the borderline between robustness and unacceptability".

The Court was not willing to conclude that the Coroner had demonstrated an 'apparent bias' but conceded that her conduct came close to this.

The Court concluded that the Coroner's conduct was not sufficient to justify a fresh Inquest as a ground on its own, but it was a factor that was taken into account in conjunction with the new evidence, leading to the Court's ultimate decision in favour of the family to direct a new Inquest in the interests of justice.

Conclusion

The cases discussed above emphasise the importance of working closely alongside clients to ensure that evidence is carefully martialled and obtained so that it is complete, and any contradictions, flaws or sensitivities are addressed in further evidence or by experts so that the Coronial proceedings can progress fairly.

Further, the discussion above also highlights the significance of preparing witnesses thoroughly for questioning in advance of an Inquest to ensure that there is a sound factual basis that is presented to the Court without leaving any fundamental gaps in the factual picture that may come to light and potentially serve as a basis for a new Inquest to be granted. This also ties in with the responsibility of the Coroner to probe the evidence and the witness in order to investigate the case at hand, and witnesses need to be adequately prepared for the extent of inquisition.

Finally, the cases serve as a reminder of the obligations of the Coroner not only to test the witness evidence but also to be mindful that Coronial questioning does not stray into the area of cross-examination or leading the witnesses to agree to particular propositions in order to conveniently fit into a particular profile of events to align with the Coroner's own initials views.

For more information please contact:

Chloe Hopkins
Solicitor
T: 020 3436 2369
E: chopkins@keoghs.co.uk

Disclaimer and Copyright Notice

The contents of this document are considered accurate at the time of publication. Nothing in this document constitutes specific legal advice. You should always consult a suitably qualified solicitor about individual legal matters. Keoghs LLP accepts no liability for errors or omissions in this document. All rights reserved. This document and the information contained within it are provided for personal use only. No part may be reproduced, stored in a retrieval system or transmitted in any form or by any means electronic, mechanical photocopying, microfilming, recording, scanning or otherwise for commercial purposes without the written permission of the copyright holder.

Keoghs LLP is a limited liability partnership registered in England and Wales (registered number OC 321124) which is authorised and regulated by the Solicitors Regulation Authority. A list of the names and our members is available for inspection at our registered office, 2 The Parklands, Bolton, BL6 4SE. We use the word "partner" to refer to a member of the LLP. Keoghs Scotland LLP, is a limited liability partnership registered in Scotland (registered number SO305857) which is authorised and regulated by the Law Society of Scotland and trading from its registered office The Forsyth Building, 5 Renfield Street, Glasgow, G2 5EZ. A full list of members is open for inspection at the registered office. Keoghs Scotland LLP utilises the trading name Keoghs under licence from Keoghs LLP. All services in Northern Ireland are delivered under Keoghs Northern Ireland LLP; a limited liability partnership registered in Northern Ireland (registered number NC001575) which is authorised and regulated by the Law Society of Northern Ireland and trading from its registered office address, Keoghs Northern Ireland LLP, 7TH Floor, City Exchange, 11-13 Gloucester Street, Belfast, BT1 4LS. Keoghs Northern Ireland LLP utilises the trading name Keoghs under licence from Keoghs LLP.

© Keoghs LLP. All rights reserved.

0622/AJ/V1