Neutral Citation Number: [2018] EWHC 1501 (Admin)

Case No: CO/5280/2016

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
DIVISIONAL COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 15/06/2018

Before:

LORD JUSTICE SINGH
MR JUSTICE FOSKETT
and
HH JUDGE LUCRAFT QC sitting as a Judge of the High Court

- -

Between:

The Queen (on the application of Gerard Joseph Parkinson)	**Claimant**
- v -	
HM Senior Coroner for Kent	**Defendant**
Dartford and Gravesham NHS Trust	**First Interested Party**
Sameer Hijazi	**Second Interested Party**

- -
- -

Mr Michael Rawlinson QC and Mr Edward Ramsay (instructed by **Pennington Manches LLP**) for the **Claimant**
Ms Samantha Leek QC (instructed by **Bircham Dyson Bell**) for the **Defendant**
Mr Stephen Brassington (instructed by **Clyde & Co LLP**) for the **First Interested Party**
Mr Andrew Hurst (instructed by **Radcliffes Le Brasseur**) for the **Second Interested Party**

Hearing dates: 8-9 May 2018

- -

Judgment Approved

Lord Justice Singh:

Introduction

1. This is the judgment of the Court, to which all of its members have contributed.

2. On 9 January 2011 Mrs Kathleen Parkinson died at the Accident and Emergency ("A&E") Department of Darent Valley Hospital, Dartford. She was born on 11 October 1919 and was 91 years old. Her son, Gerard Parkinson, is the Claimant in the present proceedings.

3. The Defendant is the Senior Coroner for Kent, who conducted an inquest into the death of Mrs Parkinson. The inquest took place from 9 to 27 May 2016. On 14 July 2016 the Defendant (hereafter referred to as "the Senior Coroner") delivered his findings in open court.

4. On 31 August 2016 the Senior Coroner issued a Record of Inquest. This included additional words in Box 3:

> "… On arrival in A&E she was assessed and found to be dying. Her son attempted to perform mouth to mouth resus, although advised against this by the A&E staff. She deteriorated rapidly and died soon after arriving."

5. The Interested Parties are, first, Dartford and Gravesham NHS Trust, which is responsible for the hospital; and, secondly, Dr Sameer Hijazi, who was the middle-grade doctor in charge of the A&E Department on the morning in question.

6. Permission to bring this claim for judicial review was granted on the papers by Mostyn J.

The findings made by the Senior Coroner

7. In a document headed 'Conclusion – 14 July 2016 – Gravesend Coroner's Court' the Senior Coroner set out his findings after the inquest. He first set out his summary of the evidence. After doing so he set out his findings on the facts. On the balance of probabilities he found the following facts to be established.

8. He identified two main areas of dispute at the inquest: first, the cause of the death of Mrs Parkinson and, secondly, the diagnosis and treatment of her while she was at the hospital.

9. Dealing with the first of those issues, he concluded that the cause of death was "bronchopneumonia combined possibly with right lung pulmonary thrombi", accepting in that regard the opinion of Professor Mary Sheppard (see, in particular, paras. 145-151 below).

10. The Senior Coroner went on to state:

> "While I accept the evidence from Gerard Parkinson and his sisters that Mrs Parkinson was an active lady for her age there is clear evidence both from her medical history and the evidence of Dr Becker the general practitioner, that she had suffered for some time prior to her death from dementia. She was unwell on 21 December 2010 when Dr Rush attended her and treated her with antibiotics on the diagnosis of a chest infection. At a little after 5:00am on 9 January 2011 when Mrs Parkinson was taken ill and taken by ambulance to hospital she arrived in my findings sometime between 6:15am and 6:20am and was there seen by a nurse and examined as is recorded in the notes.
>
> It was apparent to Dr Hijazi the doctor who saw Mrs Parkinson that she was in agonal breathing and given the other recorded findings he formed the view that she was sadly dying. It is clear that Gerard Parkinson did not accept this and he wanted his mother treated, and when that had been declined by Dr Hijazi I confirm that Mr Parkinson had become extremely angry and I am satisfied that he did make threats towards the doctor and was obstructive. I also accept from the evidence of Dr Hijazi that he was extremely concerned and considered security to deal with the situation. I find that as a result of the way the doctor was treated by Mr Parkinson this did result in him not being able to carry out a full examination of Mrs Parkinson, which given the evidence I have considered, I consider to be understandable. It is right to say that Mrs Parkinson was provided with intravenous fluid, antibiotics and gelofusine. The evidence of Dr Hijazi is supported and I accept by the evidence of Alison MacKay, the agency nurse who was on duty and Sister Taylor."

11. Turning to the second issue which he had identified, the diagnosis and treatment of Mrs Parkinson, the Senior Coroner stated as follows:

> "Dealing with the diagnosis and treatment of Mrs Parkinson I consider that the treatment provided by Dr Hijazi was appropriate given the limited time between Mrs Parkinson's arrival at the hospital and her subsequent unfortunate death. While tests and scans could have been conducted, from a practical point of view there would not have been sufficient time for this to be carried out and completed and treatment provided prior to her death to realistically have affected the outcome.
>
> It was in my view perfectly reasonable for Dr Hijazi to have concluded that with her agonal breathing and the results of the examination and tests available to him … Mrs Parkinson was in the course of dying. Despite this he did not provide the

> treatment that I have already outlined I do not accept that there was any failure to diagnose and treat Mrs Parkinson given the circumstances to which I have referred that the doctor encountered when he attempted to examine Mrs Parkinson."

12. The Senior Coroner then turned to the submissions which had been made on behalf of the family, the Trust and Dr Hijazi. He said:

> "… Prior to the start of the inquest I indicated I did not accept that this was an inquest that should be heard pursuant to Article 2 of the European Convention on Human Rights, but that I would keep this under review during the course of the hearing. I confirm this I did. I have considered the family's submission in this respect but I remain of the view that this inquest should not have been conducted on Article 2."

13. The Senior Coroner then considered whether he should make a finding of unlawful killing on the ground that there had been gross negligence manslaughter. He directed himself as to recent authority on that subject and said as follows:

> "Whilst I accept there was obviously a duty of care owed to the deceased I do not accept that this has been breached or made a material contribution to the death and certainly was not so serious that it can be categorised in so far as gross negligence.
>
> On the evidence I do not accept that there is any evidence that Mrs Parkinson was neglected in the treatment and the care she was provided with at the Darent Valley Hospital by Dr Hijazi or other members of the staff."

14. Further, the Senior Coroner concluded that there was no evidence to consider justifying a conclusion that the death was due to an accident.

15. He ended in this way:

> "On the evidence that I have read and heard, I have come to the conclusion that the death of Kathleen Parkinson was due to natural causes, and I am satisfied that any additional treatment that could have been provided to her in the short time she was at Darent Valley Hospital, would have been ineffective given the advanced stage of dying which she was at the time of her arrival at the hospital on 9 January 2011. I have considered the submissions pursuant to paragraph 7 schedule 5 of the Coroners' Justice Act 2009, I do not consider any report is necessary from me. May I finally express my sympathy to the family."

The Claimant's Grounds of Challenge

16. The Claimant advances the following five grounds of challenge:

(1) The Senior Coroner's finding that the enhanced investigative duty under Article 2 did not arise in this case can only have been based upon a misinterpretation of the applicable law and in breach of the Claimant's Convention rights.

(2) The Senior Coroner's finding regarding the medical cause of death was irrational.

(3) The Senior Coroner's use of a short form Conclusion to find that Mrs Parkinson died from "natural causes" did not constitute a sufficient discharge of his duties under the Coroners and Justice Act 2009 ("CJA"), under subordinate legislation and at common law; and/or was irrational.

(4) The Senior Coroner's finding that the Claimant's conduct obstructed the care which would otherwise have been provided by Dr Hijazi to Mrs Parkinson was irrational.

(5) The Senior Coroner's failure to make a Prevention of Future Death Report can only have arisen from a misunderstanding of the nature of his duty to do so under the CJA.

17. The Claimant asks that the Record of Inquest should be quashed by this Court and that a fresh inquest should be ordered; alternatively, that this Court should use its own powers to remedy the defects in the Record of Inquest; and further that the Senior Coroner should be ordered to make a Prevention of Future Death Report.

Material Legislation

18. Section 5 of the CJA, so far as material, provides:

> "(1) The purpose of an investigation under this Part into a person's death is to ascertain –
>
> (a) who the deceased was;
>
> (b) how, when and where the deceased came by his or her death;
>
> (c) …
>
> (2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998 …, the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.

> (3) Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than –
>
> > (a) the question mentioned in subsection (1)(a) and (b) (read with subsection (2) where applicable);
> >
> > (b) the particulars mentioned in subsection (1)(c).
>
> This is subject to paragraph 7 of Schedule 5."

19. Para. 7(1) of Sch. 5 to the CJA provides:

> "(1) Where –
>
> > (a) a senior coroner has been conducting an investigation under this Part into a person's death,
> >
> > (b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and
> >
> > (c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,
>
> the coroner must report the matter to a person who the coroner believes may have power to take such action."

20. Section 10 of the CJA, so far as material, provides:

> "(1) After hearing the evidence at an inquest into a death, the senior coroner (if there is no jury) … must –
>
> > (a) make a determination as to the questions mentioned in section 5(1)(a) and (b) (read with section 5(2) where applicable), and
> >
> > (b) …
>
> (2) A determination under subsection (1)(a) may not be framed in such a way as to appear to determine any question of –
>
> > (a) criminal liability on the part of a named person, or

(b) civil liability.

(3) …"

21. The procedure at an inquest is governed by the Coroners (Inquests) Rules 2013 (SI 2013 No. 1616). Rule 34 provides that a coroner must make a determination and any findings required under section 10 of the CJA by using Form 2.

22. The Schedule to the Rules sets out what Form 2 (Record of an Inquest) must contain. According to that Form, the Record should include:

> "(1) Name of the deceased (if known)
>
> (2) Medical cause of death
>
> (3) How, when and where, and for investigations where section 5(2) of the CJA applies, in what circumstances the deceased came by his or her death
>
> (4) Conclusion of the coroner as to the death
>
> (5) Further particulars required by the Births and Deaths Registration Act 1953."

