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Albion Chambers INQUEST TEAM NEWSLETTER

Neglect: Correction

The Chief Coroner HHJ Lucraft QC, sitting as part of the Divisional Court, ruled on 12 February 2020 that a coroner was wrong not to have left neglect to the jury, in a case where a woman died of malnutrition having suffered with malabsorption after bariatric surgery. The case illustrates the not only the difficulties of treating those with significant physical and mental health complications, but also that such complications will not prevent neglect being left to the jury in an appropriate case.

R (on the application of Lewis) v Senior Coroner for North West Kent [2020] 2 WLUK 180

The deceased was a woman with both physical and mental health problems. She had been diagnosed with paranoid schizophrenia, and was also obese. In 2010 she underwent bariatric surgery to address her obesity, and did lose weight afterwards. However, she was sectioned in 2010, and sent to a psychiatric unit in 2014. Her mental health and compliance with her treatment appears to have deteriorated from that point; she refused to take her medication or give blood samples. Her physical condition was poor – she had edema, hair loss, digestive and visual problems, which led to her admission to an external hospital in February 2017. After she was returned to the psychiatric unit, her physical condition deteriorated again; she was found partially conscious, with bed sores, poor oral hygiene and under-nourished. She died just over two weeks later. The cause of death was recorded as malnutrition caused by her bariatric surgery, as this had resulted in problems with nutrient absorption.

During the inquest, criticism was made of the care that she received once she had been returned to the psychiatric unit. The family pointed to the unit's failure to follow its own policies on nutrition and hydration, poor record keeping in relation to weight loss and symptom decline, and failure to seek the assistance of a dietician at a sufficiently early stage. Those working at the unit gave evidence that the problems were caused by malabsorption and non-compliance with medication.

The coroner's handling of the question of whether to leave neglect to the jury was undoubtedly problematic; the deceased's sister (the claimant) invited him to leave neglect and without saying that he would not, or giving reasons, he proceeded to sum up omitting neglect. The claimant applied to the Divisional Court to have the decision of the jury quashed, on the basis that they should have been allowed to consider neglect.

The Divisional Court agreed, and was critical of the coroner's failure to give reasons or indicate his intention not to leave this issue to the jury. In giving judgment the court emphasised the fact that the deceased had suffered significant weight loss, her records had not been kept properly and there were failures to follow policy by the psychiatric unit, as the family had alleged. The court said very clearly that neglect was available in those circumstances, notwithstanding that it would appear that none of those failures amounts to a gross failing as defined in *Jamieson*. The court ordered that a new inquest should take place.

This case illustrates a correction which I need to make to an article I wrote and training delivered last year regarding the case of Maguire[1]. In that case the deceased died after failures by multiple agencies involved in her care to identify that she was suffering with peritonitis, (ambulance unable to take her to hospital because they were unaware she had Downs Syndrome, GP failed to arrange home visit etc.). My interpretation of the judgment was that a series or collection of failings which fall short of 'gross', and are therefore not in themselves sufficient for a finding of neglect, could not be accumulated. The judgment records that it was argued on appeal that *"the Coroner was wrong to proceed on the basis that only the presence of one or more individual failings that could each be described as "gross" could justify neglect being left to the jury… acts or omissions by different individuals and/or different failures in the system can combine to form a "total picture that amounts to neglect"* (para 51), and that the coroner *"wrongly failed to consider whether various individual failings, taken as a whole, were capable of being viewed by the jury as amounting to a gross failure to provide basic medical care to a vulnerable person"* (para 53). My understanding at that point was therefore that the Coroner had proceeded on the basis that only failings which individually pass the gross-failing test could provide a foundation for neglect. In combination with paragraph 58 *"In our judgment the approach taken by the Coroner to the evidence in the inquest cannot be faulted"*, I understood the judgment to mean that the Coroner was right.

However, a local deputy Coroner contacted me to say that he had interpreted the case differently, and had been concerned enough about the ambiguity to contact the Chief Coroner (who was one of the judges sitting on the appeal). The Chief Coroner confirmed that the intention of the court was not to hold

[1] R (Maguire) v HM Senior Coroner for Blackpool & Fylde [2019] EWHC 1232 (Admin)

that individual acts of neglect falling short of gross failings could not be aggregated.

