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The 1COR Quarterly Medical Law Review

Updates and analysis of the latest legal developments

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Welcome to the thirteenth issue of the QMLR, updating you on developments in late 2022 and early 2023

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THE SUPREME COURT PROVIDES AUTHORITATIVE GUIDANCE ON THE APPLICATION OF ARTICLE 2 TO CORONIAL INVESTIGATIONS AND INQUESTS

Peter Skelton KC

R (Maguire) v HM Senior Coroner for Blackpool & Fylde and another [2023] UKSC 20

Introduction

The advent of the Human Rights Act 1998, and the incorporation into domestic law of the Article 2 right to life, has transformed coronial investigations and inquests over the last two decades. Lord Bingham's magisterial creation of the 'enhanced' investigation and conclusion in *R (Middleton) v West Somerset Coroner* [2004] UKHL 10, [2004] 2 AC 182 (later adopted by Parliament) gave coroners greater responsibility to hold the state to account for deaths. That, in turn, has significantly improved the ways in which all inquests are conducted, not just those where Article 2 is found to be engaged. Inquests are no longer haphazard affairs. They are (ordinarily) carefully planned and structured processes; and their participants, the 'interested persons', are far more involved in assisting coroners with the task of identifying the proper scope of their investigations and the lawful ambit of their conclusions.

Article 2, then, has already conquered and occupied the terrain of the coroners' courts and it is only at the frontiers of its application that legal skirmishes still occur. One such fight is the case of *R (Maguire) v HM Senior Coroner for Blackpool & Fylde and another* [2023] UKSC 20, which was argued before the Supreme Court on 22nd and 23rd November 2022, and in which judgment was given on 21st June 2023.

The central issue in the case was whether Article 2 required an enhanced inquest into the death of highly vulnerable woman, Jackie Maguire, who had become seriously unwell while in a private residential care home and had later died in hospital. The Supreme Court held unanimously that it did not. More importantly, in doing so, it took the opportunity to provide a detailed and authoritative account of how Article 2 applies to coronial investigations and inquests.

Of particular importance are the following findings:

1. Inquests involving allegations of negligence by care home staff or medical practitioners will not ordinarily engage the Article 2 enhanced procedural obligation and therefore require a Middleton conclusion.
2. Only in rare cases involving the provision of healthcare services will it be arguable that there has been a breach the Article 2 systems duty – which operates at a high level and is relatively easily satisfied.
3. Likewise, in such cases it will be exceptional for it to be arguable that there has been any breach of the Article 2 operational duty – this will depend on the specific risk of which the authorities are aware and which they have a special responsibility to protect against.
4. Coroners should keep Article 2 procedural obligation in mind throughout the course of their investigations – expanding their ambit if breaches of Article 2 become arguable and reducing their ambit if it becomes clear at any point, including at the start or at the conclusion, that no such breaches have occurred.

Jackie's death

Jacqueline Maguire, known as Jackie, was born on 28 April 1964. She had Down's Syndrome, learning disabilities, behavioural difficulties, and restricted mobility. From 1993 onwards, she lived in a care home paid for and supervised by Blackpool City Council and managed by United Response, a private residential care provider. She was subject to a Deprivation of Liberty Safeguards (DoLS), granted by the Council under the Mental Capacity Act 2005. A psychiatric assessment in 2016 had found that Jackie was a vulnerable adult with no insight and was

totally dependent on staff at the care home for her day-to-day care. She was also fearful of medical interventions, which she sought to avoid.

Jackie became ill from 16th February 2017 onwards. She was not eating well and had a sore throat and diarrhoea. On 21stFebruary 2017, she had breathing difficulties, serious pain in her stomach, and a fit. Her GP made a telephone diagnosis of viral gastroenteritis and a urinary tract infection. Ambulance paramedics attended after she collapsed later that evening. They and the care home staff tried to persuade Jackie to go to hospital for assessment, but Jackie refused and the paramedics did not think her condition was sufficiently serious to warrant transfer against her wishes. They contacted an out-of-hours GP, who, without asking for detailed observations, advised that Jackie should be monitored overnight, and her GP called in the morning.

By the morning of 22nd February 2017, Jackie was acutely unwell and repeatedly collapsing. A second ambulance was called. This time its crew concluded that it was in her best interests to use light restraint to take her to the Blackpool Victoria Teaching Hospital. Following her arrival, she was treated for presumed sepsis, but died that evening. A subsequent post-mortem revealed that for several months she had been suffering from a 3cm gastric ulcer which had perforated, resulting in peritonitis.

Jackie's care home was registered with the relevant regulator, the Care Quality Commission (CQC) and was subject to regular inspections. The CQC had inspected the home shortly after Jackie's death and had been satisfied with the systems in place and with the standard of care that it provided.

The inquest

The Coroner opened the inquest on 3rd August 2017. At the first pre-inquest review hearing (PIRH) on 8th September 2017, he rejected a submission by Jackie's family that Article 2 was engaged on the basis of arguable breaches of any substantive Article 2 obligations. At the second PIRH on 18th December 2017, he maintained this view. However, following the decision of the Strasbourg Grand Chamber in *Lopes de Sousa Fernandes v Portugal (2017) 66 EHRR 28 ('Fernandes')*, he changed his mind, ruling that Article 2 was engaged on the grounds of arguable that the care home, the ambulance service, the GPs, and/or the hospital, failed afford Jackie access to the treatment that she needed.

The inquest was held before a jury from 20th to 29th June 2018, shortly after the Divisional Court decision in *R (Parkinson) v Kent Senior Coroner* [2018] EWHC 1501 (Admin), [2018] 4 WLR 106, in which the Divisional Court rejected the argument that the systemic duty should apply to the investigation of a death resulting from 'ordinary' negligence by hospital staff. Evidence was adduced from 30 witnesses, including the care home staff, the paramedics, the GPs, and several independent medical experts. At the close of the evidence on 28th June 2018, the Coroner invited further submissions on the engagement of Article 2 and the form of conclusion to be left to the jury. The next day he ruled that the inquest had clarified matters to such a degree that Article 2 was not engaged in any relevant way, so section 5 of the Coroners and Justice Act 2009 did not require or permit a direction to the jury to give an expanded conclusion. He also rejected a submission that it was open to the jury to make a finding of neglect. He subsequently directed the jury to give a short *Jamieson*-style conclusion (named after the leading House of Lords decision in *R v HM Coroner for North Humberside and Scunthorpe, Ex p Jamieson* [1995] QB 1). They found that Jackie had died of natural causes.

Proceedings in the Divisional and the Court of Appeal

Mrs Maguire, Jackie's mother, issued judicial proceedings seeking declarations that Article 2 was engaged. She also argued that Coroner erred in law in withholding the issue of neglect from the jury. However, this point was not ultimately pursued to the Supreme Court. The Divisional Court dismissed the claim ([2019] EWHC 1232 (Admin), [2019] Inquest LR 143), holding that the Coroner's assessment was not irrational and involved no errors of law; and that it was open to him to conclude that this was a medical case within the guidance given in *Parkinson*.

Mrs Maguire appealed to the Court of Appeal, primarily on the grounds that Jackie was owed an operational Article 2 duty due to her undeniable vulnerability, coupled with the DoLS authorisation, as a result of which an expanded conclusion was required. The Court rejected this argument and dismissed the appeal ([2020] EWCA

Civ 738, [2021] QB 409), relying on *Fernandes* and the unreported decision of the Strasbourg Court in *Dumpe v Latvia* (Application No 71506/13) 16 October 2018.

The judgment of the Supreme Court

The Supreme Court unanimously rejected Mrs Maguire's appeal. Judgment was given by Lord Sales, with whom Lord Reed, Lord Lloyd-Jones and Lady Lloyd agreed without giving judgments. Lord Stephens provided a concurring judgment.

The law

Lord Sales first identifies the two substantive duties imposed on the state: the '**systems duty**' to have appropriate legal and administrative systems in place to provide general protections for the lives of persons in its territory, and the '**operational duty**' to protect a specific person or persons when on notice that they are subject to a '*risk of a particularly clear and pressing kind*' [10] (a phrase with which Lord Stephens takes issue: see below).

Drawing heavily on the judgment of Popplewell LJ in the Divisional Court in *R (Morahan) v West London Assistant Coroner* [2021] EWHC 1603 (Admin), [2021] QB 1205 (covered on this blog here), he goes on to identify the '*different levels of graduated procedural obligation*' in respect of the investigations of deaths:

1. The '**basic procedural obligation**', which arises immediately on death and whose purpose is to '*check whether there might be any question of a potential breach of a person's right to life*' [14]. It will be satisfied where there is no evidence of a breach of the systems or operational duties (*Tyrrell v HM Senior Coroner County Durham and Darlington* [2016] EWHC 1892 (Admin), 153 BMLR 208; *Kats v Ukraine* (2008) 51 EHRR 44).

2. The '**enhanced procedural obligation**', which '*applies where there is a particularly compelling reason why the state should be required to give an account of how a person came by their death*' [15]. The specific types of cases in which it arises include those where state agents have used lethal force (*McCann v United Kingdom* (1996) 21 EHRR 97); or where a person has died in prison other than by natural causes (*Edwards v United Kingdom* (2002) 35 EHRR 487; *R (Amin) v Secretary of State for the Home Department* [2003] UKHL 51, [2004] 1 AC 653, *Middleton*) [16].

3. The '**redress procedural obligation**', which arises '*in certain other cases where a relevant compelling reason is not present as the foundation for an enhanced procedural obligation, but there is still a possibility that the substantive obligations in article 2 have been breached*' [19]. A typical example is a case involving allegations of negligence in respect of the provision of medical services (*Calvelli and Ciglio v Italy* (Application No 32967/96) 17 January 2002) [19]; where the '*courts have been cautious about implying extensive positive obligations in the application of article 2*' (*Fernandes* and *Fernandes de Oliveira v Portugal* (Application No 78103/14) ('*Oliveira'*) [22]. It will be satisfied by a combination of holding an inquest without an enhanced conclusion, and the availability of a civil claim (*R (Goodson) v Bedfordshire and Luton Coroner* [2004] EWHC 2931 (Admin), [2006] 1 WLR 432) [20].