Note (i) to those provisions states that:

> "(i) One of the following short-form conclusions may be adopted
>
> I. Accident or misadventure …
>
> IV. Lawful/unlawful killing
>
> V. Natural causes …"

Note (ii) states that, as an alternative, or in addition to one of the short-form conclusions listed, the coroner may make a brief narrative conclusion.

23. According to Jervis on Coroners (13th ed.), para. 13-31, this is a list of:

> "suggested, rather than compulsory, conclusions. The object of this list is to standardise conclusions over the whole country and to make the statistics based on the Annual Return more reliable by avoiding as far as possible any overlap or gaps between the different conclusions."

24. Jervis states, at para. 13-35, that:

> "Despite the existence of an 'official' list of suggested conclusions, there is no statutory requirement that a 'conclusion as to death' be in any particular form; all that is needed is that it should be expressed in concise and ordinary language so as to indicate how the deceased came by his death. …"

25. Finally in this context, Jervis states, at para. 13-34, that the notes to the 1984 version of the form suggested that each of natural causes, industrial disease, dependence on drugs/non-dependent abuse of drugs and want of attention at birth might, in appropriate circumstances, be qualified as being causes of death "aggravated" by lack of care (now called "neglect") or self-neglect. It is observed by Jervis that this note is not replicated in the 2013 form and there is no mention of neglect. However, it was common ground before us, as we understood it, that there is no rule which prevents such a finding being made by a coroner.

Relevant Guidance

26. The Chief Coroner (at that time HHJ Peter Thornton QC) issued Guidance No. 17 headed "Conclusions: short-form and narrative". The guidance, which was based on an understanding of the relevant case law, was first issued on 30 January 2015, with a revised edition issued on 14 January 2016.

27. The concept of "neglect" was addressed at paras. 74-85 of the guidance. It was noted that a finding of neglect (formerly lack of care) was specifically approved by the Court of Appeal in *R v HM Coroner for North Humberside and Scunthorpe, ex p. Jamieson* [1995] QB 1. It may form part of the conclusion in Box 4, either as words added to a short-form conclusion or as part of a narrative conclusion: see para. 75 of the guidance.

28. Para. 76 of the guidance states:

> "Neglect is narrower in meaning than the duty of care in the law of negligence. It is not to be equated to negligence or gross negligence. It is limited in a medical context to cases where there has been a gross failure to provide basic medical attention."

29. Para. 78 of the guidance quotes from *Jamieson*, at p. 25:

> "(9) Neglect in this context means a gross failure to provide adequate nourishment or liquid, or provide or procure basic medical attention or shelter or warmth for someone in a dependent position (because of youth, age, illness or incarceration) who cannot provide it for himself. Failure to provide medical attention for a dependent person whose

> position is such as to show that he obviously needs it may amount to neglect …"

30. Para. 79 of the guidance states that this definition has been expanded more by illustration than by changes in the law, testing the words "gross failure" and "basic" against particular facts. In broad terms there must be a "sufficient level of fault" to justify a finding of neglect. Para. 79 continues:

> "… That does not mean that, for example in a medical context, there has to have been no action at all, simply that the action (or lack of it) on an objective basis must be more than a failure to provide medical attention. It must be a gross failure. The difference will be highly fact-specific."

31. Para. 80 continues:

> "In a medical context it is not the role of an inquest to criticise every twist and turn of a patient's treatment. Neglect is not concerned with the correctness of complex and sophisticated medical procedures but rather the consequences of, for example, failing to make simple ('basic') checks."

32. Para. 82 states that there must be a clear and direct causal connection between the conduct described as neglect and the cause of death, citing *Jamieson* at p. 25. Para. 82 continues:

> "… The 'touchstone' is 'the opportunity of rendering care … which <u>would have</u> prevented death: *Staffordshire* case [(2000) 164 JP 665, at 675-6]. It is not enough to show that there was a missed opportunity to render care which might have made a difference; it must be shown that care should have been rendered <u>and</u> that it <u>would have</u> saved or prolonged life (not 'hastened' death): *Khan* [at para. 43]"

At para. 83 it is said that neglect must be shown on a balance of probabilities. A "real possibility" is not enough, citing *R (Khan) v HM Coroner for West Hertfordshire* [2002] EWHC 302 (Admin). Para. 84 advises against using the phrase "aggravated by neglect" or "lack of care". It is suggested that a better phrase is that neglect "contributed to the cause of death."

The main authorities on the procedural obligations in Article 2

33. At the forefront of Mr Rawlinson QC's submissions on Article 2 was the decision of the Court of Appeal in *R (Humberstone) v Legal Services Commission* [2010] EWCA Civ 1479; [2011] 1 WLR 1460, in which the main judgment was given by Smith LJ.

34. *Humberstone* arose out of a decision by the Legal Services Commission not to request the Lord Chancellor to authorise funding for the claimant to be represented at the inquest into her 10 year old son's death, under section 6(8)(b) of the Access to Justice Act 1999. The Lord Chancellor's funding guidance provided that representation for the family of a deceased person at an inquest would be funded where this was likely to be necessary to enable the coroner to carry out an effective investigation into the death, as required by Article 2, but that only exceptional cases required such funding in order to satisfy Article 2. The High Court granted the application for judicial review. The Commission appealed against that decision but its appeal was dismissed by the Court of Appeal, which upheld the decision of the High Court on different grounds.

35. The background facts were that the claimant's son suffered an asthma attack and an ambulance was called. At first a single paramedic arrived and checked the child's oxygen level, which was low. Oxygen was given through a mask but the child collapsed. Ambulance control was then called and an ambulance eventually arrived and took the child to hospital. Attempts to resuscitate him failed and he was declared dead shortly after arriving at hospital.

36. From para. 20 of her judgment Smith LJ sought to set out "a brief uncontroversial explanation of the State's obligations under Article 2", which were not disputed in that case. At para. 21 she said:

> "The Convention was imported into domestic law by the Human Rights Act 1998. Article 2.1 provides that: 'Everyone's right to life shall be protected by law'. That primary duty imposes on the state a duty not to take life and also a duty to take appropriate legislative and administrative steps to protect life, for example by the provision of a police force and criminal justice system. It imposes on state authorities such as the police and prison authorities the duty to protect those in their immediate care from violence either at the hands of others or at their own hands: see *LCB v United Kingdom* (1998) 27 EHRR 212; *Osman v United Kingdom* (1998) 29 EHRR 245; *Edwards v United Kingdom* (2002) 35 EHRR 487 and *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653. The duty also extends to organs of the state, such as hospital authorities, to make appropriate provision and to adopt systems of work to protect the lives of patients in their care: see *Savage v South Essex Partnership NHS Foundation Trust (MIND intervening)* [2009] AC 681."

37. At para. 22 Smith LJ continued:

> "… In addition to these substantive duties, there is an obligation on the state in respect of the investigation of deaths and it is the scope of this duty which falls to be considered in this appeal. That duty has been described in *Jordan v United Kingdom* (2001) 37 EHRR 52 as requiring the initiation of an effective public investigation by an independent official body into any death where it appears that any of the state's substantive obligations has been or may have been violated and it appears that agents of the state are or may be in some way implicated."

38. At para. 23 Smith LJ observed that this obligation to investigate may be fulfilled in England and Wales by the conduct of a coroner's inquest although, in *R (Middleton) v West Somerset Coroner* [2004] UKHL 10; [2004] 2 AC 182, the House of Lords held that, in a case where the state's duty under Article 2 was at least arguably engaged, the inquest had to range more widely than was usual pursuant to the Coroners Rules 1984 (SI 1984 No. 552) and had to include consideration of "by what means and in what circumstances" the deceased had died. That of course has now become reflected in statute in section 5(2) of the CJA.

39. At para. 25 Smith LJ identified the main issue in *Humberstone* as being:

> "… whether the state's obligation to conduct an effective investigation into a death (with the associated possible necessity to provide representation) arises in all cases where a death occurs while the deceased was in the care of the state or whether it arises only in a much narrower range of cases where it is arguable that the state has breached its substantive article 2 obligations."

40. Smith LJ began her discussion of the main issue in the case from para. 52 of her judgment. At para.52 she said that:

> "… The Strasbourg jurisprudence on the question of engagement of the obligation of investigation is not always easy to understand and successive courts in this country have struggled to interpret it."

41. Smith LJ continued that the case law from Strasbourg describes two different obligations arising under Article 2:

> "… First, there is a duty imposed on the state to set up an effective judicial system by which any death, which might possibly entail any allegation of negligence or misconduct against an agent of the state may be adequately investigated and

> liability established. That will apply in a wide range of circumstances. Second, there is a duty proactively to conduct an effective investigation into the circumstances of a death in a much narrower range of circumstances where the evidence suggests a possible breach of the State's substantive duty to protect the life of those in its direct care."

That second type of duty was described by counsel in the case as "the duty of enhanced investigation", a phrase which has been adopted by Mr Rawlinson in the present case. Smith LJ concluded that the Lord Chancellor's guidance in respect of Article 2 inquests was intended to cover only the narrower range of inquests which attract the duty of enhanced investigation: see the final sentence of para. 52 of her judgment.

42. At para. 55 Smith LJ observed that the conclusions of Richards J (as he then was) in *R (Goodson) v Bedfordshire and Luton Coroner* [2004] EWHC 2931 (Admin); [2006] 1 WLR 432 had been expressly approved by the Court of Appeal in *R (Takoushis) v Inner North London Coroner* [2005] EWCA Civ 1440; [2006] 1 WLR 461 after detailed consideration of four authorities from Strasbourg. At para. 56 Smith LJ quoted with approval the entirety of para. 59 in the judgment of Richards J in *Goodson*. At para. 57 Smith LJ observed that Richards J had then considered whether his conclusions were consonant with recent domestic authorities, including *Middleton* and *R (Khan) v Secretary of State for Health* [2003] EWCA Civ 1129; [2004] 1 WLR 971 and concluded that they were.