The second sentence of paragraph 58, recording that the coroner *"considered all the relevant evidence that may point to neglect as individual acts as well as considering the potential for the cumulative effect of each of the individual acts"*, meant not that the Coroner had considered the appellant's argument and disagreed with it, but that he had found it was without factual foundation. The coroner had simply come to the conclusion that the failings, aggregated, did not amount to neglect on the facts.

Whilst the judgment is ambiguous (several practitioners, a coroner and I interpreted it as I originally did during an inquest we were conducting in the week of the judgment's release!), having heard indirectly from the Chief Coroner that my interpretation was wrong, I wanted to alert those reading this newsletter. The case of *Lewis*, above, involves facts on which neglect must have been open to the jury on the basis of aggregating failings, and the court once again included the Chief Coroner.

Anna Midgley

How to deal with the Coroner's expert

Analysis of *R (Smith) v HM Assistant Coroner for North West Wales* [2020] EWHC 781 (Admin)

I'm sure many of us will have appeared in inquests where the coroner has appointed an independent expert to report on the care provided to the deceased, and has then given such weight to the expert's evidence that any evidence to the contrary is given fairly short shrift.

Similarly, I'm sure that some of us will have been preparing for an inquest, knowing the independent expert's evidence is in our favour, and therefore that we can expect an easy ride at the inquest itself.

What was refreshing about the case of *Smith*, heard last month, is that the coroner rejected the causation evidence of their own expert and on judicial review the Divisional Court, which included the Chief Coroner, upheld that decision.

The Facts

Leah Smith died on 2 May 2017, aged 27. She had been referred to a mental health liaison by her GP on 20 March 2017 because she had been noted to express paranoid delusions. She was seen by doctors and nurses over the coming weeks, but did not see a consultant psychiatrist until 25 April 2017. On 28 April 2017 she sadly hanged herself, and died in hospital a few days later.

The Trust responsible for Leah's care conducted a Root Cause Analysis report, which concluded that inadequate medical cover for home treatment team patients in the West was a root cause.

The coroner decided Article 2 was engaged, and commissioned a report from Dr Maganty, a consultant forensic psychiatrist. His report highlighted "a singular lack of availability/access to a consultant psychiatrist" and concluded that there was a "failure of provision of basic medical care" and that the death "was not only predictable but was entirely preventable". Dr Maganty was not sitting on the fence in the way he expressed his opinion. Accordingly the family sought critical findings in the Record of Inquest, including a finding of neglect.

However, at the inquest Dr Maganty gave his evidence before the Trust's two psychiatrists. The latter, Dr Mehr, disagreed with Dr Maganty's opinion that, had Leah been seen by a consultant psychiatrist sooner, she would have been treated with olanzapine. His evidence was that the doctor who had seen Leah initially "did what everybody else as a psychiatrist would have done".

Use of statistics – the *Chidlow* question

Dr Maganty's conclusion that the death was preventable was based on statistics, namely that for those patients experiencing a first episode psychosis who receive appropriate treatment, the five-year mortality rate is less than 0.1%. He therefore concluded that over 99% of those who received treatment did not kill themselves, and therefore Leah's death was predictable and preventable.

In making an assessment of Dr Maganty's evidence, the coroner considered the case of *Chidlow* [2019] EWHC 581 (Admin) and decided the fact Leah did not see a consultant psychiatrist until 25 April did not, on the balance of probabilities, have any causative effect on her death.

Somewhat remarkably, in upholding the coroner's decision the Divisional Court noted that "Dr Maganty's use of statistics was couched in very general terms" (!).

The decision on this point perhaps begs the question – if the statistical evidence suggests a probability of 99.9% versus 0.1%, what further steps need to be taken to demonstrate the deceased was in the 99.9% group rather than the 0.1% group on *Chidlow* grounds?

The decision to reject the independent expert's conclusion

The Claimant on review also sought to argue the coroner's decision to reject Dr Maganty's conclusion on causation was irrational, relying heavily on the fact the Trust had indicated at a Pre-Inquest Review that it accepted what was said by Dr Maganty and his conclusions, even suggesting there was no need for Dr Maganty to attend the inquest.

Despite those apparent concessions, the Divisional Court decided the coroner was not bound to accept Dr Maganty's conclusions, particularly where they had been somewhat undermined by the later evidence of the Trust's two psychiatrists.

On this and the previous question, the Divisional Court emphasised that it was important to distinguish between what ought to be left to a jury (or considered by a coroner sitting alone) and what could properly be concluded once the question had been left. Here, the coroner sitting alone had considered the evidence and had effectively preferred the evidence of other witnesses to that of Dr Maganty, thereby entitling her to reject his conclusions.