Lord Sales charts the familiar advent of the '**enhanced inquest**' following the Human Rights Act 1998, the decision in *Middleton*, and the Coroners and Justice Act 2009, section 5 of which placed *Middleton* on a statutory footing [25-29]. He goes on to set out why rulings on the engagement of Article 2 are so important in coronial proceedings:

> *30. Nonetheless, by reason of the interaction of the substantive obligations under article 2 and the enhanced procedural obligation, a ruling that the enhanced procedural obligation arises in a particular case may often imply a judgment that the substantive obligations are engaged and that one or other of them has arguably been breached. Therefore, the issue in this appeal has implications beyond simply the form of the verdict which the jury was asked to give in this case. Where a public authority such as an NHS trust breaches the substantive positive obligations inherent in article 2 it may be sued for*

> *compensation for breach of its duty under the HRA to act compatibly with that Convention right: Savage, para 72 (Lord Rodger).*
>
> *31. The question whether an enhanced procedural obligation under article 2 is engaged in a relevant way in relation to an inquest has additional consequences in practice. Where it appears that an expanded verdict may be required, because it is thought the enhanced procedural obligation is applicable, legal aid will be available to assist with the involvement of the deceased's family by the provision of legal representation. This was the issue which arose in Humberstone.*

He also explains how coroners should approach the application of Article 2 as their investigations evolve – in some cases diverging towards a *Middleton* conclusion, in other cases converging on a *Jamieson* conclusion, as occurred during the inquest into Jackie's death:

> *32. Also, a coroner will have to keep the implications of the article 2 procedural obligation in mind throughout the course of the inquest, to ensure that the examination of the circumstances of the death is sufficient to satisfy that obligation in the particular context. A coroner's assessment of this might alter during the course of an inquest, as more information comes to light as a result of his or her inquiries. The ambit of the investigation might have to be expanded, if information gathered by the coroner suggests that a simple case appearing to involve no relevant state involvement is in fact more complicated and gives rise to an arguable breach of article 2, with the consequence that the enhanced form of the procedural obligation applies and there is a requirement for an expanded form of verdict. On the other hand, information gathered before the start of an inquest (see, eg, Morahan, para 71) or in the course of it may eliminate areas of uncertainty and show that there is no arguable breach of article 2 such as to require an expanded form of verdict. This occurred, for example, in Tyrrell…*

Later in his judgment, Lord Sales looks more closely at the development of the substantive positive obligation by reference to the Strasbourg decisions in *Osman*, *Powell v United Kingdom* (2000) 30 EHRR CD362 and *Calvelli* [34-39]. He then examines the decisions in *Fernandes* and *Oliveira*, and more briefly the domestic decisions in *Rabone v Pennine Care NHS Trust (INQUEST intervening)* [2012] UKSC 2, [2012] 2 AC 72, and *Parkinson* [40-62]. He recognises that *Fernandes* definitively established that cases of medical negligence will not normally involve a violation of the substantive right to life [49]. The two exceptions to this are where '*an individual patient's life is knowingly put in danger by denial of access to life-saving emergency treatment*' (para 191), or '*where a systemic or structural dysfunction results in a patient being deprived of access to life-saving treatment and the authorities knew about or ought to have known about that risk and failed to undertake the necessary measures to prevent that risk from materialising*' (para 192) [50].

From *Oliveira*, Lord Sales draws out three important themes. First, a stricter standard of scrutiny will apply to those cases where the vulnerability of the deceased is particularly high [57-58]. Second, operational choices must be borne in mind when considering the provision of public healthcare and other public services [58]. Third, in assessing the application of the operational duty, it is '*relevant to take into account the wider interests of the vulnerable person who is said to be at risk, in terms of promoting their autonomy, integration into society and relationships of trust with those caring for them*' [59].

Application of the law to the facts

Lord Sales reformulates the issues on appeal into four basic questions.

(1) Was there an arguable breach of the systems duty on the part of the care home, so as to trigger the enhanced procedural obligation?

Answer: No. The Coroner was entitled to find that there was no such breach, relying in part on the findings of the CQC [144].

> *146. It is clear that the systems in place at the care home were capable of being operated in a way which would ensure that a proper standard of care was provided to residents at the home, even though there may have been individual lapses in putting them into effect. As explained in Humberstone, para 71,*

> *and Parkinson, para 91, individual lapses in putting a proper system into effect are not to be confused with a deficiency in the system itself. The same point was made in Fernandes, para 195 (para 50 above).*
>
> *147. There is no sound basis for adopting a different approach to the provision of care in a care home as distinct from in a hospital or other healthcare environment. If anything, one would expect higher (or, at least, equivalently high) standards to be required according to the systems duty under article 2 as it applies to healthcare providers, as they will in many situations be directly on notice of a risk to life in relation to patients in their care to an extent going beyond what would usually be the case in a care home. The individual being cared for may be vulnerable and may suffer a loss of liberty in both environments, but this does not change the application of the systems duty in the healthcare context and it is difficult to see why it should make a significant difference in the ordinary care context. Moreover, in the healthcare context the scope of the systems duty is modulated to take account of the specific type of risk in relation to which the state has assumed a responsibility to protect the individual in the light of his or her specific circumstances, and there is no good reason to adopt any different approach in the ordinary care context.*

Jackie's vulnerability and loss of liberty was more analogous with a patient's loss of autonomy in a hospital setting, than with a prisoner in a prison [148].

Lord Sales goes on to deprecate what he calls '*reverse-engineering*' of a systems duty based on the facts of an individual case [159]. He clarifies that '*the authorities show that the proper approach to the systems duty is more forward-looking than this, and requires an assessment of the systems which it is generally reasonable to expect the relevant body to have in place in advance of any particular incident.*' He also reiterates the principle '*that it is not for the court, but rather for the competent authorities of a contracting state to consider how their limited resources should be allocated between competing priorities: Fernandes, para 175. This principle underscores how limited are the circumstances in which it will be appropriate to find a breach of the systems duty*.' [160]

(2) Was there an arguable breach of the systems duty on the part of any of the healthcare providers, so as to trigger that obligation?

Answer: No. Applying *Powell*, *Calvelli* and *Fernandes* [182], the system was appropriate and effective [183], despite individual lapses of performance [184].

(3) Was there an arguable breach of the operational duty on the part of the care home, so as to trigger that obligation?

Answer: No. The fact that the state has assumed a degree of responsibility for an individual does not automatically make it arguable that Article 2 is engaged:

> *186. The issue of assumption of responsibility raises the question, assumption of responsibility for what? The authorities show that the degree to which assumption of responsibility is a factor relevant to the operational duty under article 2 depends upon the specific risk to life of which the authorities were aware and which they understood had to be guarded against.*

Applying *Rabone*, *Fernandes*, *Oliveira*, and *Morahan*:

> *190. When an individual is placed in a care home, a nursing home or a hospital, the state's operational duty in the targeted sense derived from Osman, para 116, does not involve an assumption of responsibility extending to taking responsibility for all aspects of their physical health, with the consequence that if he or she dies from some medical condition which was not diagnosed and treated in time the state's duty is engaged and the enhanced procedural obligation in terms of accountability is triggered. Even though the individual may not be at liberty, the state is not for that reason made the guarantor of the adequacy of healthcare provided to them in all respects, with an enhanced obligation to account if things go wrong. That would not be consistent with the established approach in relation to cases of alleged medical negligence and the approach adopted in the suicide risk cases discussed above.*

Whether or not Article 2 is engaged will depend on '*the specific risk of which the authorities are aware and which they have a special responsibility to protect against*' (*Morahan*, *Tyrrell*, *Kats*) [193-198]. So in Jackie's case '*the operational duty applied to the staff at the care home in a graduated way, depending on their perception of the risk to Jackie*' [199]. The care home staff were aware that she was experiencing serious health problems and took appropriate steps to seek medical advice and call an ambulance [204].

(4) Was there an arguable breach of the operational duty on the part of any of the healthcare providers, so as to trigger that obligation?

Answer: No. Jackie's care home was intended to be an environment in which her autonomy was promoted, and she was treated with dignity and respect [206]. Critically, '*None of the healthcare professionals involved was on notice that Jackie's life was in danger, so as to engage the Osman operational duty*.' [208]

Lord Stephens' judgment

Lord Stephens concurred with Lord Sales and his short judgment is of little consequence. Of note, however, is that he takes issue with Lord Sales' use of the phrase '*risk to life of a particularly clear and pressing kind*', preferring to stick to the Osman criterion of a '*real and immediate risk to life*' [241]. He's right, though no one reading Lord Sales' judgement would conclude that he was seeking to reformulate the longstanding operational duty test.

Concluding comments

The Supreme Court's judgment is long, repetitious, and overwrought. It also uses outmoded terminology. Inquest 'verdicts' have now been known as 'conclusions' for many years, distinguishing them more clearly from the findings of the criminal courts. People are no longer said to 'commit suicide', which carries judgmental connotations of criminal wrongdoing and sinfulness. Instead, they 'die by suicide'.

Nevertheless Lord Sales' explanation of the legal principles governing the application of Article 2 to inquests is masterly and a welcome return to form after the Supreme Court's last, disastrous, foray into coronial law in the muddled majority decision in *R (Maughan) v Oxfordshire Senior Coroner* [2020] UKSC 46, [2021] 1 AC 454 (covered on this blog here). So, despite its flaws, the judgment deserves close reading by all those with a professional interest in the inquest process.

One final point is worth noting. Midway through his judgment, Lord Sales expresses a degree of frustration at the fact that the Coroner's counsel took a studiously neutral stance in the appeal, making submissions on the general legal framework, but not addressing the appellants arguments on their merits and not ensuring that all of the relevant facts were before the court [117]. This, he says grumpily, necessitated the Justices having to inform themselves of the underlying material and evidence that was originally put before the Coroner.

Lord Sales therefore takes the opportunity to issue guidance to prevent such a situation recurring:

> *In future, I would suggest that in a situation like this the onus on counsel for a coroner, whilst remaining neutral, is to act as an amicus curiae (advocate to the court) and assist to ensure that the court is given the full factual picture, including if necessary by drawing the court's attention to matters not emphasised or omitted by a claimant, as well as alerting it to relevant law and authorities.*

MONTGOMERY AND MATERIAL CONTRIBUTION

Marcus Coates-Walker

CNZ v Royal Bath Hospitals NHS Foundation Trust and (2) Secretary of State for Health and Social Care

Background

In January 2023, Mr Justice Ritchie handed down an important decision dealing with Montgomery and causation in birth injury claims.

The relevant findings of fact:

1. The Claimant was born in a very poor state at 01.03 on 3 February 1996. She was a twin and her sister was born about an hour before her.
2. She had suffered acute profound hypoxic ischaemia (PHI) for between 14 and 18 minutes duration (mid point 16 minutes).
3. 3 minutes of that PHI occurred after her birth until she was resuscitated at around 01.06.
4. The acute PHI caused the Claimant's cerebral palsy.
5. Fetal bradycardia was occurring from around 00.50 (the mid point of 00.48 to 00.52).

The Claimant's case:

1. Her mother requested caesarean section (CS), but her requests were refused or delayed. In addition, her mother was never offered elective caesarean section (ECS) despite it being a reasonable treatment option.
2. When the hospital finally decided to deliver the Claimant by CS, the operation was carried out negligently late. That caused or materially contributed to the development of her acute PHI.

The Defendants' case:

1. In 1996, ECS was not a reasonable treatment option to offer during the antenatal period. Therefore, it was not offered. Offering and advising normal vaginal delivery was the correct practice and the Claimant's mother did not request caesarean section antenatally.
2. There was no negligence during the labour and the parents' requests for CS were granted in a timely way.

At trial, the judge heard evidence from a series of highly respected experts with considerable experience in medico-legal work in this field, including:

1. Mr Forbes and Mr Tuffnell (Consultant Obstetricians).
2. Dr Newton and Dr Rosenbloom (Consultant Paediatric Neurologists).
3. Dr Dear and Dr Fox (Consultant Neonatologists).

Issues

In a judgment that runs to over 100 pages, Mr Justice Ritchie dealt in detail with questions of informed consent and causation in birth injury claims.

Montgomery - The antenatal period

Given the Claimant's mother's obstetric history, she argued that she did not want either artificial rupture of membranes (ARM) or an epidural. Her case was that she had been refused an ECS in the antenatal clinic. This

allegation was defended on the basis that: (a) no such request had been made; and (b) in 1996 the standard management for twins where there had been previous vaginal delivery and no concerns about fetal position was vaginal delivery (NVD). Therefore, it was argued that ECS was not a 'reasonable alternative treatment'.