43. At para. 58 Smith LJ summarised the position in the following way:

> "I would summarise his conclusions by saying that article 2 imposes an obligation on the state to set up a judicial system which enables any allegation of possible involvement by a state agent to be investigated. That obligation may be satisfied in this country by criminal or civil proceedings, an inquest and even disciplinary proceedings or any combination of those procedures. This obligation envisages the provision of a facility available to citizens and not an obligation proactively to instigate an investigation. Only in limited circumstances (I depart from Richards J only so far as to decline to call them exceptional) will there be a specific obligation proactively to conduct an investigation. Those limited circumstances arise where the death occurs while the deceased is in the custody of the state or, in the context of allegations against hospital authorities, where the allegations are of a systemic nature such as the failure to provide suitable facilities or adequate staff or appropriate systems of operation. They do not include cases where the only allegations are of 'ordinary' medical negligence."

44. Before we leave that passage it is right to observe that it cannot have been intended and certainly does not have the effect of stating in a comprehensive way all of the situations in which the enhanced duty of investigation can arise. For example, it is not only "where the death occurs while the deceased is in the custody of the state".

We note that, at para. 63, Smith LJ herself mentioned deaths caused by the direct actions of state agents (for example shooting by a soldier) and not only deaths in custody.

45. What this underlines is that the pronouncements of any judge should never be regarded as if they were set out in a statute. Smith LJ was not seeking to set out a general and comprehensive list of the situations in which the enhanced duty of investigation can arise. She was simply seeking, helpfully, to summarise the principles which can be derived from the Strasbourg case law as it stood at that time, particularly in the context of medical cases.

46. Citing *Takoushis*, at para. 60 of her judgment, Smith LJ sought to summarise the position in that case as follows, at para. 61:

> "… We see the Court distinguishing between two types of article 2 obligation in respect of investigation: the wide obligation to provide judicial procedures available to citizens by which any death can be investigated if a citizen wishes to have allegations investigated and the obligation of proactive investigation by the state in a narrower range of circumstances. The decision of the court was that the circumstances of the death did impose on the state the duty of proactive investigation (to be effected by coroner's inquest) because the allegations went beyond the negligence of individual professionals and included allegations of systemic failure. …"

47. At para. 64 Smith LJ cited in full the conclusions of the Court of Appeal in *Takoushis*, at paras. 105-107, where Sir Anthony Clarke MR said:

> "105. Subject to what is said in paras 97-103 above (where the court expressed its reservations about the effectiveness of adversarial civil proceedings) we agree with those conclusions. It seems to us that, however it is analysed, the position is that, where a person dies as a result of what is arguable medical negligence in an NHS hospital, the state must have a system which provides for the practical and effective investigation of the facts and for the determination of civil liability. Unlike in the cases of death in custody, the system does not have to provide for an investigation initiated by the state but may include such an investigation. Thus the question in each case is whether the system as a whole, including both any investigation initiated by the state and the possibility of civil and criminal proceedings and of a disciplinary process, satisfies the requirements of article 2 as identified by the European court in the cases to which we have referred, namely (as just stated) the practical and effective investigation of the facts and the determination of civil liability.

> 106. The question is whether the system in operation in England in this case meets those requirements. In our opinion it does. The system includes both the possibility of civil process and, importantly, the inquest. We can understand the point that the possibility of civil proceedings alone might not be sufficient because they do not make financial sense and may not end in a trial at which the issues are investigated. However, in the context of the other procedures available, an inquest of the traditional kind, without any reading down of the 1988 Act, by giving a wider meaning to 'how' as envisaged in the *Middleton* case [2004] 2 AC 182, and provided that it is carries out the kind of full and fair investigation which is discussed earlier in this judgment … in our opinion satisfies the requirement that there will be a public investigation of the facts which will be both practical and effective.
>
> 107. In these circumstances, while article 2 is engaged in the sense described above, the present system including the inquest does not fall short it its requirements in any way. On the contrary, it complies with it."

48. At para. 65 Smith LJ observed that the whole of that section of the judgment in *Takoushis* is *obiter*. The ratio of that case was that the allegations included systemic failures so that Article 2 was engaged in the sense that it did give rise to a proactive duty of enhanced investigation.

49. At para. 66 Smith LJ said that Court's conclusions in *Takoushis* were correct and were consistent with what the House of Lords later said in *R (Gentle) v Prime Minister* [2008] UKHL 20; [2008] AC 1356. She summarised her conclusions based on the authorities in the following way at para. 67:

> "I am satisfied from examination of all these authorities that, in respect of duties of investigation, there are two senses in which article 2 may be said to be engaged. It may be engaged in a very wide range of cases in which there is an obligation to provide a legal system by which any citizen may access an open and independent investigation of the circumstances of the death. The system provided in England and Wales, which includes the availability of civil proceedings and which will in practice include a coroner's inquest, will always satisfy that obligation. In addition, article 2 will be engaged in the much narrower range of cases where there is at least an arguable case that the state has been in breach of its substantive duty to protect life; in such cases the obligation is proactively to initiate a thorough investigation into the circumstances of the death."

50. Finally, in considering *Humberstone*, it is important to recall what Smith LJ said at paras. 71-72. At para. 71 she said that, although it is not always easy to decide whether an inquest will engage Article 2:

> "… it will be necessary for care to be taken to ensure that allegations of individual negligence are not dressed up as systemic failures …"

51. At para. 72 Smith LJ said that:

> "… the person best placed to decide whether article 2 is engaged is the coroner who is to conduct the inquest. …"

52. As we have seen the duty of enhanced investigation is "parasitic" upon an arguable breach of the substantive obligations in Article 2. It is well recognised that Article 2 not only imposes a negative obligation on the state, for example not to take a person's life unless the exceptional situations described in Article 2 exist, but may also impose positive obligations on the state to protect human life. The position was considered by the House of Lords in *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74; [2009] 1 AC 681, in which the main opinion was given by Lord Rodger of Earlsferry. At para. 19 Lord Rodger said:

> "Fundamentally, article 2 requires a state to have in place a structure of laws which will help to protect life. In *Osman v United Kingdom* 29 EHRR 245, 305, para 115, the European court identified the "primary duty" of a state under the article as being:
>
> 'to secure the right to life by putting in place effective criminal law provisions to deter the commission of offences against the person backed up by law-enforcement machinery for the prevention, suppression and sanctioning of breaches of such provisions.'
>
> But, as the parties in *Osman's* case recognised, the state's duty goes further, and article 2: 'may also imply in certain well defined circumstances a positive obligation on the authorities to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual.'"

53. Having considered the duty which may sometimes be imposed on the police, as in *Osman*, Lord Rodger went on to consider the duty to protect against suicide in the case of prisoners from para. 25 of his opinion. He considered the duty to protect other detainees at para. 33 and the duty to protect against suicide in the case of conscripts from para. 34. In that context he drew a distinction between a general obligation of

the state to have in place a system of regulation and also an "operational" duty to try to prevent a suicide. Lord Rodger then turned to the position on the facts before the House of Lords in *Savage*, where, at the time of her death Mrs Savage had been detained under section 3 of the Mental Health Act 1983. In that context he addressed the duty to protect the lives of hospital patients from para. 44 of his opinion. At paras. 44-45 Lord Rodger said:

> "44. Mrs Savage was a detained patient, but first and foremost she was a patient in a hospital. And it has long been recognised that a state's positive obligations under article 2 to protect life include a 'requirement for hospitals to have regulations for the protection of their patients' lives'. See the opinion of the commission in *Işiltan v Turkey* (1995) 81-B DR 35, which the European court relied on, for instance, in *Calvelli and Ciglio v Italy* Reports of Judgments and Decisions 2002-I, p 25, para 49. When referring to the state's obligations to protect life, the court said:
>
> 'Those principles apply in the public-health sphere too. The aforementioned positive obligations therefore require states to make regulations compelling hospitals, whether public or private, to adopt appropriate measures for the protection of their patients' lives'
>
> See also *Tarariyeva v Russia* (2006) 48 EHRR 669, para 74, and *Dodov v Bulgaria* (2008) 47 EHRR 932 , para 80.
>
> 45. These passages show that a state is under an obligation to adopt appropriate (general) measures for protecting the lives of patients in hospitals. This will involve, for example, ensuring that competent staff are recruited, that high professional standards are maintained and that suitable systems of working are put in place. If the hospital authorities have performed these obligations, casual acts of negligence by members of staff will not give rise to a breach of article 2. The European court put the point quite shortly in *Powell v United Kingdom* 30 EHRR CD 362, 364:
>
> 'The court accepts that it cannot be excluded that the acts and omissions of the authorities in the field of health care policy may in certain circumstances engage [the state's] responsibility under the positive limb of article 2. However, where a contracting state has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, it cannot accept that matters such as error of judgment on the part of a health professional or negligent co-ordination among health professionals in the treatment of a particular patient are sufficient of themselves to call a contracting state to account from the standpoint of its positive obligations under article 2 of the Convention to protect life.'

See also *Dodov v Bulgaria* 47 EHRR 932, para 82."

