Overturning a coroner's verdict

Coroners' investigations are limited in nature leaving families seeking answers, as Ben Keith and Benjamin Burge explain

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Why is it so difficult to overturn a coroner's verdict at inquest level? And are coroners entitled to reach the decisions they do with regards the scope of the inquest?

Death affects us all. As family members in an inquest, individuals have the right to know by what means and in what circumstances their loved ones died. This right is contained within section 5(2) of the Coroners and Justice Act 2009 (CJA 2009).

As the UK deals with the devastating consequences of covid-19, this right has become even more important. As recent rulings this summer illustrate, when families fail to receive the answers they require or expect, the courts are reluctant to interfere with or overturn the coroner's verdict.

Article 2 of the European Convention on Human Rights protects the right to life and places a procedural obligation on the state to investigate a death for which it may be responsible. Case law states that in determining 'how' an individual has died, the inquest must consider 'by what means and in what circumstances'.

The coroner is prohibited from framing determinations that attribute criminal or civil liability to a named person. Those decisions are for the courts.

MAGUIRE

The courts have considered these provisions in circumstances where death follows medical mishap. The well-settled approach (in *Lopes de Sousa Fernandes v Portugal* (ECtHR application no 56080/12 (2018) 66 EHRR 28)) was set out by the Lord Chief Justice (LCJ) in *R (Maguire) v HM Senior Coroner for Blackpool and Fylde* [2020] EWCA Civ 738.

In cases involving medical negligence the state's positive obligations are regulatory, including necessary measures to ensure implementation, such as supervision and enforcement.

In 'very exceptional cases' a state may be responsible under the substantive limb of article 2. These include:

1. A specific situation where an individual patient's life is knowingly put in danger by denial of access to lifesaving emergency treatment as opposed to circumstances where the patient received deficient, incorrect or delayed treatment.
2. Where a systemic or structural dysfunction in hospital services deprives a patient of access to lifesaving treatment; and the authorities knew or ought to have known about the risk but nevertheless failed to undertake the necessary measures to prevent it from materialising, thus putting the patient's life in danger.

Four factors are used to determine if there are exceptional circumstances, for example, the acts or omissions of the provider must go beyond mere error or medical negligence in denying emergency treatment when a patient's life is at risk.

The court drew a distinction between ordinary negligence cases, where the procedural obligation does not apply; and cases of systemic failure where it does.

The case followed the death in hospital of Miss Maguire in February 2017. Cause of death was recorded as a perforated gastric ulcer and peritonitis; and pneumonia. Since 1993, she had been living at a residential care home. She had Down's Syndrome, learning and behavioural difficulties, and some physical limitations. She received personal care from staff who had no medical or nursing training.

Maguire became ill two days before her death and died the day she was admitted to hospital. A GP had advised that she be persuaded to attend hospital, but that if she refused she should be monitored overnight – which is what happened. Due to her deterioration an ambulance was called the following morning.

The judicial review was dismissed on the basis that the criticisms alleged against the care home, the paramedics, and the GP in failing to get her to hospital the night before she died (and the absence of any plan, protocol, or guidance) did not amount to the systematic regulatory failing envisaged by the jurisprudence.

STURGESS

In *R (Sturgess) v HM Senior Coroner for Wiltshire and Swindon [2020] EWHC 2007*, Dawn Sturgess had died in July 2018 after unknowingly spraying herself with Novichok found in a bottle disguised as perfume several months after the poisoning of Sergei and Yulia Skripal. The appeal challenged the coroner's preliminary ruling to consider only the acts and

omissions of two Russian nationals, including how the Novichok arrived in Salisbury. The inquest would not investigate whether it involved other members of the Russian state or the source of the Novichok.

On Article 2, the court upheld the coroner's decision confirming that the obligations do not extend to investigating agents of another state believed to be implicated in the death.

It went on to consider whether the coroner was wrong to avoid investigating Russia's responsibility more generally, by relying on the requirements to avoid determining criminal and civil liability; and/or because Russian responsibility for the death was too remote.

In the absence of criminal proceedings and a significant time lapse, the court held that an inquest was the appropriate forum to investigate the source of the Novichok and the directions given to the two Russians.

The court was equally "puzzled" by the coroner's reluctance to consider the actions of the two men on the basis that it could potentially lead to a civil liability determination against Russia (the Inquest Rules allow for a determination of unlawful killing).

The ruling also doubted that the "broad discretion" given to the coroner justified the narrowing of his investigation to the extent he had proposed. In these unusual circumstances, the matter was remitted to the coroner for further consideration.

IROKO

In *R (Iroko) v HM Senior Coroner for Inner London South [2020] EWHC 1753*, the chief coroner in England and Wales applied the LCJ's approach, stating that the court's role in considering the decision of the coroner was narrow.

Mrs Iroko died in hospital following cardiac arrest. Issues arose over the application of the NHS trust's 'do not attempt cardiopulmonary resuscitation' policy. Her death was reported and at a preliminary ruling it was held that there was no evidence that any failure or dysfunction in her treatment was systemic or due to a failure to put in a place a regulatory framework.

Therefore, the procedural requirements of article 2 and section 5(2) CJA 2009 did not apply, despite accepting there may have been failings in her care.

At the inquest, the coroner confirmed the position in respect of article 2, concluding that Iroko died from acute intestinal obstruction.

While accepting the coroner had an obligation to keep article 2 under review and noting some deficiencies by hospital staff, the court was unpersuaded that they cumulatively gave rise to 'systemic dysfunction' such as to require an article 2 inquest. The judicial review was dismissed.

HIGH THRESHOLD

Over the summer, the divisional court has sought to maintain its stance on the overruling or quashing of a coroner's decision. The threshold remains curiously high and families are left aggrieved by the limited nature of the coronial investigation and the courts' review process.

But a divergence appears to be emerging between deaths in a medical setting and those played out in the international arena, as coroners tread the tightrope of the CJA 2009. While the courts restrict reviews of the former, there is a willingness to entertain the latter.

For understandable reasons, the public expects greater coronial investigations into the serious incidents that occurred in Salisbury, but that leaves families who lose loved ones as a result of actions by our own medical authorities feeling neglected.

As the UK faces difficult questions about the covid-19 death toll, families of the deceased will want to know what really happened in the hours and days preceding those deaths.

There will be an expectation on coroners to consider both the individual circumstances of a coronavirus victim's death, and to examine the presence of any systemic or structural dysfunction within the hospital services throughout this pandemic.

If this threshold is maintained families will continue to be left with unanswered questions.

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