The judge queried how far back *Montgomery* actually applied. Acknowledging that this judgment was based on changing societal attitudes to consent which were premised on greater personal autonomy and access to information (particularly from the internet), he found that it applied as far back as 1996. However, he questioned whether it applied much earlier than about 1993.

> *It applied to the 1999 events in the case, but how far back can this decision be taken? I doubt it can be taken as far back as the 1950s or 1960s. I make no decision on those decades. I wonder if it could be applied to clinical practice in the 1980s. Again I make no decision on that question. As for the 1990s, taking into account the rationale expressed for the movement from paternalism to patient choice there may be a tipping point at which the growth of the internet (Berners-Lee released his system in 1993), the changes in societal values and GMC guidelines and the passing of the Human Rights Act 1998 and other legislation came together to generate the change from paternalism to patient choice. So does Montgomery apply to the facts of this case in February 1996, two years before the passing of the Human Rights Act 1998 and before the internet had really developed much? I admit that I am troubled by this. I consider that it probably does. I have considered whether a watered down form of the ruling would have applied or whether a tapered growth of the Montgomery duty to consent properly could be the correct approach in 1996 but I do not consider I am permitted to do so as a Court of first instance without an indication for such in the Supreme Court's judgment.*

Ultimately, the judge found that the antenatal consent process was reasonable and lawful for medical practice in 1996. He found that CS was discussed with the parents and they agreed to NVD with IOL and as little intervention as possible. Therefore, the claim failed in this regard.

However, he considered that:

> *There is an inherent illogicality in the approach taken by the 1st Defendant's department. All of the Defendants' witnesses and Mr Tuffnell asserted that ECS was not a reasonable treatment option antenatally for M because she had achieved NVD twice before, was healthy and her twins were in a cephalic position and healthy. But they all also gave evidence that if M had requested CS (CSMR) and persisted, despite being put through two or perhaps three counselling sessions against that choice, they would and should have agreed to her choice for CS as her birth plan. Such agreement must in logic mean that CS was a reasonable medical treatment option for M despite being more risky for her. Indeed the undisputed evidence was that in 1995-1996 42% of twin births were by CS. In my judgment it is not logical for the Defendant to assert that CS was an unreasonable treatment option in the face of those matters.*

Therefore, he found that CS was a reasonable treatment option. This raises an issue of some importance. Even if there is a Trust policy in place not to offer a particular treatment option as standard management, if a patient would ultimately be given such treatment if they fought hard enough for it, logic dictates that it must be a reasonable treatment option which should be discussed with the patient. In another case with another mother where CS was not discussed, the 'illogicality' of the department's policy might have produced a different result.

The delivery of the Claimant

In summary, it was found that:

1. The crucial period relevant to the allegations was between 00.25 and 01.03 (a period of 38 minutes).
2. There was a negligent delay of 6.5 minutes in delivering the Claimant.
3. At 00.25 / 00.26, there was a negligent failure to discuss the necessary reasonable treatment options (including CS and ARM) and the associated risks and benefits with the parents. In short, Montgomery

applied even in circumstances where the need for treatment was imminent and time was of the essence:

> *I consider that Mr Forbes' criticisms of Doctor Tristram at this point are reasonable and valid. I consider that what all reasonable doctors would have done is to set out the options, the risks and benefits and to seek the parents' choices on those options before going to the consultant. In my judgment Montgomery applied at this point. Doctor Tristram needed to know, before she checked with the consultant, what the parents' choices were. To obtain their informed choices she needed to inform them of the risks and benefits of the options of CS or NVD with possible ARM (low and high). She should have given them the right to choose CS and asked whether they would accept low or high ARM or ARM at all in the absence of EA.*

At 00.35, a further discussion took place and there were similar failures. It was found that the parents had made a clear choice for CS but this was ignored. There was a failure to act on their decision and to act urgently in taking the Claimant's mother to theatre. The clinician was criticised for taking it 'slowly':

> *I accept the Claimant's criticism of this approach as too paternalistic. Patient choice was being ignored at this stage. Doctor Tristram was, on her own evidence, proceeding slowly with ARM without having obtained permission to do a high one and she did not record M's permission to do so. The parents were requesting CS and in my judgment at that time in the circumstances Doctor Tristram should have agreed to that request (subject to reassessment to see if the baby's head had descended so far that CS was no longer the right option once they were in theatre).*

It was held that the total negligent delay was between 5 and 8 minutes (mid point of 6.5 minutes). The Claimant should have been delivered by 00.55 to 00.58. This would have been within the non-damaging 10 minute period of PHI.

This application of *Montgomery* in the context of an imminent delivery rather than antenatally is different to how previous Courts have dealt with this issue (see *ML v Guy's* [2018] EWHC 2010). Mr Justice Ritchie explained that the difference in this case was that the Claimant's father was in the delivery room at 00.26 and able to speak for the Claimant's mother and they both chose CS which they had made clear. Whether *Montgomery* applies in the context of an imminent birth where a mother gives birth alone in the absence of a birthing partner is therefore unclear. This appears to be fact specific rather than generating a new principle of wider application. However, in recent times where the impact of Covid-19 has seen a significant limitation on who can attend the delivery room, this decision potentially creates a different standard of consent for those mothers giving birth alone and those who have someone in the room who can speak on their behalf.

Causation

In summary, it was found that:

1. On the balance of probabilities, the duration of the acute PHI was 14 to 18 minutes (midpoint 16 minutes).
2. The Claimant was suffering bradycardia during those 16 minutes which is likely to have started between 00.48 to 00.52 (midpoint 00.50).
3. The agreed expert evidence was that the first 10 minutes of acute PHI are not generally damaging. However, the minutes thereafter (minutes 10 to 16 in this case) cause increasing or incremental brain damage. Therefore, it was held that there were around 6 minutes of damaging PHI.
4. Had the 6.5 minutes of negligent delay not occurred, the Claimant would have been born at 00.56 / 00.57 by CS. This would have been within the non-damaging 10 minute window.
5. Therefore, on the findings of fact, all of the Claimant's brain injury was caused by the negligence and 'but for' causation was satisfied.

However, at the extreme ends of the range of the factual findings, earlier delivery would have avoided some but not all of the damage. It was here that the judge was troubled most. He conducted a detailed analysis of the authorities concerning 'but for' causation and material contribution.

To assess the quantum attributable to the negligence, the Court needed to decide what the Claimant's functional outcome would have been but for the negligent delay.

The judge held that, in the context of acute profound hypoxic ischaemia, every minute counts:

> *The agreed evidence was that every minute of acute PHI over the first 10 minutes caused increasing or incremental brain cell deaths which could number in the tens or hundreds of thousands. I find that this damage minute by minute was more than de minimis.*
>
> *I find on the evidence before me, that medical science is unable to identify with generality, accuracy or detail the functional effect of each minute of brain cell deaths. Both experts, Doctor Newton and Doctor Rosenbloom, advised that they could not predict the pattern or severity of the resulting functional disability from a minute by minute increase in the duration of the PHI suffered.*

On the basis that there is no linear relationship between minutes of acute PHI and functional outcome, the judge found that medical science was unable to identify with generality, accuracy or detail the functional effect of each minute of brain cell deaths. It was scientifically impossible. Therefore, the Claimant was entitled to recover 100% of the damage caused by the PHI on the basis of the material contribution test.

In doing so, the judge rejected the 'Aliquot theory' advanced by Dr Lewis Rosenbloom on behalf of the Defendant. In short, Dr Rosenbloom argued that the likely functional outcome caused by acute PHI could be broken down into 5 minute blocks of time (or aliquots). In that way, a Court could assess the level of disability that the Claimant would have had in any event. The judge rejected this theory, partly because there was insufficient evidence to support the proposed distinctions:

> *Thus in my judgment the Aliquot theory, honestly and helpfully put forwards, as it was, by an impressive and experienced expert, is not an acceptable, fair or practicable way to apportion quantum in this Cerebral Palsy case caused by acute PHI.*

However, he considered that, if fairness was the only test, the Court should apportion quantum so that a Defendant is only liable for the brain damage which it caused and not that which would have occurred in any event. He suggested that a fair way to apportion damages would be by way of a percentage based on the relative durations of the PHI caused by the negligent delay compared to the PHI which would have been suffered in any event.

In exploring whether an apportionment was possible in this case, the judge conducted a detailed analysis of how a Court should approach 'indivisible' vs 'divisible' injuries. He drew a distinction between: (a) 'trigger' injuries; and (b) injuries that are 'dose related' and therefore divisible:

> *I do not consider that the term indivisible applies to the Claimant's brain injuries in this case. An indivisible disease is one which starts when triggered and then goes on and gets worse or takes its course whatever the exposure to the noxious substance after the triggering event. These diseases are not divisible in the sense that they are not reduced by stopping the exposure and do not get worse on increasing the exposure. They start and then they progress, like cancer or mesothelioma.*

Brain damage caused by PHI is not a trigger disease. It does not grow like cancer or mesothelioma once triggered. The spread of brain damage due to PHI is wholly dose dependent. The more PHI the fetus suffers the greater the brain damage. However the word indivisible may apply to the functional outcome caused by one or more minutes of acute PHI.

Whilst the judge was clearly attracted to the fairness of an apportionment of quantum based on a percentage tied to the relative duration of acute PHI, he ultimately summarised his analysis of the law as follows:

> *I accept that there is a distinction to be drawn between impossibility of proof for apportionment of functional outcome and difficulty over proof for apportionment of functional outcome. The dividing line depends on the evidence. I consider that in the case before me, where the Claimant's cerebral palsy has been caused by one noxious factor: acute PHI, and where the agreed medical evidence is that every minute of PHI caused increasing brain damage, the scientific gap is how to attribute the breach PHI (or each minute of brain damage) to each or any functional deficit.*
>
> *In law I consider that the cases I have reviewed above show that if there is a scientific gap making proof of causation of functional outcome, therefore also quantification, impossible in contra-distinction to merely difficult, then the Claimant will recover 100% of the damage she has suffered due to the acute PHI so long as the Claimant can prove that the breach made a material contribution to the reduced functional outcome which was more than de-minimis.*

However, in cases involving divisible ('dose related') injuries, where the evidence allows the functional outcome to be attributed in percentage proportions to the negligent and non-negligent causes, the judge's clear view was that there should be an apportionment.

Material contribution is an ever-developing area of clinical negligence work. However, the question of when an apportionment should and should not be applied may well be the next hotly contested chapter in its evolution.

This is another important case for practitioners who undertake clinical negligence work to get to grips with.

CONSENT AND FACTUAL CAUSATION – TWO RECENT CASES

Richard Mumford

Watts v North Bristol NHS Trust [2022] EWHC 2048 (QB)

Snow v Royal United Hospitals Bath NHS Foundation Trust [2023] EWHC 42 (KB)

Two cases from the past year illustrate the importance of factual causation as an issue in litigation concerning consent to treatment and provide various reminders on points of practice that will be of interest to those working in the field of clinical negligence.