54. At para. 46 Lord Rodger observed that the fact that patients are suffering from mental illness is also relevant to the authority's obligations under Article 2. He said:

> "… the vulnerability of people suffering from mental illness, and the consequential need to protect them, are themes that run through the case law of the European court. …"

55. Lord Rodger helpfully summarised the relevant obligations of health authorities from para. 67. At paras. 68-72 he said:

> "68. In terms of article 2, health authorities are under an over-arching obligation to protect the lives of patients in their hospitals. In order to fulfil that obligation, and depending on the circumstances, they may require to fulfil a number of complementary obligations.
>
> 69. In the first place, the duty to protect the lives of patients requires health authorities to ensure that the hospitals for which they are responsible employ competent staff and that they are trained to a high professional standard. In addition, the authorities must ensure that the hospitals adopt systems of work which will protect the lives of patients. Failure to perform these general obligations may result in a violation of article 2. If, for example, a health authority fails to ensure that a hospital puts in place a proper system for supervising mentally ill patients and, as a result, a patient is able to commit suicide, the health authority will have violated the patient's right to life under article 2.
>
> 70. Even though a health authority employed competent staff and ensured that they were trained to a high professional standard, a doctor, for example, might still treat a patient negligently and the patient might die as a result. In that situation, there would be no violation of article 2 since the health authority would have done all that the article required of it to protect the patient's life. Nevertheless, the doctor would be personally liable in damages for the death and the health authority would be vicariously liable for her negligence. This is the situation envisaged by *Powell's* case 30 EHRR CD 362.
>
> 71. The same approach would apply if a mental hospital had established an appropriate system for supervising patients and all that happened was that, on a particular occasion, a nurse negligently left his post and a patient took the opportunity to commit suicide. There would be no violation of any obligation

> under article 2, since the health authority would have done all that the article required of it. But, again, the nurse would be personally liable in damages for the death and the health authority would be vicariously liable too. Again, this is just an application of *Powell's* case.
>
> 72. Finally, article 2 imposes a further 'operational' obligation on health authorities and their hospital staff. This obligation is distinct from, and additional to, the authorities' more general obligations. The operational obligation arises only if members of staff know or ought to know that a particular patient presents a 'real and immediate' risk of suicide. In these circumstances article 2 requires them to do all that can reasonably be expected to prevent the patient from committing suicide. If they fail to do this, not only will they and the health authorities be liable in negligence, but there will also be a violation of the operational obligation under article 2 to protect the patient's life. This is comparable to the position in *Osman's* case 29 EHRR 245 and *Keenan's* case 33 EHRR 913. As the present case shows, if no other remedy is available, proceedings for an alleged breach of the obligation can be taken under the Human Rights Act 1998."

56. As we have seen the facts of *Savage* concerned a person who had been compulsorily detained under the Mental Health Act. In *Rabone v Pennine Care NHS Trust* [2012] UKSC 2; [2012] 2 AC 72 the Supreme Court had to consider the position of a person who was not compulsorily detained but was a "voluntary" patient with mental health problems. In that case the claimants brought action for negligence in circumstances where their daughter had committed suicide. An issue arose as to whether an operational duty could arise under Article 2 in the case of a hospital patient who is mentally ill but not detained under the Mental Health Act. The main judgment was given by Lord Dyson JSC. He noted that in a number of cases the European Court of Human Rights has held that, in principle, the operational duty could arise: for example in *Watts v United Kingdom* (2010) 51 EHRR SE 66, where the applicant complained that her transfer from her existing care home to another care home would reduce her life expectancy. In *Watts* the Court held, at para. 88, that a badly managed transfer of elderly residents of a care home could well have a negative impact on their life expectancy as a result of the general frailty and resistance to change of older people and therefore Article 2 was "applicable". However, for various reasons, the claim failed on its facts: see para. 18 in the judgment of Lord Dyson in *Rabone*.

57. At para. 19 Lord Dyson said that such cases are to be contrasted with cases involving hospital deaths resulting from what Lord Rodger had described in *Savage* as "casual acts of negligence". The leading Strasbourg case in this category is *Powell v UK* (2000) 30 EHRR CD 362, which was considered by Lord Rodger in *Savage*.

58. At para. 22 Lord Dyson observed that no decision of the European Court had been cited where the Court clearly articulates the criteria by which it decides whether an Article 2 operational duty exists in any particular circumstances. It was therefore

necessary to see whether the cases give some clue as to why the operational duty has been found to exist in some circumstances and not in others. This underlines, in our view, the importance of looking at the precise factual circumstances of particular decisions. This is a point that Lord Dyson went on to make at para. 25 of his judgment in *Rabone*:

> "… The common law of negligence develops incrementally and it is not always possible to predict whether the court will hold that a duty of care is owed in a situation which has not been previously considered. Strasbourg proceeds on a case by case basis. The jurisprudence of the operational duty is young. Its boundaries are still being explored by the [European Court] as new circumstances are presented to it for consideration. …"

59. It should also be noted that, at para. 21, Lord Dyson had said:

> "… It is clear that the existence of a 'real and immediate risk' to life is a necessary but not sufficient condition for the existence of the duty. This is because … a patient undergoing major surgery may be facing a real and immediate risk of death and yet the *Powell* case shows that there is no Article 2 operational duty to take reasonable steps to avoid the death of such a patient."

60. At para. 33 of his judgment Lord Dyson said that:

> "… The Strasbourg jurisprudence shows that there is such a duty to protect persons from a real and immediate risk of suicide at least where they are under the control of the State. By contrast, the [European Court] has stated that in the generality of cases involving medical negligence, there is no operational duty under article 2."

61. At para. 34 Lord Dyson then proceeded to consider on which side of the line an informal psychiatric patient falls. He concluded that the Trust did owe the operational duty to the patient to take reasonable steps to protect her from the real and immediate risk of suicide. Although she was not a detained patient, she was under its control. It was clear that, if she had insisted on leaving the hospital, the authorities could and should have exercised their powers under the Mental Health Act to prevent her from doing so. The distinction, concluded Lord Dyson, was one of form, not substance. He said:

> "… her position was far closer to that of such a hypothetical patient than to that of a patient undergoing treatment in a public hospital for a physical illness. …"

62. On behalf of the Senior Coroner Ms Leek QC has placed particular reliance on the recent decision of the European Court of Human Rights in *Lopes de Sousa Fernandes v Portugal* (app. no. 56080/13), judgment of 19 December 2017. The brief facts were that the applicant's husband was admitted to a hospital; he was examined by a doctor after treatment was given and the situation was found to be under control. Subsequently his condition deteriorated. He later died. The death certificate said that he had died from septicaemia caused by peritonitis and a perforated viscus: see paras. 23-27. The Court took the opportunity to "reaffirm and clarify the scope of the substantive positive obligations of States in such cases": see para. 162.

63. It should be noted that, as the Court emphasised at para. 163 of its judgment, different considerations arise in other contexts, in particular in the case of the medical treatment of persons deprived of their liberty or of particularly vulnerable persons under the care of the state, where the state has direct responsibility for the welfare of those individuals.

64. The judgment in *Fernandes* is, in our view, clearly of great importance. It was a judgment of the Grand Chamber. The Court self-consciously decided to review its case law in this area and restate it. In our view, the judgment represents the latest, very recent and authoritative summary of the applicable principles under Article 2 by the European Court.

65. At paras. 163-167 the Court reiterated general principles, which are well established in its previous case law. At paras .166-167 it said:

> "166. In the particular context of health care the Court has interpreted the substantive positive obligation of the State as requiring the latter to make regulations compelling hospitals, whether private or public, to adopt appropriate measure for the protection of patients' lives (see, among many other authorities; *Oyal v Turkey,* no 4864/05, s.54, 23 March 2010, and *Lambert and Others v. France* [GC], no 46043/14, s 140, ECHR 2015 (extracts)).
>
> 167. However, it has not excluded the possibility that the acts and omissions of the authorities in the context of public health policies, may, in certain circumstances, engage the Contacting Parties' responsibility under the substantive limb of Article 2 (see *Powell*, cited above)."

66. At para. 168 the Court said:

> "In cases where allegations of medical negligence were made in the context of the treatment of a patient, the Court has consistently emphasised that, where a Contracting State has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, matters

> such as an error of judgment on the part of a health professional or negligent coordination among health professionals in the treatment of a particular patient are not sufficient of themselves to call a Contracting State to account from the standpoint of its positive obligations under Article 2 of the Convention to protect life (see, among many other authorities, *Powell*, cited above, and *Sevim Güngör v. Turkey* (dec.), no. 75173/01, 14 April 2009)."

67. At paras. 182-184 of its judgment the Court distinguished an exceptional line of cases which "went beyond a mere error or medical negligence", which concern circumstances where the medical staff, in breach of their professional obligations, failed to provide emergency medical treatment despite being fully aware that a person's life would be put at risk if that treatment was not given. However, it said that in that sort of case the failure to provide emergency medical treatment resulted from "a dysfunction in the hospital services … ." It also described this as being "a structural issue linked to the deficiencies in the regulatory framework."

68. At paras. 185-196 the Court considered that the approach which it had adopted hitherto should be clarified. At para. 186 the Court reaffirmed that, in the context of alleged medical negligence, a state's substantive positive obligations

> "are limited to a duty to regulate, that is to say, a duty to put in place an effective regulatory framework compelling hospitals, whether private or public, to adopt appropriate measures for the protection of patients' lives."

69. At para. 189 the Court emphasised that a state's obligation to regulate must be understood in a broader sense which includes the duty to ensure the effective functioning of that regulatory framework. The regulatory duties thus encompass necessary measures to ensure implementation, including supervision and enforcement.

70. From para. 190 the Court said that there were certain "very exceptional circumstances" in which the responsibility of the state under the substantive limb of Article 2 may be engaged in respect of the acts and omissions of healthcare providers.

71. The first type of exceptional circumstance was described at para. 191 and

> "concerns a specific situation where an individual's life is knowingly put in danger by denial of access to life-saving emergency treatment … It does not extend to circumstances where a patient is considered to have received deficient, incorrect or delayed treatment."

72. The second type of exceptional circumstances was described in para. 192 and

> "arises where a systemic or structural dysfunction in hospital services results in a patient being deprived of access to life-saving emergency 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, thus putting the patients' lives, including the life of the particular patient concerned, in danger …"

73. At para. 193 the Court acknowledged that on the facts it may sometimes not be easy to distinguish between cases involving "mere medical negligence" and "those where there is a denial of access to life-saving emergency treatment …" However, the Court went on, from para. 194, to set out the factors which, taken cumulatively "must be met." First,

> "the acts and omissions of the health-care providers must go beyond a mere error or medical negligence, insofar as those health-care providers, in breach of their professional obligations, deny a patient emergency medical treatment despite being fully aware that the person's life is at risk if that treatment is not given …"

74. Secondly, at para. 195, the Court said that:

> "The dysfunction at issue must be objectively and genuinely identifiable as systemic or structural in order to be attributable to the state authorities, and must not merely comprise individual instances where something may have been dysfunctional in the sense of going wrong or functioning badly …"

75. Thirdly, at para. 196, the Court said that:

> "There must be a link between the dysfunction complained of and the harm which the patient sustained."