The Record of Inquest

In her Reasons, the coroner made various findings about the failures in the care provided to Leah. However in the Record of Inquest, the coroner entered brief factual information in Box 3, before providing a short non-critical narrative in Box 4. The Claimant challenged this, seeking to include the critical findings in the Record of Inquest.

The Divisional Court refused the Claimant's application to amend the Record of Inquest, describing the suggested amendment as reading

"more like a Statement of Case" than the Conclusion of a coroner's inquest.

In the course of a few paragraphs which many practitioners will find helpful when advocating for a non-critical form of words in future inquests, the Divisional Court held that:

- In a *Jamieson* inquest a conclusion must be factual, expressing no judgment or opinion
- In an Article 2 inquest, the inquest should culminate in an expression of the jury's conclusion on the disputed factual issues at the heart of the case (*Middleton*)
- Any narrative is expected to summarise those factual conclusions briefly (*Middleton*)
- To add the critical findings sought "would have compromised the essential brevity and simplicity required of a Conclusion"
- It was correct for the criticisms to be placed in the Reasons, and not in the Conclusion

Final thoughts

In many respects elements of this decision may be seen as surprising, particularly when seen in the light of authorities such as *Tainton*, but it perhaps goes to show how reluctant the higher courts will be to interfere with a reasoned decision from a coroner who has considered the relevant authorities.

The judgment is useful for all practitioners seeking to challenge the conclusions of an independent expert based on statistical evidence, and also for inviting a coroner to include any critical findings in their Reasons while keeping the Record of Inquest brief, neutral and factual.

Alexander West

More oversight needed of deaths in custody?

Every four days, a person in prison takes their own life – a shocking and unacceptable death toll. Levels of distress are at record high levels, with 166 recorded incidents of self-harm every day[1]. There are 308 deaths in prison in total (six deaths every week) and 90 self-inflicted deaths (one self-inflicted death in prison every four days). Of those, 158 deaths are categorised as due to 'natural causes', 58 recorded as other and 56 awaiting classification.

Those are some of the very alarming statistics published by the charity 'Inquest' in January of this year in their report "Deaths in Prison: A national scandal"[2]. They rightly raise significant questions as to why so many people in prison are taking their own lives and whether these deaths are preventable. One of the worst examples of broad brush, opaque and subjective terminology is 'natural causes'. This term has the potential to be misleading when not explicitly pegged to having occurred in prison or other state detention. Without that context, it does not reflect how the extremely poor living conditions and difficulties of access to regular healthcare and medication impacts upon those suffering from pre-existing illness. These sorts of difficulties are particularly highlighted by the Covid-19 health pandemic and the increased risks for those in prison.

Inquest's report identified areas in need of immediate reform, and surely the current health crisis will also have put a further spotlight on the conditions people are facing in not only custody, but any situation where they are deprived of their liberty. Anyone subject to restrictions such as prisoners, mental health patients subject to section or those being detained in immigration detention centres, are reliant on an appropriately funded system of care. That system must have sufficient safeguards that, when things go wrong, the individual affected can not only challenge those potentially at fault, but do so knowing that their experience means it shouldn't happen again to anyone else. That is in theory the system we have. If someone sadly loses their life in custody and the state has failed in its positive obligations under Article 2 of the European Convention on Human Rights to protect that person's life, an inquest is held to find out what went wrong. Narrative conclusions are regularly returned and even Prevention of Future Deaths reports are drafted and those have affected policy change over time, however they still fall short of achieving the systemic change needed to safeguard people detained by the State.

The recommendations and suggestions from Inquest include a recommendation for the formation of a new independent body: a 'National Oversight Mechanism'. It is hoped that this would provide a level of scrutiny, and ultimately accountability, that would bring together the repeated failings we see on a case by case basis into a broader context. It is suggested this body would collate, analyse and monitor learning and implementation arising out of post-death investigations. Practically speaking, it may be many years before this could be set up and begin effecting change. It is surely, though, a vital instrument if we are to give any teeth at all to the recommendations made by Coroners, and if the families who have lost loved ones are to find any solace in knowing that going through the process of an inquest could prevent someone else suffering the same fate.

Charley Pattison

[1] Ministry of Justice statistics 2019

[2] https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=bb400a0b-3f79-44be-81b2-281def0b924b

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