In *Watts v North Bristol NHS Trust* [2022] EWHC 2048 (QB) Bourne J heard an appeal from the County Court in a case concerning spinal surgery. The Claimant suffered from back and leg pain along with numbness and some weakness. He attended a consultation with a spinal surgeon on a private basis, following which microdiscectomy was proposed. The Claimant then attended an NHS consultation with a different surgeon who proposed spinal fusion instead. The Claimant went ahead with spinal fusion with regrettably poor results. The judge at first instance found that there had been a failure by the NHS consultant to advise on the pros and cons of microdiscectomy as an alternative to fusion and that the Claimant's informed consent was not therefore obtained.

However, the claim failed on factual causation - the Claimant had failed to prove, on the balance of probabilities, that he would have chosen microdiscectomy over fusion. The trial judge had, in particular, been concerned by the failure of the Claimant's first witness statement to address, at all, the issue of why microdiscectomy would have been preferred. The Claimant's second statement, served close to trial, failed, in the judge's view, adequately to provide reasons for preferring microdiscectomy, other than it being less invasive and a shorter procedure. Microdiscectomy produces a different outcome from fusion, in that it only treats nerve compression and referred pain, not constitutional back pain, spinal 'tilt' or instability, whereas fusion would in principle address all aspects.

The judge directed himself by reference to *Smith v Barking, Havering and Brentwood Health Authority* [1994] 5 Med LR 285, in which Hutchison J referred to the difficulty for a claimant in giving reliable answers to this type of question after the event and added:

> *"Accordingly, it would, in my judgment, be right in the ordinary case to give particular weight to the objective assessment. If everything points to the fact that a reasonable plaintiff properly informed, would have assented to the operation, the assertion from the witness box made after the adverse outcome is known, in a wholly artificial situation and in the knowledge that the outcome of the case depends upon that assertion being maintained, does not carry great weight unless there are extraneous or additional factors to substantiate it. … Of course the less confidently the judge reaches a conclusion as to what objectively the reasonable patient might be expected to have decided, the more readily will he be persuaded by her subjective evidence."*

The Claimant appealed against the judge's finding on the point of factual causation, arguing that the judge himself was guilty of a lack of reasoning in his rejection of the Claimant's evidence as to which procedure he would have chosen. Bourne J, in rejecting this ground of appeal, noted at [40] that the:

> *"…question for me on this appeal is not whether I would have made a different finding but whether I am satisfied that the Judge's finding of fact was plainly wrong, meaning that it was a finding which no reasonable Judge could have reached. For that proposition, see* Henderson v Foxworth Investments Ltd *[2014] UKSC 41, [2014] 1 WLR 2600 at [62]…"*

and that this gave rise to a:

> *"…high hurdle necessary to overturn a finding of fact"* [46].

He noted at [48]:

> "[The Claimant] *supported his assertion by claiming that the choice was an obvious one. The Judge was entitled to, and did, reject that view. Choosing microdiscectomy would have meant rejecting the strong advice of the surgeon who was, in effect, standing by to operate. In particular it would have meant rejecting his advice about "tilt" and instability. It would also have meant giving up a likelihood of the back pain being relieved. Whilst there were also factors leaning in favour of microdiscectomy, the Judge was entitled not to be persuaded that they made the choice obvious. Indeed, if microdiscectomy was the obvious choice, then* [the NHS surgeon's] *advice to opt for fusion would have been irrational, but the expert witnesses at the trial agreed that that advice was reasonable."*

By contrast, *Snow v Royal United Hospitals Bath NHS Foundation Trust* [2023] EWHC 42 (KB) was a case in which the court (HHJ Richard Roberts, sitting as a Judge of the High Court) was ready to conclude that, with proper discussion of the options, the patient would have made a different choice.

The case concerned surgery for rectal cancer. The two surgical techniques under consideration were Total Mesorectal Excision (TME) and Trans-anal Total Mesorectal Excision (TaTME). The perceived advantage of the latter was a lower risk of permanent colostomy being required. The Claimant underwent TaTME but unfortunately suffered complications namely impotence, urinary and faecal incontinence, exacerbation of lower anterior resection syndrome (LARS) and psychiatric injury.

The Defendant accepted that there had been a negligent failure to counsel the Claimant of the risk of LARS, urogenital injury and of reverting to an open procedure. However, the Claimant's case went further – that there was a failure to advise the Claimant, first, that his surgeons had performed only one TaTME previously and that the evidence suggested a higher risk of unfavourable outcomes early in the learning curve and, second, that NICE Guidance stated that there was insufficient evidence to know if TaTME was safe enough and works well enough. By way of background to the latter point, the judge was asked to consider the extent to which the practice in this case had departed from NICE Guidance. Whilst reminding himself that failing to follow NICE guidance is not prima facie evidence of negligence, but that to do so calls for some sort of explanation (as per *Price v Cwm Taf University Health Board* [2019] PIQR P14), the Judge considered that there had been multiple

departures from those recommendations without good explanation. He noted at [107] that the operating surgeon accepted in evidence that the Claimant was not informed of six out of the seven material risks identified by NICE. With the addition of the failure to inform the Claimant of the number of such surgeries performed by the surgeon, it was a short step to find that, with this information, the Claimant would have elected instead for TME.

Comment

These cases serve to illustrate the necessity of careful consideration on both sides as to factual causation in consent cases. It is likely to be insufficient for a claimant merely to assert (after the event) that they would have elected to undergo an alternative procedure (or none at all); the evidence on both sides must address the counterfactual position of what would have been decided if a bare minimum of adequate information as to the alternatives was made available. Sometimes that will be rendered more complicated by dispute as to what the alternatives in fact were and/or what should have been said about them; however, a claim that does not address these points risks failing for want of proof.

Some other practitioner points arising from the cases include Bourne J's observation at [69] of *Watts* in respect of the joint statement that: *"In my view the experts were asked far too many questions, causing the document to be weighed down with material that did not identify their positions on the decisive issues. Some of the experts' answers did not begin by identifying agreement or disagreement and/or were discursive rather than concisely identifying the differences between their positions."*

Also, at [173-175] of *Snow*, the pitfall of an expert having failed to read all the literature relied on by the other side before entering the witness box (including where necessary seeking out copies of published literature rather than expecting it to be provided by the opposing party).

Matthew Barnes appeared for the Defendant/Respondent in Watts v North Bristol NHS Trust. He did not contribute to this article.

WHO GETS TO GO TO THEATRE FOR URGENT SURGERY FIRST?

Matthew Donmall

Middleton v Frimley Health NHS Foundation Trust [2022] EWHC 2981 (KB)

Deputy High Court Judge Jonathan Glasson KC heard this case concerning the timing of revascularisation surgery at Frimley Park Hospital, and whether it was mandatory for the Claimant to be operated on within 6 hours of the onset of his symptoms of leg ischaemia, and in priority over another patient, Patient B.

Much of the factual context of the case was not seriously in dispute. The Claimant's symptoms of numbness and pain to his right leg started between 10.00 and 11.00 on 18 November. By 12.30, the Claimant was unable to move his right leg, and the plan was for an urgent CTA (computed tomography angiography) and for him to be nil by mouth in anticipation of possible surgery. The CTA was reported at 16.55, and it was decided that there was a need for urgent surgery. The hospital only had one emergency operating theatre. Patient B had gone into theatre at 14.10 for a laparoscopic small bowel resection and did not finish until 17.57. At 16.55, there was already another patient already booked ahead of the Claimant for a diverticular perforation and peritonitis – surgery took place from 18.00 to 23.25. The Claimant was intubated at 23.36 and was in theatre at 23.56, undergoing a femoro-femoral crossover graft, which created a new route for blood to flow from the left side of the groin to the right, thereby restoring blood flow to the right leg.

The Claimant's expert opined that the Claimant should have been in theatre between 14.00 and 15.00, i.e. within six hours of developing ischaemia to the right leg between 10.00 and 11.00. The Defendant's expert, in contrast, considered that the Claimant needed urgent surgery, but not *immediate* surgery, in particular because he had

had a history of vascular disease (so was better able to withstand occlusion), and the leg was not cold and mottled.

The Judge found in favour of the Defendant. Surgery was not mandated by 15.00 for nine reasons that he enumerated. These included that, while surgery was urgent, the Claimant was a patient with a chronic history of vascular disease which meant he could withstand ischaemia for longer; where a patient falls within the range of urgent cases is a question of clinical judgment; it was reasonable for a CTA to be obtained before surgery; and it would not have been reasonable to put an operating theatre 'on hold' for the Claimant (i.e. to delay the treatment of other patients).

However, the Judge went on to find that even had it been mandatory for the Claimant to be in surgery by 15.00, he would not have been more urgent than Patient B who was already in surgery at that point, nor indeed had the Claimant established that Patient B's surgery could have been delayed.

This case therefore demonstrates the considerable difficulties that a claimant may face in trying to establish that urgent surgery should have taken place by a specific point in time. First, 'urgency' may be considered a matter of degree, informed by clinical judgment on the specifics of a patient's situation. Second, a claimant's case does not fall to be considered in isolation, but rather in the historical context of what was happening in the hospital at the time, and establishing that a claimant should 'jump the queue', or that theatre should be put 'on hold' for a particular patient, can be very difficult.

Hannah Noyce appeared for the Defendant. She did not contribute to this article.

THIRD PARTY COSTS ORDERS AND EXPERTS: ORDER RESTORED

Gareth Rhys

Miss Martine Robinson v Liverpool University Hospitals NHS Trust v Mr Christopher Mercier [2023] EWHC 21 (KB)

Sweeting J in the High Court allowed a medico-legal expert's appeal against a Third Party Costs Order ("TPCO") made against him. The TPCO had awarded the Defendant NHS Trust the full sum of the costs incurred by it in the defence of the action brought by the Claimant.

Background to the appeal

QMLR reported on the County Court decision and TPCO here.

The Appellant medico-legal expert was a general dental practitioner ("the Expert") who had acted as an expert witness for the Claimant, alleging negligence against the Defendant/Respondent NHS Trust. In particular, the claim was that the NHS Trust's maxillofacial surgeon negligently failed to remove a molar whilst under general anaesthetic. The claim proceeded on the basis of the Claimant's expert evidence.

During the trial the Expert made concessions as to his expertise. He conceded that he had never worked as a maxillofacial surgeon and was therefore less able to comment on the case than the Defendant's expert, who was. He also conceded that he had not performed a dental extraction under general anaesthetic for over 20 years and lacked any experience consenting patients for general anaesthetic. After the evidence had been heard at trial, the Claimant withdrew her claim.

The NHS Trust sought a TPCO in the County Court pursuant to Part 46.2 and Part 46.8 CPR 1998 and Section 51 of the Senior Courts Act 1981 for £52,056.57 against the Expert, reflecting the total costs incurred by the NHS Trust in the defence of the claim. The NHS Trust made the application on the basis that the Expert should not have been giving evidence in this case at all and that he failed to comply with his duties to the Court as an expert witness. The application was granted by the Recorder, although she did note that *"it is right to observe that*

making a Costs Order in these circumstances is set very high. Hence the use of the word 'exceptional' in the making of such a Wasted Costs Order" [20].

The High Court appeal

Sweeting J in the High Court overturned the order of the Recorder.

In his judgment, Sweeting J emphasised the high threshold test in *Phillips v Symes* [2004] EWCH 2330 at [95] that a costs order may be made against an expert *"in the event that his evidence is given recklessly in flagrant disregard for his duties".* The Judge recognised at [30] that the threshold for a TPCO is higher than the wasted costs order test in s51(6) of the Senior Courts Act 1981.