76. Finally, again at para. 196, the Court said:

> "The dysfunction at issue must have resulted from the failure of the State to meet its obligation to provide a regulatory framework in the broader sense indicated above …"

77. When the Court turned to apply those criteria to the facts of the case before it, it found that the complaint was in essence that the medical treatment provided to Mr Fernandes had been deficient because of the negligence of the doctors who had treated him. In the Court's view, an alleged error in diagnosis leading to a delay in the administration of proper treatment, or an alleged delay in performing a particular medical intervention, cannot in themselves constitute a basis for considering the facts

of this case on a par with those concerning denial of healthcare: see para. 200 of the judgment.

78. Recognising with realism the difficulties posed for his argument by the decision of the European Court in *Fernandes*, Mr Rawlinson urged upon this Court that, if necessary, it should decline to follow that recent case. He submits that the decisions of the European Court are not made binding on courts in this jurisdiction. Undoubtedly that is correct, since section 2 of the Human Rights Act 1998 ("HRA") imposes a duty on courts here to take into account any relevant decision of the European Court. In that respect the legal position can be contrasted with the position under European Union law, where section 3 of the European Communities Act 1972 imposes an obligation on courts in this country to follow any relevant principle of EU law enunciated by the Court of Justice of the European Union.

79. In support of his submission Mr Rawlinson relies upon the recent decision of the Supreme Court in *D v Commissioner of Police of the Metropolis* [2018] UKSC 11; [2018] 2 WLR 895, in particular on the judgment of Lord Mance DPSC at paras. 152-153. In that passage Lord Mance recognised that it has now been long established that in general courts in this country should follow the clear and consistent jurisprudence of the European Court of Human Rights: see *R (Ullah) v Special Adjudicator* [2004] UKHL 26; [2004] 2 AC 323 and *R (Al-Skeini) v Secretary of State for Defence* [2007] UKHL 26; [2008] AC 153. This is because, as Lord Mance said:

> "The general aim of the Human Rights Act 1998 was to align domestic law with Strasbourg law. Domestic courts should not normally refuse to follow Strasbourg authority, although circumstances can arise where this is appropriate and a healthy dialogue may then ensue … Conversely, domestic courts should not, at least by way of interpretation of the Convention rights as they apply domestically, forge ahead without good reason. …"

80. However, at para. 153 of his judgment, Lord Mance said that there are cases where the English courts can and should, as a matter of domestic law, go with confidence beyond existing Strasbourg authority and he cited the decision of the Supreme Court in *Rabone* in support of that. He said:

> "… If the existence or otherwise of a Convention right is unclear, then it may be appropriate for domestic courts to make up their minds whether Convention rights should or should not be understood to embrace it. Further, where the European Court of Human Rights has left a matter to states' margin of appreciation, then domestic courts have to decide what the domestic position is, what degree of involvement or intervention by a domestic court is appropriate, and what degree of institutional respect to attach to any relevant legislative choice in the particular area …"

81. We do not consider that any of those exceptional circumstances applies in the present context. Accordingly, in our view, this Court should follow the very recent and authoritative statement of the relevant principles set out by the European Court in *Fernandes.*

Summary of the relevant principles on Article 2

82. We hope it will be helpful if we summarise here the relevant principles which are to be found in the authorities to which we have made detailed reference above. This summary applies to medical cases.

83. Article 2 imposes both substantive positive obligations on the state and procedural obligations.

84. The primary substantive positive obligation is to have in place a regulatory framework compelling hospitals, whether private or public, to adopt appropriate measures for the protection of patients' lives.

85. The primary procedural obligation is to have a system of law in place, whether criminal or civil, by which individual failures can be the subject of an appropriate remedy. In the law of England and Wales that is achieved by having a criminal justice system, which can in principle hold to account a healthcare professional who causes a patient's death by gross negligence; and a civil justice system, which makes available a possible civil claim for negligence. We note that, in the present case, there is in fact an extant civil claim which has been brought by the Claimant against the NHS Trust which ran the hospital (which is the First Interested Party in the present judicial review proceedings).

86. The enhanced duty of investigation, which falls upon the state itself to initiate an effective and independent investigation, will only arise in medical cases in limited circumstances, where there is an arguable breach of the state's own substantive obligations under Article 2.

87. Where the state has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, matters such as an error of judgment on the part of a health professional or negligent coordination among health professionals in the treatment of a particular patient are not sufficient of themselves to call the state to account under Article 2.

88. However, there may be exceptional cases which go beyond mere error or medical negligence, in which medical staff, in breach of their professional obligations, fail to provide emergency medical treatment despite being fully aware that a person's life would be put at risk if that treatment is not given. In such a case the failure will result from a dysfunction in the hospital's services and this will be a structural issue linked to the deficiencies in the regulatory framework.

89. At the risk of over-simplification, the crucial distinction is between a case where there is reason to believe that there may have been a breach which is a "systemic failure", in contrast to an "ordinary" case of medical negligence.

90. Furthermore, we do not regard the principles in *Fernandes*, which we have sought to summarise above, as being inconsistent with what the courts of this country have said under the HRA. Rather the distinction between a systemic failure and ordinary negligence cases is one which is also to be found in the domestic case law, for example in *Savage* and *Rabone*. Indeed the decision of the Court of Appeal on which Mr Rawlinson placed greatest reliance, *Humberstone*, makes the same distinction. It was (as most if not all such cases will be) a decision on its particular facts. Although Mr Rawlinson sought to characterise the failure in *Humberstone* as being a delay by the ambulance crew, in fact Smith LJ clearly regarded the alleged failure in that case to be of "a systematic nature such as the failure to provide suitable facilities or adequate staff or appropriate systems of operation": see para. 58 in her judgment. She expressly then went to contrast that situation with "cases where the only allegations are of 'ordinary' medical negligence": see also para. 58.

91. Finally, we remind ourselves in this context that Smith LJ said, at para. 71, that care should be taken to ensure that allegations of what are in truth allegations of "individual negligence" are not "dressed up as systemic failures"; and, at para. 72, that the person best placed to decide whether Article 2 is engaged is the coroner who conducts the inquest.

92. Against that framework of legal principle, we turn to address each of the five grounds of challenge in this case. We propose to take ground 5 out of order, and deal with it immediately after ground 1, because those two grounds raise similar issues. We will then address grounds 2, 3 and 4 in turn.

Ground 1: failure to comply with Article 2 and section 5(2) of the CJA

93. On behalf of the Claimant Mr Rawlinson submits that the Senior Coroner erred in law by failing to make any findings as to "the circumstances" in which Mrs Parkinson came to meet her death. He submits that that was a failure to comply with the requirements of Article 2 and section 5(2) of the CJA.

94. We deal first with what was a subsidiary argument made by Mr Rawlinson. He submits that the present case can be regarded as analogous to cases such as *Rabone* because there was evidence that Mrs Parkinson lacked mental capacity: there was a degree of dementia in her case. We do not accept that submission. A case like *Savage* concerned compulsory detention of a patient under the Mental Health Act. *Rabone* was very similar to such a case because, although there was not compulsory detention and the patient was strictly speaking a "voluntary" patient, she was in an analogous situation, for reasons that Lord Dyson explained. Furthermore, both of those cases concerned a suicide risk. The present case is nothing like that sort of case on its facts. This is a case about emergency diagnosis and treatment in an A&E department. Frequently there will be patients who come in to A&E who have mental capacity issues, either because they are very elderly or for some other reason. In our view, the normal principles which we have set out earlier apply.

95. We should also mention briefly an argument that was at one time set out in the Statement of Facts and Grounds, at para. 5.14.2, to the effect that an Article 2 investigation was required as there was "credible evidence … that there was a policy

of not treating elderly people on grounds of age." We should record that at the hearing before us Mr Rawlinson confirmed that that argument was not being pursued.

96. In that context we also would reject any suggestion, if it were made, that the inclusion of the "do not resuscitate" notice in this case had the effect that Mrs Parkinson was denied appropriate medical treatment. When the evidence as it was before the Senior Coroner is considered as a whole, it is clear that that was a reference only to the administration of CPR (cardio-pulmonary resuscitation). It was a matter for the clinical judgement of Dr Hijazi but it will be readily apparent that the administration of CPR can be harmful to the interests of a patient, in particular an elderly patient. For example, it is well known that it can lead to ribs being broken. It is also clear, on the facts of the present case, that medical treatment was indeed provided to Mrs Parkinson, for example a saline drip.

97. We turn therefore to the primary submission which was made by Mr Rawlinson. He submits that, even if the law is correctly set out in *Fernandes*, this was a case where there was arguably a systemic failure on the part of the hospital authorities and so the enhanced duty of investigation did arise under Article 2.

98. Mr Rawlinson accepts that the hospital had a system in place in the form of a policy which governed the triage system to be used when a patient came into A&E. That was based on a nationally recognised system known as the Manchester Triage System ("MTS").

99. The First Interested Party also had in place a 'Resuscitation Policy'. The version placed before the Court is dated October 2010. The policy incorporated the procedure on 'Do Not Attempt Cardio-Pulmonary Resuscitation', and 'Patient At Risk (PAR) scoring for deteriorating patients, training requirements and clinical guidelines.'

100. Para. 5 included reference to the cardiac arrest team. At para. 5.2 the policy stated:

> "With the aim of preventing cardiopulmonary arrest the Trust has devised an Early Warning System. **Known hereafter as Patient At Risk (PAR) scoring**. All clinical staff are trained in the identification of critically ill patients and the use of physiological observation charts to enhance decision making and care escalation. This preventative system incorporates a critical care outreach service, which supports the senior medical staff in managing medical emergencies. The resuscitation officer re-enforces the PAR scoring tool and the outreach team during resuscitation training sessions. The outreach team and resuscitation officer educate staff on how to use the PAR score appropriately." (Bold in original)

101. Para. 5.3 referred to the Medical Emergency Team and stated:

> "Patients who deteriorate to PAR score 6 or above are classed as a medical emergency. Staff must dial 2222 stating ***medical emergency*** and their location. A medical emergency team is then activated. This expert team will then promptly attend and

> help stabilise the patient with the ward staff. The composition of the team can be seen in appendix 2." (Bold in original)

102. Appendix 1 in the policy was headed 'Patient At Risk (PAR) scoring (Early Warning System)' and said:

> "The aim of the scoring system is to allow the early identification of patients at risk of deterioration in their clinical condition and thereby improve their management. It is applicable to all adult areas of Darent Valley Hospital. …"

103. Appendix 2 referred to who were to be members of the arrest teams, including the "Core Adult Cardiac Arrest Team" and also the "Cardiac Arrest/Emergency Team".