Sweeting J considered that the Recorder was wrong to conclude that the Expert, whose experience was in general dentistry, transgressed his area of expertise by commenting on breach and causation in this case. The Judge was content that general dental practitioners were able to assess the viability of teeth, which was the issue central to the decision not to extract the molar. The reason for the general anaesthetic was the Claimant's fear of dental procedures, and the operation would otherwise have been carried out by a general dental practitioner. Consequently, the Expert did not have to be a maxillofacial surgeon in order to comment [38]-[46]. Furthermore, Sweeting J held that the Expert had been asked by the Claimant to identify breaches of duty, not to address failures in the conduct of the operation specifically [66].

In his conclusion, the Judge reiterated that this was not an exceptional case and did not involve a flagrant or reckless disregard of an expert's duty to the court [69]. The appeal was allowed and no costs whatsoever were ordered against the Expert.

Comment

Before the judgment of Sweeting J in the High Court, this case represented the second significant TPCO awarded against a medico-legal expert in clinical negligence proceedings (the first being *Thimmaya v Lancashire NHS Foundation Trust* [2020] 1 WLUK 437, covered here, which was referred to by the Recorder in her judgment at [21]).

This decision should dispel some of the anxiety felt among medico-legal experts caused by the TPCO and the Recorder's judgment. The author of QMLR's article on the Recorder's judgment commented that *"the present case ought to serve as an important reminder to experts that they must only accept instructions which fall strictly within their own area of expertise, both in terms of specialty, and in terms of contemporaneous practice".* It appears that, following this judgment of the High Court, any such reminder is (re)confined to exceptional cases involving a flagrant or reckless disregard of an expert's duty to the court. The Court's discretion to award TPCOs against experts in clinical negligence cases is restricted to cases surmounting that high threshold.

Giles Colin appeared for the Respondent, Liverpool University Hospitals NHS Trust. He did not contribute to this article, although he reported for QMLR on the case at first instance.

HIGH COURT FINDS LONG WAITING TIMES FOR TRANS HEALTHCARE ARE LAWFUL

Lucy McCann

R. (on the application of AA (A Child)) v National Health Service Commissioning Board (NHS England) [2023] EWHC 43 (Admin)

Background

The demand for young people receiving gender identity development services ('GIDS') and for adults receiving gender identity disorder services (also, helpfully, 'GIDS') has increased substantially from 2012 to 2017, and the NHS is struggling to meet this demand. In May 2022, young people seen for the first time following a children's

GIDS referral waited on average for 1066 days (i.e. nearly three years), see [32]. The reality is that many trans patients feel forced to have treatment privately, often resorting to 'crowdfunding' to cover their private medical expenses. For many young trans people, such long waiting times for treatment have a significant detrimental impact on their mental health and in the process, many undergo irreversible physiological changes.

This challenge was brought by six Claimants. The first two are children who were referred to the Tavistock and Portman NHS Foundation Trust ('the Tavistock') which is currently the sole provider of children's GIDS. One Claimant had been waiting 18 months for a first appointment and another had been waiting nearly three years. The third and fourth Claimants are both adults, one had been waiting over two years for a first appointment, the other for over four years. The effect of the long waiting times on the Claimants is described in the judgment at [35-38].

The fifth Claimant, Gendered Intelligence, is a trans-led charity. The sixth Claimant, the Good Law Project (GLP), readers will no doubt be familiar with, and is a not-for-profit campaign organisation which brings strategic litigation. Gendered Intelligence and the GLP were also involved in the *Bell v Tavistock* case in the High Court [2020] EWHC 3274 (Admin), written about here, and in the Court of Appeal [2021] EWCA Civ 1363 written about here).

The Claimants pursued five grounds of challenge. The first three alleged that NHSE were in breach of its statutory duty:

Under reg. 45(3) of the NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 ('the 2012 Regs') to ensure that 92% of NHS patients referred have commenced appropriate treatment within 18 weeks of referral; and

Under s.3B of the National Health Service Act 2006 by delaying puberty blocking treatment in such a way that children are unable to access the services before the onset of puberty; and

Under s.2 of the Health Act 2009 by failing to have regard to the right of adult gender dysphoria patients under the NHS Constitution to commence treatment within 18 weeks of referral.

The Claimants also alleged that NHSE directly, or alternatively, indirectly, discriminated against the first to fourth Claimants with regard to their protected characteristic of gender reassignment and also failed to comply with its public sector equality duty to make arrangements for the provision of services for people seeking treatment for gender dysphoria.

The decision

On the first ground, Chamberlain J held that the duty under reg.45(3) "*is a duty to make arrangements with a view to ensuring that the 18- week standard is met […] the regulation does not regard failure to achieve that standard, without more, as a breach*" [99]. He continued that the question of whether NHSE was in breach of reg.45(3) fell to be answered against the background of what it was presently and pointed to a number of factors affecting waiting times including (i) the marked increase in demand for services (ii) recent clinical controversy surrounding GID treatment (iii) the difficulty in recruiting and retaining specialists and (iv) and the need to redesign the commissioning model, see [101].

Earlier in the judgment, the Court summarised the steps NHSE are taking in light of the findings of the Cass Review. Namely, NHSE are planning to decommission the children's GIDS at the Tavistock by the spring of 2023 and replace it with two main centres in Alder Hey Children's Hospital in Liverpool and GOSH in London, as well as a number of other regional services, combined with a significant increase in funding [22 – 23]. Chamberlain J found NHSE's account of efforts made to reduce waiting times "*impossible to stigmatise* […] *as unreasonable or inadequate"*, such that it was impossible to say NHSE was currently in breach of its duty, at [102].

For similar reasons, the High Court held that the Claimant's second ground failed, see [108-111]. The High Court dismissed the third ground on the basis that the NHS Constitution does not impose any additional duties on NHSE beyond those set out in the 2012 Regs, see[115].

Chamberlain J did not find that waiting times amounted to direct discrimination on the basis of gender reassignment, because there were factors specific to GIDS which resulted in longer waiting times which did not apply to other specialist services, as described above, see [145]. Chamberlain J concluded:

> *"if there were evidence that the long waiting times for GID services were the result of a decision about the allocation of resources which was related to the shared protected characteristic of many services users (gender reassignment), a direct discrimination claim would succeed. The difficulty for the claimants is that there is no such evidence. On the contrary, as I have said, the evidence shows that the long waiting times have increased despite NHSE's willingness to increase very substantially the resources available for this service area" [147].*

The Judge also dismissed the Claimants' indirect discrimination argument, because the Claimants had not identified a PCP which applied to those who were not seeking GIDS, at [151-153]. The public sector equality duty challenge was also dismissed, see [172-173].

Comment

Despite a recent decision concluding that GLP did not have standing to bring a COVID-19-related 'public interest' judicial review (see *R (Good Law Project & Runnymede Trust) v Prime Minister and SSHSC [2022] EWHC 298)*, NHSE did not challenge the GLP's standing. Interestingly, Chamberlain J observed that it was not obvious to him why there was any need to add Gendered Intelligence and GLP as Claimants when the first four Claimants plainly did have standing. He stated: "*the availability of a better placed, directly affected challenger will generally tell against according standing to an individual or organisation seeking to litigate in the public interest*" see [175], making reference to two other High Court decisions he made on standing in relation to the GLP. The author's reading is that, had NHSE challenged the GLP's standing in this case, they would have been successful.

Recently, the employment tribunal has tended to be the arena in which transgender people (and those who encounter them)'s rights are contested. In my view, this judgment contains welcome clarification from the High Court on the scope of the protected characteristic of 'gender reassignment' under s.7 of the Equality Act 2010. The High Court upheld the definition adopted in the Employment Tribunal decision of *Taylor v Jaguar Land Rover Case No 1304471/2018*, namely that this includes those who are 'gender-fluid' and 'transitioning', see [129]. The High Court went further to find that those with the protected characteristic of gender reassignment do not need to have undergone any form of medical transition, see [129], and do not need to have started their process of transition but must simply 'propose' to undergo at least part of any such process – distinguished from a 'passing whim', at [131]. The High Court observed that not every child referred to GIDS will have this protected characteristic but there is no reason in principle why they cannot, provided they have made a settled decision, at [131-132].

The Claimants are appealing this decision.

Departing from Guidelines and Balancing of Risks in Different Medical Settings

Alice Kuzmenko

Mrs Marion O'Brien (Administratrix of the Estate of Mr John Berry (Deceased)) v Guy's & St Thomas' NHS Trust [2022] EWHC 2735 (KB)

At [99] HHJ Tindal (sitting as a Judge of the High Court) summarises aptly that "*this case turns not on debates about causation – or indeed the definition of Sepsis – but on a simple question, albeit with a complex answer: Was the decision to prescribe Mr Berry 400mg on 4th March 2017 Bolam-negligent*?"

This article will focus on the issue relating to guidelines, which is likely to be the central take-away point for practitioners. Mr Berry was administered 400mg of Gentamicin on 4 March by Dr Meyer. The parties were agreed that the dosage caused the Claimant ototoxicity side effects.

The Court summarised the issues as:

1. Was the 400mg dose 'excessively high' because Dr Meyer simply applied the ICU Gentamicin guideline that was itself *Bolam*-negligent in failing to adequately take into account the extent of a patient's renal impairment, ototoxicity risks, and in departing from other national and in-house guidelines for no good reason?

2. Irrespective of the ICU Gentamicin guideline, was the prescription 'excessively high' and *Bolam*-negligent in all circumstances (including the extent of renal impairment, risk of ototoxicity, and the departure from the guidelines)?

3. Even if prescription at 12:30 was not *Bolam*-negligent, was the decision to administer at around 20:30 *Bolam*-negligent?

Factual background

At the relevant time, Mr Berry was in end-stage renal failure. On 3 March 2017, Dr Thom (Renal Registrar) prescribed 80mg of Gentamicin and 1.2 of Vancomycin. These antibiotics were to deal with the queried overlying infective process, indicated by fluctuating NEWS infection scores, consistently high heart rate, low blood pressure, and high CRP. It is accepted that Mr Berry did not meet the clinical criteria for sepsis, but did have a significant infection, which may have progressed into sepsis if not treated with antibiotics. Mr Berry was soon after moved to ICU, due to concerns around his clinical presentation, infection, and risk of sepsis.

Gentamicin is a strong aminoglycoside antibiotic that disrupts the ability of Gram-positive and Gram-negative bacteria to make proteins. In high concentrations, it has a bacteriocidal effect (ie: it kills that bacteria). The peak level within the bloodstream takes place within 30-60 minutes of the dose, after which it is gradually absorbed by the kidneys. Follow up doses take place when the Gentamicin in the blood drops below the 'trough' level of less than 1 mg/L. Re-prescribing Gentamicin any earlier could create a 'twin peak' response but with a weaker bacteriocidal effect, and it raises the risk of ototoxicity. In renal patients with minimised kidney function, the absorption process is slower and more damaging.

The next morning, Mr Berry showed some clinical improvements, but his inflammatory markers significantly increased. Dr Meyer reviewed Mr Berry with this background of knowledge. He prescribed a 400mg Gentamicin dosage, to be administered once the trough level was reached (which it did that evening). After some delay, the dosage was administered. By then, Mr Berry's NEWS score had dropped, and he was clinically improving, but his inflammatory markers were still high. He was moved to a normal ward later on.