104. Appendix 3 made it clear that all wards, including the A&E department, had standard Trust resuscitation trolleys and defibrillators.

105. Mr Rawlinson submits that it was not clear at that time whether the Patient at Risk ("PAR") policy applied to the A&E department at all. He notes that the policy was changed in February 2011, to make it clear that it did not apply to A&E "unless the decision has been made to admit the patient". That, of course, was after the events with which this case is concerned.

106. Mr Rawlinson also submits that it was not clear how the two policies interacted with each other. He submits that the PAR score might well lead to a different outcome from the MTS score. In particular, he submits that the consequence of a PAR score of 6 (as Mrs Parkinson had) was that the medical emergency team should have been called on the number 2222. That did not in fact happen in this case.

107. Finally, Mr Rawlinson submits that the lack of clarity about the relevant policies meant that there was a systemic issue about training for healthcare staff, including agency nurses.

108. On behalf of the First Interested Party Mr Brassington submits that there was no systemic failure; there was no confusion in the minds of the staff at A&E between the PAR and MTS systems; and there was no lack of relevant training. In that regard he was supported by the submissions made on behalf of the Senior Coroner by Ms Leek.

109. It is important in this context not to confuse the concept of a Medical Emergency Team with the separate concept of a Cardiac Arrest Team. We are satisfied on the evidence before the Senior Coroner and this Court that, although the Resuscitation Policy referred, in Appendix 2, to both the Medical Emergency Team and the Cardiac Arrest Team, the two were distinct and were understood to be so.

110. Furthermore, we accept Mr Brassington's submission that a medical emergency team will not usually be needed in A&E. Its purpose is to provide for emergency response to take place in those parts of the hospital where there is usually no permanent medical presence otherwise. This was supported at the inquest by the evidence given

by Mr Kika when answering questions from Mr Payne, counsel to the inquest (at pp.771-2 of the transcript):

> "… The PAR score is a management, a risk management tool and validated. It is required in A&E to actually highlight or pinpoint patients that may be deteriorating given the very busy environment that A&E is. If the tool that was working in A&E just solely to identify a patient that may deteriorate while you are busy trying to do something else. As a result the 2222 is not applicable at all to A&E, I mean this is our bread and butter this is what we do. I do need someone else to come from a different department to sort my patient out for me, that's what I trained to do. Therefore, with A&E policy any tool you are actually, it is reasonable to modify it to suit the practical environment, and for A&E this has been done in such a way that the 2222 does not apply at all in A&E. We cannot mobilise the medical emergency team every time we have five patients coming into resus. The system would completely just break apart. We have one registrar who is on call, you don't expect the registrar to leave the ward where there are also very ill patient come to A&E, when we are trained to deliver that sort of care. So that does not apply.
>
> Mr Payne: Is it fair to say that the sort of situation referred to in the resuscitation policy in the box we have just looked at, is that more applicable to wards?
>
> Mr Kika: It is absolutely more applicable to wards and not A&E."

111. Very importantly, in our view, the only witness who appeared at the inquest who was both independent of the parties concerned and could give expert evidence about A&E procedures was Mr Gavalas (see para. 164 below). His evidence was clear that he would never call the medical emergency team to A&E. At p.672 of the transcript he said:

> "… the medical emergency team, otherwise known as MET is basically for use in the wards. In A&E we have the ability and the capacity and the experience to treat our patients, so I have never called, I cannot recall any time when we had to call the MET team in the emergency department because we can shift our patients are [*sic*] their conditions are changing, it is a dynamic condition, we can shift them from A to B, as their condition worsens we can take them to resuscitation bay, we can call the crash team, we do not use the MET in Accident and Emergency".

112. We also accept Mr Brassington's submission that there is no evidence before the Senior Coroner or this Court that only the Medical Emergency Team would have been competent to diagnose pulmonary embolism or would be more competent than those doctors who would be in A&E.

113. Furthermore, although the Medical Emergency Team would have what has been described in this case as a "well stocked trolley", there was also a resuscitation trolley in the A&E department. That was in accordance with Appendix 3 to the Resuscitation Policy.

114. We also reject the suggestion made by Mr Rawlinson that there was a systemic issue in that the doctors concerned did not know how the MTS system worked. The people who needed to know how it worked were the nurses who had to apply the triage system when the patient first came into A&E. The purpose of the triage system is to decide at that stage how quickly a new patient should be first seen by a doctor. It was perfectly clear from the evidence given before the Senior Coroner that the relevant staff did understand how the MTS should work. In particular Sister Taylor was clear that the MTS system and the PAR system were separate (transcript at p.254). Nurse Relox (who was the actual triage nurse in this case) also understood that it was the MTS that had to be used to prioritise patients in A&E and did not confuse it with the PAR score. At pp.486-7, she gave evidence as follows

> "Mr Payne: And can you very, very briefly just summarise what the key things are that you were taught as a triage nurse?
>
> Ms Relox: We need to prioritise patient, we have this they call it Manchester triage, we have the coding, the colour coding, if it's red it's like resuscitation already, orange can be seen within, what do you call, minutes. And then we have the yellow that can wait but we give the treatment, and green can wait.
>
> Mr Payne: Is that, are you describing the PAR score, the priority?
>
> Ms Relox: Prioritising the patient. How you prioritise the patient.
>
> Mr Payne: And is that by reference to the Manchester score or the PAR score?
>
> Ms Relox: Manchester."

115. Furthermore, the evidence was clear that Mrs Parkinson was in fact seen within 10 minutes of the MTS score of 2. That was in accordance with the MTS policy. We note that, in contrast, a PAR score of 6 would have had the consequence that the patient should be seen within 15 minutes, whereas Mrs Parkinson was in fact seen within 10 minutes.

116. Mr Rawlinson asked a rhetorical question: why should Mrs Parkinson have been given a PAR score as well as the MTS score if it were not to have any consequence? The answer is, as Mr Brassington submitted before us, that the PAR score is used to indicate that any patient in a hospital is developing indicators of deterioration; but there has to be a *baseline* as a person may go through hospital. Accordingly, a PAR is generated at various stages, including at the outset when they arrive at the hospital. That was its only relevance in the present case.

117. Finally in this context we address the issue of training. There was evidence before the inquest that there was training provided on the MTS system for all relevant nurses, including agency nurses. The evidence of Nurse MacKay when she was answering questions by Mr Rawlinson was as follows, at p.464 of the transcript:

> "Mr Rawlinson:… [as] an agency nurse who is not an employee, a direct employee of the Trust, how do you become acquainted with Trust policies, for instance, in respect of resuscitation?
>
> Ms McKay: Because we have to read the policies.
>
> Mr Rawlinson: I see, and just tell me a little bit about those arrangements. Who requires you to read the policies, how are you required to do it?
>
> Ms McKay: It's the actual emergency department, and whoever is in charge of that department. Whenever you go there to work the shift, in the beginning you have to sign a form to say that you have read through operational policies, that's policies and procedures within that department."

118. Also of relevance in this context is the evidence given by Mr Morrison (the Resuscitation Service Manager). At p.868 of the transcript, he said:

> "Just one thing I do want to say as I have been questioned on it is, we have a policy but a massive part of my job, which is what I should be doing today, is training people. So in relation to this, any grey areas which clearly we have highlighted are not grey with our staff because they are trained. You have clearly said you had a mixture of opinions, well we have a mixture of people, you had agency nurses who are not employed on a permanent basis so they perhaps wouldn't have got all of the training, but the vast majority of our staff are highly trained by me, by my service and if there are grey areas, they are very clearly rectified, but we will also clarify the policy."

119. Mr Morrison's evidence was also of importance more generally in relation to the relevant policies. He was clear that there was no confusion in practice on the ground but that the Resuscitation Policy would be changed to reflect the practice. At p.866 he gave evidence in answer to a question from Mr Ramsay (junior counsel for Mr Parkinson):

> "Mr Ramsay: So can I just ask you about this because if in the, well let me ask you this. Did the PAR scoring apply to A&E at the time?
>
> Mr Morrison: The PAR scoring is there as a tool to support staff, but the algorithm would need to be adapted for the Emergency Department due to the skills and resources already in that department, because it is called an Emergency Department, or the old term was Accident and Emergency, so the resources already in that department are huge in comparison to your average ward in Darent Valley Hospital. So the PAR scoring, and you are quite right to highlight this, it is an area of clarification that we need to go and update and clarify our policy, so you have highlighted something that we didn't pick up on. But it is a clarification point. *We haven't had any individual incidents because the staff in the Emergency Department and the intensive care unit are very clear that due to the resources, human and equipment, that the actions would need to be adapted*. Now, if and we still need to keep a fairly open mind so if the Emergency Department had a bad day and they were severely under-resourced with human resources, they could fall back onto this system and the outreach and call the medical emergency team. But if they did that routinely every day without fail our hospital would fall apart and we would not have emergency cover for sick patients on the wards, so there is an element of common sense and I appreciate for anyone reading our policy it isn't clear and I apologise for the amount of time this has taken and I will go straight back to the Trust and update our policy, but *the staff are clear and we have never had any issues in relation to that*." (Emphasis added)

120. In all the circumstances of this case, we conclude that the Senior Coroner was perfectly entitled to reach the view that there was no systemic issue which arose. Therefore, there was no arguable breach of the substantive obligations in Article 2. It followed that there was no enhanced duty of investigation under Article 2 either.