The Court found that, on balance, Mr Berry's infection and risk of sepsis worsened across the day and if not for the Gentamicin dose administered 4 March, he would have developed sepsis.

Dialysis restarted on 6 March and the Gentamicin levels did not reach trough level until 10 March. Months later, he was diagnosed with Gentamicin-associated vestibular ototoxicity, by June he had mobility limitations, and by July he was using a wheelchair. Unfortunately, in 2018, he suffered unrelated problems and died in hospital in January 2019.

The Guidelines

There were various guidelines on Gentamicin at the time. These are set out in fuller detail at [11] – [14]. In summary, the guidelines were:

1. NICE/BNF guideline for Gentamicin;

2. Renal Handbook 2014;

3. General Renal Impairment Guideline: this was the Defendant's general ward guideline on antibiotics use for patients with renal impairment;

4. The Antibiotic Use in Adult Patients with Renal Impairment Guideline;

5. ICU Guideline on Gentamicin: this was the Defendant's guideline on the use of Gentamicin, but only in the critical care areas of the hospital.

Law on Guidelines

This is explored by HHJ Tindal in detail from [75] – [87] and pithily summarised at [88]:

1. Even 'national' clinical guidelines are not a substitute for clinical judgment in individual cases;
2. Nor are they a substitute for expert evidence, but may inform expert evidence;
3. Departure from national guidelines is not necessarily prima facie evidence of negligence, but is likely to call for explanations;
4. Compliance with national guidelines may be inconsistent with negligence, if the guideline constitutes a *Bolam*-compliant body of opinion/practice. Where the guidelines are unsatisfactory, it may still militate against negligence;
5. Defendants cannot in principle set their own *Bolam* standard of care;
6. Guidelines are not a substitute or shortcut to the *Bolam/Bolitho* approach on considering standard of care.

The Court's conclusions

The Court found that on 4 March 2017, Mr Berry had a worsening systemic infection, with risk of it developing into sepsis, but that he was also showing considerable improvements in presentation and had good tolerance of dialysis. Far from ignoring or overlooking Mr Berry's condition, Dr Meyer deliberately decided on a mixed clinical strategy. The 80mg dose of Gentamicin given on 3 March was inadequate to prevent Mr Berry's inflammatory markers from worsening, and Dr Meyer realistically had "*one shot*" at a bacteriocidal dose to stem the infection. There were clear and serious risks of the infection developing into sepsis, and underlying vulnerabilities meant the infection could be life-threatening if left untreated – these outweighed the uncertain risk of ototoxicity. Dr Meyer prioritised the worsening systemic infection, yet still considered Mr Berry's renal function; consequently, he chose a lower than maximum dose available and deferred the administration of the second dose until Mr Berry's Gentamicin level fell below the trough level.

In considering the Defendant's ICU Guideline on Gentamicin, the Judge noted it was "*surprisingly sloppily-drafted*" and "*most concerningly, it is internally inconsistent*". He categorised it as not *Bolam*-compliant, and as it was an in-house guideline, any compliance with it would regardless not militate against negligence. He then went on at [106] to [113] to express why the 400mg Gentamicin dose was not *Bolam*-negligent. Focusing on the points concerning the guidelines:

1. Dr Meyer neither applied the ICU guideline (still less automatically), nor did he ignore or overlook Mr Berry's condition or extremely limited renal function. This was shown by Dr Meyer's mixed clinical strategy and risk/benefit analysis. He independently exercised his clinical judgment, which was logical and, in the court's view, reasonable.
2. Even if Dr Meyer did apply/adopt, rather than adapt, the ICU Guideline, the Guideline distinguished between renally-normal and renally-impaired patients, leaving room for individual clinical judgment.
3. Even if the ICU guideline was applied/adopted, there are cogent reasons for the 'one size fits all' approach in an ICU – amongst other reasons, the court noted the impracticality of undertaking extremely labour-intensive CCR/GFR tests (particularly as patients' conditions often change rapidly on ICU and some like Mr Berry may not be passing urine to test CCR/GGR for), and the need for simple and clear guidelines applicable to all, *"not a confusion of different guidelines where applying the wrong one could lead to someone's death".*

4. Although the national guidelines constitute a reasonable body of clinical practice generally, there is another reasonable body on ICU wards, where the balance of risk on ICU will often be different than in other setting such as ordinary wards.

5. The different balance for such seriously ill dialysis-dependent ICU patients is factored in by other guidelines – there were therefore good, logical, and cogent reasons to depart from NICE and other general Gentamicin guidelines where the risk from infection outweighs the risk of ototoxicity.

In the round, Dr Meyer departing from the NICE/BNF guideline for Mr Berry was justified. Mr Berry required a high bacteriocidal dose of Gentamicin, there was good reason to give it to him on ICU shortly before he was moved to a ward (where he could only have received a smaller dosage), and it was better to have prescribed and deferred administration, rather than to wait in prescribing altogether.

The Judge's response to the remaining challenges were as follows:

1. The decision to administer Gentamicin on 4 March was logical, reasonable, and accorded with a responsible body of clinical opinion, as Mr Berry still presented a mixed clinical picture and was on dialysis.

2. The focus of renal specialists differs from that of ICU specialists – it makes sense that Dr Thom and Dr Meyer struck the balance so differently. Dr Meyer needs to be judged by the standards of his own specialism in Intensive Care, and not that of his non-ICU renal colleagues.

3. The administration of the Gentamicin was also justified, as in the eight hours since prescription, there was no evidence of any significant clinical change, and the risk of infection just as much (or possibly more so) outweighed the risk of ototoxicity.

For the above reasons, the prescription and administration of 400mg of Gentamicin was not negligent.

Comment

This case provides food for thought on clinical guidelines.

Firstly, there is a clear distinction on their value depending on the source – internal hospital guidelines will not carry the same weight as national guidelines, particularly in terms of reflecting a *Bolam*-compliant body of opinion/practice.

Secondly, it reasserts the importance of practitioner's own clinical judgment. Not every case will fit the guidelines, and practitioners must be able to adapt – they should not simply adopt or automatically apply guidelines.

Thirdly, it highlights the difference that even the setting of the clinical practice may give rise to variations in what would be reasonable practice. While a 400mg dosage would be excessive from the perspective of a renal registrar on an ordinary ward, an 80mg dosage is inadequate from the ICU perspective where the infection carries greater risk than it ordinarily would. Again, this feeds into the fact that guidelines cannot simply be followed slavishly.

Jim Duffy acted for the Claimant in this case. He did not contribute to this article.

CANCER AND CONTRIBUTORY NEGLIGENCE: WHO IS THE OBJECTIVELY REASONABLE PATIENT?

Nicholas Jones

Otu v Vivek Datta [2022] EWHC 2388 (KB)

When will a patient be partly at fault for not following up when their doctor negligently fails to arrange an appointment? That was the question asked of the High Court in *Otu v Datta*, a case concerning the death of the Claimant's husband ("the Deceased") from colon cancer with metastatic spread to the liver.

Facts

In May 2014, the Deceased was seen in the Defendant's clinic after suffering from intermittent bowel problems over the previous few years, including haemorrhoids, bleeding, and severe pain when passing stools. He was diagnosed with an anal fissure and prescribed Diltiazem cream.

Despite being "*sure*" that the fissure was the cause of the symptoms, the Defendant wrote the following in a discharge letter to the Deceased's GP, copied to the Deceased: "*I think at some point, because he has change in bowel habit, he ought to have a colonoscopy and we will arrange this in a few weeks' time*" [32]. The colonoscopy was never arranged.

The Deceased applied the cream as instructed and his symptoms went away for some eight months. In fact, the anal fissure had masked the presence of colon cancer, which was eventually diagnosed in August 2016 following a series of further medical appointments. By that time, it had already metastasised to the liver.

In September 2016, the Deceased's serum carcinoembryonic antigen ("CEA") was measured at 23 which, while indicative of cancer, is relatively low on the scale, and cancer was found in 13 of 33 lymph nodes. Despite aggressive treatment which, by April 2017, had successfully stabilised the cancer, Mr Otu subsequently deteriorated and the cancer was found to have metastasised to his lungs, bones and again to his liver. He died from his condition on 24 January 2019.

The Defendant admitted only a breach of duty for the failure to arrange the colonoscopy, leaving the court with three issues to determine.

Factual causation

The first issue – whether the Deceased would have in fact attended a colonoscopy if he had been invited to do so – was dealt with briefly in the Claimant's favour. There was simply no reason to believe that a patient who had never missed an appointment would have skipped this one, notwithstanding the fact that his symptoms had resolved thanks to the cream, and that colonoscopies are distinctly unpleasant.

Medical causation

The second issue was whether, following the notional colonoscopy which would likely have taken place in July 2014, subsequent treatment would have been curative. To answer this, the primary question was whether metastatic spread to the Deceased's liver had already taken place by July 2014. It was accepted by the Defendant that, if there had been no such spread by that date, then the claim would succeed.

Despite finding, firstly, that the cancer was likely to have already spread from the colon to between one and three lymph nodes by July 2014, the Court concluded that, on the balance of probabilities, it had not yet metastasised to the liver.

In reaching that conclusion, it is worth noting that Mrs Justice Stacey explicitly paid no heed to the scientific literature on tumour doubling time ("TDT") and the timing of metastatic spread in the life of a primary tumour, which was provided by the parties' oncology experts Dr Bessell and Dr Falk (about whom she was extremely complimentary at [19]-[21]). Due to their theoretical basis, lack of proven application to the Deceased himself, and, in the case of TDT, known insufficiencies, the papers referenced on those topics were described by the

Court as "*of very limited use*" [56] and as simply reinforcing of each expert's contrasting view "*rather than of evidential value*" [68].

Instead, Mrs Justice Stacey was persuaded of her conclusion on medical causation by the clinical picture that could be established of the Deceased at the material times. This included the "*particularly significant feature*" that the Defendant's expert could not explain why the CEA reading in September 2016 "*would be so low if there had already been liver metastases for two years*" [83].

Further, the lymph node incursion found to have taken place by 2014 was "*minor*" [78], and at that time he had no red flag indicators of cancer such as significant weight loss, fatigue, fever, nausea, or loss of appetite [82]. It was also relevant that he underwent several examinations between July 2014 and 2016, none of which identified cancer up until the eventual diagnosis [79].

Contributory negligence

Finally, the Defendant argued that the Deceased was partly to blame for the lack of colonoscopy, as he had been informed of the plan to undergo the procedure and should therefore have pursued the clinic when it was not arranged.

The Court rejected this argument by asking what an objectively reasonable patient would have done in the Deceased's position. Crucially, the plan for the colonoscopy was made "*out of an abundance of caution*", rather than with a "*sense of urgency*", and the Defendant had been confident in his diagnosis of an anal fissure such that the Deceased "*would not have felt unduly troubled or left with the impression that he might have cancer*" [33]. The fact that the Deceased had not told his wife of the suggested colonoscopy or the possibility of cancer, which the Defendant likely mentioned at consultation "*in passing*" [33], was further proof that the Deceased did not consider a colonoscopy to be a "*serious possibility*" [34]. Moreover, after applying the prescribed cream, the Deceased's condition cleared up. It was reasonable to believe, therefore, that "*the problem was resolved*" [92].

Full liability therefore lay with the Defendant, and the Claimant was awarded agreed damages of £700,000.

Comment

On the facts, it is hard to disagree with the Court's conclusion on contributory negligence. But it is not to so difficult to imagine cases in which the line would be less clear cut.

Consider a scenario in which the Defendant had told the Deceased: "I am certain that you don't have cancer, but I *strongly recommend* that you undergo a colonoscopy to rule it out, which I will arrange". Would such a statement impose some level of responsibility on a patient to chase the clinic if the colonoscopy was never organised, potentially leading to a finding of contributory negligence?

The focus of Mrs Justice Stacey's analysis in *Otu* was on the Deceased's understanding of his *diagnosis*, rather than the Defendant's plan for further investigation: it was reasonable for the Deceased not to have followed-up on the colonoscopy principally because the Defendant expressed their certainty as to a separate diagnosis and mentioned the colonoscopy merely in passing.

But in the above scenario, would the doctor's certainty of diagnosis still hold sway? The answer to that question depends on what precisely is expected of an objectively reasonably patient. If the expectation is that they make decisions based on what the doctor has told them about their *condition* and the likelihood of severe illness, then it may be reasonable for a patient to conclude that the doctor's colonoscopy advice, however forcefully communicated, was superfluous. After all, if there is such certainty as to the lack of cancer, and the patient is never in fact invited for a colonoscopy, wouldn't the objectively reasonable patient conclude that the procedure was unnecessary after all?

On the other hand, one might conclude that a reasonable patient is expected to act in accordance with the crux of the "next steps" advice communicated to them by their doctor. If that advice is unequivocal as to what should be done notwithstanding the given diagnosis – in this scenario, that the patient should undergo a "just-in-case" colonoscopy – then it could be said that a reasonable patient would not go behind that clinical judgment.

Inevitably, the answer likely lies somewhere between the two. Counsel for the Defendant in *Otu* unsuccessfully prayed in aid the concept of patient autonomy, submitting that "*medical treatment is not a matter for the doctor alone*" [91]. This judgment reminds us that identifying the point at which any such patient autonomy will begin to erode a doctor's duty of care requires a close analysis of the facts: of what the patient knew, of the context in which the advice was given, and of the interaction between that advice and the later development of the patient's condition.

AN END TO THE PLUS OF GALBRAITH IN INQUESTS?

Dominic Ruck Keene

R (Police Officer B50) v HM Coroner for East Yorkshire and Kingston Upon Hull [2023] EWHC 81 (Admin)

The Divisional Court (Stuart-Smith LJ and Fordham J) considered a challenge to a Coroner's application of the *Galbraith* test as to what conclusions can safely be left to a jury in an inquest into the death of Mr Lewis Skelton. Mr Skelton had been shot by a Police Firearms Officer, and the jury was left to consider a conclusion of unlawful killing. Their decision is a significant step towards a pruning back of the *Galbraith Plus* test to be essentially one of evidential sufficiency, bar in exceptional circumstances.

The Galbraith Plus test

The clearest expression of the 'plus' element of the *Galbraith* test is *R (Secretary of State for Justice) v HM Deputy Coroner for the Eastern District of West Yorkshire* [2012] EWHC 1634 (Admin) where judicial review proceedings were brought to challenge the Coroner's decision to leave verdicts of unlawful killing by murder and unlawful killing by gross negligence manslaughter to the jury. At [20]-[22] Haddon-Cave J reviewed Galbraith Plus and at [23] he provided his own formulation

> *"It is clear, therefore, that when coroners are deciding whether or not to leave a particular verdict to a jury, they should apply a dual test comprising both limbs or 'schools of thought', i.e. coroners should (a) ask the classic pure Galbraith question "Is there evidence on which a jury properly directed could properly convict etc.?" (see above)* ***plus (b) also ask the question "Would it be safe for the jury to convict on the evidence before it?". The second limb, arguably, provides a wider and more subjective filter than the first in certain cases. In my view, this extra layer of protection makes sense in the context of a coronial inquiry where the process is inquisitorial rather than adversarial, the rights of interested parties to engage in the proceedings are necessarily curtailed and coronial verdicts are at large."*** [Emphasis added]

The Facts

Mr Skelton had a long history of mental ill health. On 29 November 2016 he was observed holding a small axe or hatchet while walking '*with purpose'* down a public road. The police were informed and told he was '*waving the axe around*', and were also made aware that he had at least some history of mental ill health. However, they were told that he had not actually approached or interacted with anyone. Police Officer B50, after an unsuccessful attempt to Taser Mr Skelton, shot him, believing that he had been threatened by Mr Skelton and that he potentially posed a threat to three members of the public.

The Divisional Court noted that the CCTV did not suggest that Mr Skelton had threatened Officer B50, and also did not suggest that Mr Skelton was threatening any members of the public at the point he was shot.

The Issues

The core ground of challenge was that the Coroner had failed to apply the *Galbraith* test correctly in his decision to leave an unlawful killing conclusion to the jury.

The Divisional Court began its extensive review of the relevant case law at [32-35], noting that:

> *"32. The decision in Galbraith is important not merely because of the extremely well known statement of principle to be applied when assessing a submission of "no case" in a criminal trial but also because it authoritatively decided which of two schools of thought should be followed in carrying out that assessment. Giving the judgment of the Court, Lord Lane CJ identified the two schools and the overriding approach to be adopted at 1040G-H:*
>
> > "There are two schools of thought: (1) that the judge should stop the case if, in his view, it would be unsafe (alternatively unsafe or unsatisfactory) for the jury to convict; (2) that he should do so only if there is no evidence upon which a jury properly directed could properly convict. Although in many cases the question is one of semantics, and though in many cases each test would produce the same result, this is not necessarily so. A balance has to be struck between on the one hand a usurpation by the judge of the jury's functions and on the other the danger of an unjust conviction."
>
> *33. At 1041B-C Lord Lane identified that adopting the first approach ("unsafe" or "unsatisfactory") would involve the trial judge applying his views to the weight to be given to the prosecution evidence and as to the truthfulness of their witnesses and so on. That had been said by Lord Widgery CJ in Barker (1975) 65 Cr App R. 287, 288 to be clearly not permissible…*
>
> *35…Lord Lane stated the correct principle at 1042B-E:*
>
> > "How then should the judge approach a submission of "no case"? (1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case. (2) The difficulty arises where there is some evidence but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence, (a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case. (b) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury. It follows that we think the second of the two schools of thought is to be preferred.
> >
> > There will of course, as always in this branch of the law, be borderline cases. They can safely be left to the discretion of the judge."

The Divisional Court went on consider the origin of the 'plus' in the judgment of Lord Woolf MR in *R v HM Coroner for Exeter and East Devon ex p Palmer* [2000] Inquest Law Reports 78. At [36] the Divisional Court held:

> *"The immediate issue in Palmer, which was a claim for judicial review of the coroner's refusal to leave a verdict of unlawful killing to the jury, was what approach the courts should adopt when deciding whether to intervene with a coroner's decision. That in turn involved the Court of Appeal in considering the proper approach of the coroner when deciding whether to leave an issue (in that case unlawful killing). In relation to that issue, Lord Woolf at [41] set out the classic Galbraith statement of principle which was agreed to be applicable to a coroner's assessment whether to leave an issue. He then went on to consider how the Wednesbury unreasonableness test should be applied by the court where a Coroner's decision to leave an issue is challenged:*
>
> > 46. In a difficult case, the Coroner is carrying out an evaluation exercise. He is looking at the evidence which is before him as a whole and saying to himself, without deciding matters which

> are the province for the jury, "Is this a case where it would be safe for the jury to come to the conclusion that there had been an unlawful killing?" If he reaches the conclusion that, because the evidence is so inherently weak, vague or inconsistent with other evidence, it would not be safe for a jury to come to the verdict, then he has to withdraw the issue from the jury. In most cases there will be only a single proper decision which can be reached on any objective assessment of the evidence. Therefore one can either say there is no scope for Wednesbury reasonableness or there is scope, but the only possible proper decision which a reasonable Coroner would come to is either to leave the question to the jury or not, as the case may be.
>
> 47. However, as was pointed out by the Lord Chief Justice in Galbraith, in these cases there will always be borderline situations where it is necessary for the Coroner to exercise a discretion. It is only in such a situation that he has any discretion. It follows, therefore, that the test of reasonableness enunciated in Wednesbury has to play in relation to decisions as to whether to leave a particular issue to the jury or not, a role which is extremely limited.
>
> …
>
> 49. … The coroner's duty is only to leave to a jury those verdicts which it would be safe for a jury to return. He is under a duty not to leave to a jury a verdict which it would be unsafe for them to return. To that extent he acts as a filter to avoid injustice."

The Divisional Court commented at [37-38] that it was not obvious that Lord Woolf was intending to add anything of substance to the *Galbraith* test –

> *"To say that the evidence is so inherently weak, vague or inconsistent (a clear reference back to the language of Galbraith category 2) that it would not be "safe" for a jury to come to that verdict seems to us to be indistinguishable in context from saying that the evidence is so weak, vague or inconsistent that (without usurping the function of the jury) no jury properly directed could properly convict the defendant. His observations were directed to demonstrating how limited is the possible scope for the existence of a "discretion"; and, in consequence, how limited is the scope for the application of a test of Wednesbury reasonableness."*

The Divisional Court noted that nevertheless in *R v Inner South London Coroner, ex p. Douglas-Williams* [1999] 1 All ER 344 Lord Woolf MR had again revisited the question of the extent of the discretion of a coroner not to leave to the jury what is, on the evidence, a possible verdict, holding at 348J-349C that:

> *"The conclusion I have come to is that, so far as the evidence called before the jury is concerned, a coroner should adopt the Galbraith approach in deciding whether to leave a verdict. The strength of the evidence is not the only consideration and, in relation to wider issues, the coroner has a broader discretion.* ***If it appears there are circumstances which, in a particular situation, mean in the judgment of the coroner, acting reasonably and fairly, it is not in the interest of justice that a particular verdict should be left to the jury, he need not leave that verdict****. He, for example, need not leave all possible verdicts just because there is technically evidence to support them. It is sufficient if he leaves those verdicts which realistically reflect the thrust of the evidence as a whole. To leave all possible verdicts could in some situations merely confuse and overburden the jury and if that is the coroner's conclusion he cannot be criticised if he does not leave a particular verdict."* [Emphasis added]

The Divisional Court went to review the subsequent significant decisions concerning *Galbraith* and *Galbraith Plus* (including in particular *R (Bennett) v HM Coroner for Inner South Londo*n [2007] EWCA Civ 617 and *West Yorkshire*). They conclude that:

> *"As this review of the authorities shows,* ***it is established by authority that is binding upon us that there is some (if small) distinction between the position of a coroner deciding what verdict to leave to a jury after hearing all the evidence and of a judge considering whether to stop a case after the conclusion of the prosecution case.*** *The distinction flows from the differences in process between the*