Ground 5: breach of para. 7 of Sch. 5 to the CJA

121. We can take this ground shortly. It is common ground between Mr Rawlinson and Ms Leek that ground 5 is not necessarily dependent on ground 1. This is because it is an issue which arises from the provisions of purely domestic legislation (para. 7 of Sch. 5

to the CJA) and therefore does not turn upon the obligations on the state in Article 2. However, for reasons which are very similar to those which arise in relation to ground 1, we would reject ground 5.

122. We have set out the terms of para. 7 of Sch. 5 above. It is clear from those terms that the duty to do a Prevention of Future Death report only arises where a coroner has a relevant "concern" (sub-para. (b)) and forms the relevant "opinion" (sub-para. (c)).

123. On the facts of the present case the Senior Coroner did not have such a concern or form such an opinion. We accept the submissions made by Ms Leek that that was a conclusion which was reasonably open to the Senior Coroner on the evidence before him. This is in substance for the same reasons that he was entitled to conclude that there were no systemic issues which required investigation under Article 2.

Grounds 2 and 3: finding regarding the medical cause of death was irrational and conclusion of "natural causes" insufficient

124. Challenging the findings of fact made by a coroner involves submitting that no reasonable coroner could have arrived at the relevant conclusions. It is, in effect, a rationality challenge, the suggestion being that the findings made (by reference to the balance of probabilities) were perverse. Merely to state the proposition in that way is sufficient to demonstrate that ordinarily this is a threshold that is extremely difficult for an applicant for judicial review to cross.

125. Mr Rawlinson does not shrink from the task and submitted that each of the following findings is capable of challenge on the basis that the evidence did not support the finding and/or that the Senior Coroner's reasoning in support of the findings does not withstand scrutiny:

(1) That the medical cause of death was "bronchopneumonia combined possibly with right lung pulmonary thrombi" (see para. 9 above).

(2) That no action that the hospital might reasonably have taken could have changed the outcome.

(3) That Dr Hijazi was prevented from examining Mrs Parkinson at 06:50 by the Claimant's behaviour.

126. Mr Rawlinson also submitted that the Senior Coroner failed to make a finding as to the time of Mrs Parkinson's death, a factor that he contended was central to the other conclusions of fact to which we have referred. In relation to the timing, all that the Senior Coroner said on the issue can be gleaned from the additional words recorded in Box 3 (see para. 4 above).

127. A review of the evidence for the purposes of considering these submissions must be conducted against the background of the threshold that must be passed to enable this court to intervene (see para. 124 above). The issue is not whether this court agrees or disagrees with the Senior Coroner's conclusions: it is whether the court has been satisfied that his conclusions were sufficiently at variance with the evidence as to be perverse.

128. We will deal with each of the challenged findings separately although there is inevitably an inter-relation between (i) and (ii). It should be borne in mind that the analysis of the evidence concerning the medical cause of death needs to be seen in the context of the case that the Claimant was endeavouring to advance before the Senior Coroner, namely, that his mother died from a pulmonary embolism (or, more accurately, a shower of pulmonary emboli) which would, had there been a timeous administration of thrombolytic therapy, have been prevented.

That the medical cause of death was "bronchopneumonia combined possibly with right lung pulmonary thrombi"

129. The Senior Coroner's conclusion under challenge is a direct "lift" from the opinion of Professor Mary Sheppard expressed in her report dated 24 June 2013, that report having been prepared for the North Kent police. She said this in the report:

> "In my opinion bronchopneumonia combined possibly with right lung pulmonary thrombi were her cause of death based upon the post mortem reports and histological evidence I have examined."

130. In his Conclusion the Senior Coroner said this:

> "I accept the evidence of Professor Mary Shepperd (sic), a highly experienced cardiac pathologist who carried out an examination of the slides, considered the reports of the pathologists who had carried out post-mortem examinations. She gives as her opinion as to the cause of death as bronchopneumonia combined possibly with right lung pulmonary thrombi and I accept this as the cause of death."

131. The Senior Coroner described Professor Sheppard as a Fellow of the Royal College of Pathologists and Associate Professor of Cardiovascular Pathology at the Royal Brompton Hospital in London. She had given further evidence which, on any view, would have justified the Senior Coroner's description of her as "highly experienced". She said that she had "for the last 30 years been a Consultant Pathologist with autopsy experience", specialising particularly in "pulmonary and more lately cardiac pathology". She said she was "now a Professor of Cardiac Pathology at St George's Hospital Medical School" and had "quite a lot of expertise in sudden death, particularly sudden cardiac death". Her report had indicated that she was a Consultant in Histopathology/Reader in Cardiovascular Pathology. She said she dealt with general autopsies "with regard to the lung and the heart in particular as an expert area", had "published widely" and had done "a lot of teaching in that area." When asked how many post-mortems she would carry out or review each year, she said that she would look at cardiac examinations particularly" which she quantified as "800 per year", saying that she had "built up a database of 6,000 cases." Her report indicated that she provided reports for coroners and the police throughout the country and opinions for the prosecution and for defence solicitors.

132. Before we deal with the substance of her opinion, it is instructive to note how she became involved in the inquest. Prior to preparing the report for the police, Professor Sheppard had been instructed by or on behalf of the Claimant and indeed prepared a report. We have not been shown that report, but it was before the Senior Coroner and it appears from the questioning by Counsel for the Senior Coroner that it expressed the view that Mrs Parkinson died from "terminal bronchopneumonia". Counsel quoted certain things said about that report by the Claimant in a letter to Professor Sheppard. They were as follows:

> "… you have provided me with a report that does not fulfil the remit for which is was commissioned."
>
> "… the report is not only a departure from the explicit instructions I gave you, I believe it is also seriously flawed."

133. Thus, whilst the Claimant at one stage obviously felt that Professor Sheppard was an expert upon whose evidence he hoped he could rely at the inquest, it emerged that her view did not coincide with his preferred view.

134. Leaving aside for a moment the substance of the questioning by Counsel and the answers she gave, the witness was questioned about the report dated 24 June 2013 by Counsel for the Senior Coroner, by Mr Ramsay for the Claimant and briefly by Counsel for the Trust. She gave reasons for the view she had expressed in her report and unless the Senior Coroner was persuaded that her evidence could not withstand any contrary views of other witnesses and/or itself could not withstand logical scrutiny, he was plainly entitled to rely and act upon it.

135. Professor Sheppard's involvement subsequent to her instruction by the Claimant came about after the first post-mortem had been undertaken by Dr Peter Jerreat, Consultant Pathologist, and a second post-mortem report by Dr Colin Clelland, Consultant Histopathologist. The first was carried out on 13 January 2011 (so 4 days after Mrs Parkinson died) and the second was carried out on 8 March, just under 2 months later.

136. Dr Jerreat's findings were that the lungs "showed very congested more solid bases with pus exuding from the section surfaces compatible with early pneumonia." He found that the pulmonary arteries were patent and there was no thrombo-embolism. He found that the left anterior descending artery showed between 60% and 90% occlusion with calcification and atheroma. He gave the "disease or condition immediately causing death" as "bilateral pneumonia and pulmonary oedema" (Question 1(a) on the post-mortem report) and a "disease or condition that did not cause death but contributed in some way" as "coronary artery disease" (Question 2).

137. As indicated above, Dr Clelland's post-mortem was conducted just under two months after the first post-mortem during which period the body had been frozen or refrigerated. Dr Clelland found that the pulmonary artery trunks were normal, but the smaller branches of the right pulmonary artery contained "many small recently formed pulmonary emboli". They were up to 10mm long, were lying free and "have obstructed the blood flow to the right lung". Dr Clelland took 10 histological samples from the lungs, only one of which showed bronchopneumonia which he described as

demonstrating "one small focus of early bronchopneumonia". His conclusion was that "[there] was nothing to suggest that pneumonia was the primary cause of death as the pneumonic changes appeared localized to one small part of the right lung." He was also of the view that there was "nothing to suggest a cardiac cause of death".

138. There was clearly a division of view about the influence of pneumonia on the death. Professor Sheppard confirmed in her oral evidence that she (and indeed Drs Swift and Benbow: see paras. 139-142 and 144 below) were brought into the case to consider the histology and to express an opinion based on "the alternative investigations carried out by Dr Clelland and Dr Jerreat."

139. We will return to Professor Sheppard's view, which the Senior Coroner accepted, below (see paragraphs 145-151), but, as indicated above, two other experts had been instructed to assist in resolving the differences. The first was Dr Benjamin Swift, a forensic pathologist, who was instructed in February 2012 by the Kent Police to give an opinion on the cause of death.

140. He was provided with the reports of Drs Jerreat and Clelland (including a Supplemental Report from Dr Clelland), as well as certain other medical reports. In his observations he said this:

> "The consideration of the pathological findings in this case is hindered by the apparent differing opinions given by the Consultant Pathologists. I would strongly question whether Dr JERREAT, a highly experienced Forensic Pathologist and Member of the Home Secretary's Register of Forensic Pathologists, would have missed a massive pulmonary thromboembolism at original post-mortem examination. The subsequent finding of multiple small thromboemboli would not necessarily constitute a life-threatening event …. It is my experience, and that of many others, that small pulmonary thromboemboli are frequently identified at post-mortem that bear no relevance to the cause of death. One could argue that the finding of small volume thromboemboli in only one lung at post-mortem does not necessarily represent a cause of death therefore."

141. Accordingly, he did not think that pulmonary emboli (which he referred to as thromboemboli: see paragraph 152 below) had been shown to be causative of death. He went on, however, to say this:

> "Although Dr JERREAT suggested that the cause of death included pneumonia, this has been shown to not be the case. It should be noted, however, that it may be difficult to diagnose bronchopneumonia at post-mortem based solely upon macroscopic findings. Given the histology that has since been produced, it would be fair to consider this as not relating to Mrs PARKINSON's death."

142. He thus discounted pneumonia and went to say that it was difficult to postulate the precise cause of death, but "on the balance of probabilities" he considered it was "as a result of acute heart failure resultant from her coronary artery disease, as evidenced by the presence of pulmonary oedema and congested hepatic appearance."