> *two jurisdictions, as explained by Lord Woolf in Douglas-Williams at 348-349 and Collins J in Anderson at [21]-[22]: see [41] and [44] above. Although the Court of Appeal has identified considerations of safety as relevant to the coroner's decision, there is limited guidance from the Court of Appeal about what should inform those considerations…. We reiterate that in Galbraith itself Lord Lane emphasised that "safe" and "unsafe" can mean sufficiency or insufficiency of evidence on which a jury could properly reach a guilty verdict. In contrast,* ***Bennett suggests that the concept of safety is an evidential one: see [54] above. This seems to us to be in accordance with conventional principle and, in almost all cases, to provide the answer to Leveson J's rhetorical question: on the face of it, if a verdict is (properly) open to the (properly directed) jury on the evidence how can it be said to be in the interests of justice that it not be left for the jury to consider? Any other approach, save for one based upon the wider interests of justice as suggested in Douglas-Williams runs straight into the risk of usurping the proper function of the jury****. This risk is, to our minds, accentuated in the light of Maughan now that all short form conclusions, including suicide and unlawful killing, may now be reached on the balance of probabilities: see the Chief Coroner's Leeming Lecture delivered on 22 July 2022, at paragraph 51.*
>
> *We are not strictly bound by other first instance decisions, but should follow them unless convinced that they are wrong.* ***We doubt whether we would have formalised the "Galbraith plus" test as was done in the West Yorkshire case; but it has been endorsed by subsequent first instance decisions even though the parameters of the "plus" element have not been made clear. We are not convinced that the formulation is wrong; but the devil is in the detail of what may render it unsafe to leave a conclusion to the jury in a case where, without usurping the function of the jury, it appears that there is evidence sufficient to enable a properly directed jury properly to return that conclusion. What is clear is that it is not open to a coroner, in a case which passes the classic Galbraith test of evidential sufficiency, to withdraw a conclusion under the guise of lack of "safety" just because they might not agree with a particular outcome, however strongly****. While being fully alert to the need for the coroner (and the court) to act as a filter to avoid injustice, we agree with the observation of Pepperall J that "where there is evidence upon which a jury properly directed could properly reach a particular conclusion or finding then it is likely to follow that the jury could safely reach such conclusion or finding." Likely but not inevitable; and, on present authority, it appears that the categories of consideration that could (at least in theory) render it unsafe to leave a suitably evidenced conclusion to the jury are not closed*." [Emphasis added]

With regards to the decision under challenge, the Divisional Court held at [80-1] that while the Coroner had not expressly stated there was a sufficiency of evidence to leave the conclusion of unlawful killing to the jury, it would be verging on the unreal to say that he had not applied the correct test. There was a sufficiency of evidence, and therefore

> *"…this was one of the normal run of such cases where that sufficiency of evidence meant that it was safe to leave it…. we cannot persuade ourselves that the lack of a single sentence recording the Coroner's view that the second limb of "Galbraith plus" was satisfied should lead to his ruling being set aside for want of reasons or other legal error. Although there has been a tendency to treat the "plus" safety aspect as a separate requirement, it is to be remembered that in Palmer, which is generally regarded as the origin of the "Galbraith plus" test, Lord Woolf expressed the test compendiously: "is this a case where it would be safe for the jury to come to the conclusion that there had been an unlawful killing?""*

Further, there was no question that the interests of justice required that particular conclusion not to be left to jury despite that sufficiency of evidence – "*Reverting to the limited guidance provided by the Court of Appeal in Douglas-Williams, it cannot be said that leaving unlawful killing to the Jury was liable to overburden or confuse them; or that it would not reflect the thrust of the evidence (albeit that the evidence was contentious and contested)*."

Comment

The Divisional Court appear regretfully to have concluded that the 'Plus' element was too deeply entwined into the coronial jurisdiction to be entirely uprooted. Nevertheless, the strength of their critical analysis and extent to which they sought to prune back its wider application suggests that it will be a brave Coroner who on no other basis than a somewhat lack of safety decides not to leave a particular conclusion to the jury. The far safer ground will always be a lack of sufficient evidence.

FRESH INQUEST INTO DEATH BY SUICIDE FOLLOWING CESSATION OF BENEFITS IS GRANTED

Alice Kuzmenko

Joy Dove v (1) HM Assistant Coroner for Teesside and Hartlepool and (2) Dr Shareen Rahman [2023] EWCA Civ 289

In Issue 10 of QMLR, I considered the judgment of the Divisional Court that refused the Applicant's four grounds seeking an order to quash the Coroner's determination. That article, and a more detailed summary of the factual background, can be found here.

This case concerned Ms Whiting, who had a history of spinal conditions, mental health problems, and suicidal ideation. In September 2016, Ms Whiting needed a reassessment for her ESA benefit allowance. She requested a home visit due to her mobility problems and anxiety. The DWP failed to action this, and required her to attend an appointment in person. Ms Whiting was unable to do so, at that time being housebound with pneumonia.

DWP took no steps to ascertain the reasons for Ms Whiting's non-attendance and considered that no 'good cause' was proven for Ms Whiting's failure to attend, that there was no evidence of limited capability for work, and stopped her ESA benefits on 7 February 2017.

Between 10 and 15 February 2017, Ms Whiting had discussions with DWP about this decision, and both she and a CAB representative submitted decision reconsideration requests. However, she was found dead on 21 February. The medical cause of death was recorded as being the synergistic effects of morphine, amitriptyline, and pregabalin, and cirrhosis. At the inquest, the Coroner referenced the ESA problems, but gave a short-form conclusion of suicide.

Following the inquest, two pieces of fresh evidence were obtained. The first was a report by an Independent Case Examiner ('ICE') report which criticised the DWP for failing to refer Ms Whiting for a home visit for her reassessment, failing to call her/undertake a safeguard visit, and failing to contact her GP. The second was a psychiatric report from Dr Turner which concluded that "*there was likely to have been a causal link between [the Department's] failings outlined in the…ICE report and Jodey's state of mind immediately before her death.*"

Ground i: The Divisional Court was wrong to conclude that a fresh Jamieson inquest was not necessary or desirable in light of the fresh evidence relating to the abrupt cessation of Ms Whiting's benefits by the DWP and the likely effect of that on Ms Whiting's mental health.

The Appellant submitted to the Court of Appeal that the fresh evidence obtained since the first inquest revealed at least a possibility that the abrupt cessation of Ms Whiting's benefits was a factor that contributed to the deterioration in her mental state, which led to her taking her on life. A fresh inquest would investigate if there was a causal connection between the failings identified in the ICE report and Ms Whiting's death, with the assistance of objective evidence from Dr Turner's report.

The Court considered that the evidence before the Coroner in the first inquest did not go beyond the assertions of the Deceased's family, to link Ms Whiting's death to the fact that the Department stopped her benefits. However, the ICE report set out why Ms Whiting's benefits were cut suddenly, and it was accepted that the DWP

should not have done so, and that their failings were extensive. Furthermore, Dr Turner's report concerned the way in which the abrupt cessation of benefits was likely to have affected Ms Whiting's state of mind.

Consequently, the Court concluded that the subjective evidence of Ms Whiting's family members "*is a forensic world away from evidence of an expert psychiatrist who can speak with objectivity, drawing on long clinical experience, about the likely impact on the deceased's established mental illness of actions by third parties such as the Department*" [67].

Further, the Court accepted that the Divisional Court was in error in separating the issue of Ms Whiting's mental health deterioration from her death and in approaching causation on the basis of whether the death would have occurred 'but for' the particular act or omission.

At [70], the Court laid out four reasons for its decision that, contrary to the First Respondent's submission, it should be open to a coroner to investigate the impact of past events on a person's mental health in a suicide case:

1. There is existing authority which shows that it is open to a coroner to record facts which contributed to the circumstances which may or may not have led to death;

2. There was no support for the First Respondent's approach distinguishing between physical causes that may have contributed to death (e.g. an unattended open window or sexual assault) and psychiatric causes that may have exacerbated mental illness;

3. It is undesirable to restrict a coroner's discretion to conduct whatever investigations are appropriate within a Jamieson inquest to establish 'how' a person came to their death, and;

4. It is the role of a coroner to investigate whether a deceased intended to take their own life and whether they did so while their mind was disturbed. In this way, investigating the cause of any such disturbance may be part of, or lie very close to, matters which are already before the coroner.

For these reasons, the Court of Appeal found that the Divisional Court was in error in its approach to the fresh evidence in two different respects.

The Court then turned to consider the statutory test of whether it is necessary or desirable in the interests of justice that a further inquest should be held. It was reiterated that an inquest's purpose is to seek out and record as many of the facts concerning the death as the public interest requires and to establish the 'substantial truth'. The Court considered that the family should have the opportunity to invite a coroner to make a finding of fact that DWP's actions contributed to Ms Whiting's deteriorating mental health, and if that finding were to be made, it would be open to the family to invite the Coroner to include a reference to that finding in the conclusion at box 3 or 4 of the ROI. This was considered to be desirable.

Further on desirability, the Court considered at [72] – [73] that:

1. The matter of the possibility for the cessation of benefits to have contributed to Ms Whiting's death was of real significance to Ms Whiting's family, and it was reasonable for the family to press for this to be investigated – this is part of determining the 'substantial truth';

2. If a coroner finds that Ms Whiting's death was connected with the abrupt cessation of benefits by DWP, the public would have a legitimate interest in knowing that, and for the matter to be examined in public;

3. It is possible that a coroner would want to submit a PFD report, and to hear from DWP about remedial steps already taken, and a coroner should have this opportunity, and;

4. The fact that the conclusion may be the same after a second inquest is not a reason not to direct for a second inquest.

Ground ii: The Divisional Court was wrong to conclude that a fresh Middleton inquest was not necessary or desirable in light of arguable breaches of the Article 2 operational duty owed to Ms Whiting by the DWP.

This ground was dismissed by the Court, who concluded that the DWP did not owe Ms Whiting an article 2 operational duty.

In considering the facts, the Court found that some suicidal ideation was mentioned in exchanges between Ms Whiting and the DWP in 2014 and 2016, but not at all in the exchanges immediately preceding her death in 2017. There was also evidence that no one around Ms Whiting that was aware that she was at real and immediate risk of suicide. As such, there was no proper basis for concluding that the DWP knew, or ought to have known, of there being a real and immediate risk to Ms Whiting's life on cessation of the benefits. The fact that the DWP has policy arrangements for dealing with vulnerable persons did not indicate an assumption of responsibility to safeguard against the risk of suicide either.

Judgment conclusion

The Court of Appeal dismissed ground 2 of the appeal, but allowed the appeal on the basis of ground 1, and directed for a fresh Jamieson inquest to be conducted.

Comment

This author considers the following to be the key points from the decision:

1. Bear in mind not simply the content of evidence, but the potential sources that can present that evidence. Although the original inquest had evidence of the link between the cessation of benefits and Ms Whiting's deteriorating mental state from her family, such evidence sourced from an expert's perspective marked that evidence out as 'fresh evidence' for the purposes of directing a new inquest, as it provided the scope for new conclusions that could be reached by a coroner.

2. A strong reminder that the narrow 'but for' causation test is inappropriate, and rather consideration should be given to factors that are more than a 'non-trivial' cause. The Court of Appeal did not take well to the submission seeking to separate Ms Whiting's mental health deterioration from her death. Consequently, a coroner's scope of investigation can be broad, as long as it still fits the confines of considering 'how' a person came to their death.

3. In a similar vein, investigating how it came to be that a deceased's mental health deteriorated prior to their death is here considered to be within the confines of what a coroner could investigate in determining how a person came to their death.

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