143. It is to be noted that he alone of the various experts ascribed the death to cardiac failure.

144. Dr Emyr Benbow, an experienced Consultant Pathologist, was instructed by the Claimant in December 2012 to comment in particular on the findings in the microscopic sections prepared from the lungs of Mrs Parkinson, and to relate his findings to previous reports on the findings in Mrs Parkinson's previous autopsies. He did not have the advantage of seeing Dr Swift's report, but he said that he had "been unable to find any evidence of active purulent inflammation to support Dr Jerreat's conclusion that pneumonia was the cause of death" and he suggested "that had Dr Jerreat examined microscopic slides, it might be that he would have come to the same conclusion." Dr Benbow expressed the view that the cause of death was "pulmonary thromboembolism" and "deep vein thrombosis" ('DVT').

145. Professor Sheppard's report post-dated all these reports. Her conclusion was in the terms referred to in para. 129 above and she added the following:

> "I cannot comment on the extent of the bronchopneumonia based upon examination of 8 sections of lung and I do not know where these samples were taken from within the lungs. I also cannot comment on the number, extent and location of the pulmonary thrombi."

146. She went on to make the following observations:

> "I would also agree with Dr Swift that Dr Jerreat missing a massive pulmonary embolism in the main pulmonary vessels of both lobes of lung would be unlikely and there is lack of detail in the post mortem report about the pulmonary emboli described by Dr Clelland.
>
> The point that he makes that the "cause of death included pneumonia, this has been shown not to be the case," [*see [141] above*] I would disagree with that as the sampling on the lungs is limited to only 8 blocks and the sampling location we are unaware of. Although there is only bronchopneumonia in one block of lung tissue it is present so we cannot deny that there was bronchopneumonia within the lung. We cannot establish the extent of this bronchopneumonia due to the disagreement between both pathologists' macroscopic description and the lack of detail concerning the sampling that was done to the lung.

> Dr Swift thinks that her cause of death is acute heart failure resulting from coronary artery disease as there is pulmonary oedema and hepatic congestion. I disagree with this as pulmonary oedema and hepatic congestion can occur in any sudden death when the heart stops and does not specifically indicate coronary artery disease. Both Dr Jerreat and Dr Clelland disagree about the presence of coronary artery disease so it remains open as to its role in the cause of death. Unfortunately there is no histological evidence to agree or disagree with either pathologist."

147. It follows that there was a considerable measure of disagreement between these experts about the likely cause of death and concerns about the insubstantial nature of the histological evidence. There was no unanimity about the role of heart disease. What Professor Sheppard said in her oral evidence about this was as follows:

> "Given the fact that no other cause of death was found at autopsy, in other words no other organs like the brain or abdomen, showed the cause of death, you then come to the lungs and the heart in this case. The heart by description only I have to say does not confirm a cause of death. The coronary arteries by the second pathologist did not show significant narrowing and there was no damage, but that was by naked eye, and the heart weight was normal. So that, based on that evidence you have to say the heart, there is no evidence of the heart causing the death." (Our emphasis.)

148. She went on to say this:

> "Then you are left by a process of elimination with the lung, and you take the description of the initial pathologist, who was there for the first autopsy when the body was fresh, that is when you get the best findings than a frozen body … two months later."

149. She amplified or clarified the view expressed in the second of the quoted paragraphs from her report set out in para. 146 above by saying that there was histological evidence of bronchopneumonia present "on one slide admittedly", but she added that the other eight samples were taken "from a very large organ and … not all the samples came from what was the base [of the lung], [they were] from the upper lobes as well." It followed, she said, that if more sampling had been done "perhaps more bronchopneumonia may have shown up". She said that normally "bronchopneumonia is in the lower lobes, it predominates in the lower lobes" and she expressed herself as "not surprised from the sampling if done on the upper lobes that there [would not] be bronchopneumonia present." She said it was necessary to

sample extensively because there can be focal bronchopneumonia around the airways and there are "millions of airways in the lungs." Her position, as we understand it from reviewing the whole of her evidence, was (i) that she eliminated cardiac failure for the reasons already referred to, (ii) she eliminated pulmonary emboli for the reasons referred to partly above (see para. 142) and further below (see para. 150) and so (iii) what was left was bronchopneumonia, of which there was clear, albeit limited, histological evidence (in the form of one of Dr Clelland's slides) and clear macroscopic evidence (in the form of Dr Jerreat's observations), which was likely to be present elsewhere than demonstrated on the one slide. It was, therefore, reasonable to conclude that it was likely to be the substantive (or primary) cause of death. Her evidence was that there may not have been clinical signs of pneumonia prior to death because "[it] is a well-known fact that the clinical picture prior to death may or may not help you in determining the cause of death … you may … be asymptomatic and have massive bronchopneumonia."

150. The additional reasons for excluding pulmonary emboli as a <u>likely</u> (rather than a <u>possible contributing</u>) substantive cause of death were, according to Professor Sheppard, as follows:

(1) That the multiple small pulmonary emboli referred to by Dr Clelland (which he described in his oral evidence as 'thromboemboli') were "only in the right lung" and the left lung was not affected by thrombi. She observed that someone "can happily survive with one lung cut off".

(2) The size, number and distribution of the emboli observed were not such as to have been likely to cause death. The emboli described by Dr Clelland of 10 mm in length were "lying free unattached … but the main blood flow comes through the big vessel and the hilar vessel and the lobar vessel but there is no mention of" those vessels being blocked. Usually in fatal cases of pulmonary emboli, she said, the emboli occupy the large, the main vessel. In addition, she said that terminally ill elderly patients may get <u>thrombi</u> forming inside them because of poor blood flow rather than by reason of the development of DVT in the legs. She said that if Dr Clelland observed only in the region of a dozen pulmonary emboli (which is what he said in his evidence) then that is a "very small number compared to the number of branches throughout the whole right lung" and that the size (3-10 mm, which is also what he said in his evidence, although he sought to say 6-11 mm in his Addendum report submitted after the evidence had been closed and which the Senior Coroner declined to receive) was not such as would have blocked any of the main vessels. She averred that "the lung has a dual blood supply … there is the pulmonary artery [and] the bronchial arteries coming from the aorta … [so] a dozen thrombi … would not significantly compromise the blood supply."

151. Against the background of that assessment, Professor Sheppard said that "the lack of involvement of the significant major pulmonary artery and the right branch" meant that she could only say that these matters could <u>possibly</u> have contributed to the cause of death.

152. It will have been observed that in the various reports and passages of the evidence to which we have referred, the expressions 'emboli', 'thromboemboli' and 'thrombi' appear to have been used, in some instances, interchangeably. The following argument was foreshadowed in the Statement of Facts and Grounds:

> "[In] Box 2 of the Record of Inquest [the Senior Coroner] recorded Professor Sheppard's conclusion "that death was probably the result of bronchopneumonia" combined possibly with thrombi. This raises two issues. First, if he found the presence of [pulmonary embolism] was a mere possibility then why refer to it all in Box 2 (which exists to record the probable causes of death. Second, ALL the evidence before the Court was that any blood clots in the lung would be emboli not thrombi."

153. Mr Rawlinson repeated the first of these contentions by arguing that the record should only record the probable causes of death and that it was illogical to include reference to a possible cause. He is correct to say that the record should show the probable cause, but this record did indeed show such cause. The additional reference could simply be seen as surplusage that can be ignored or as something which, in the judgment of the Senior Coroner, ought to be included to reflect fully the view of the medical evidence he had accepted. Provided the probable cause is clear, we can see nothing objectionable in the manner in which the record was formulated by the Senior Coroner in this case. Furthermore, and in any event, the argument advanced does not go to the substance of the complaint made by the Claimant in this case: his complaint is that it was irrational for the Senior Coroner to have reached the conclusion that bronchopneumonia was the probable cause of death.

154. We did not understand Mr Rawlinson to advance the second proposition foreshadowed in the Statement of Facts and Grounds (see para. 152 above) in his oral argument. It would, we would observe, be very unusual for the various medical experts not to understand the significance of the terminology used and, whilst the use of the various expressions referred to in para. 152 above appear to have been used interchangeably, closer analysis suggests that there was consistency in what they said and that there was no confusion.

155. We think that it is generally understood that thrombosis is the formation of a blood clot (a thrombus) within a blood vessel. That can of itself interrupt the flow of blood. The process of embolism occurs when a blood clot separates, either in whole or in part, from its original place and travels in the blood stream to another part of the body. The fragment of the original clot thus formed is called an embolus or a thromboembolus. Both a thrombus and an embolus or a thromboembolus can prevent the flow of blood.

156. Dr Benbow said that the formation of thrombi (by primary thrombosis) in the lungs is very rare and unusual and that an embolus that arrives in the lungs from elsewhere will not initially be adherent to the lung walls. We do not understand from the transcript that Professor Sheppard disagreed with this assertion. However, her evidence was that thrombi occur in the lungs of a dying person in almost every case (caused by poor perfusion of the lung), a view shared by Dr Swift, and it is not possible to distinguish between thrombi thus formed and emboli that have arrived recently. What she did say very clearly was that whatever Dr Clelland observed, whether emboli or thrombi (as she called them), was insufficient to constitute the probable cause of death.

157. Whilst it might have been desirable for the Senior Coroner to spell this out in somewhat greater detail in his Conclusion, we can see no grounds for saying that his acceptance of Professor Sheppard's view was irrational. He obviously felt that she had greater experience and expertise than Dr Clelland and, accordingly, was entitled to prefer her view which, in any event, had a logical basis to it. There were some criticisms of the sampling undertaken by Dr Clelland that the Senior Coroner was also entitled to take into account in expressing that preference.

That no action that the hospital might reasonably have taken could have changed the outcome.

158. If the case that the Claimant had hoped would be made out at the Inquest in relation to the medical cause of death, namely, that pulmonary emboli caused the death, the only intervention that could have been taken by the hospital that might have arrested that process was the administration of thrombolytic therapy in time to have the necessary effect. Since the Senior Coroner reached the Conclusion on the cause of death to which we have referred, this issue was, strictly speaking, academic. Indeed, the precise time of death became irrelevant too. Since we have upheld that aspect of his decision, the issue is academic at this level also.

159. Nonetheless, the Senior Coroner expressed himself in this way towards the end of his Conclusion:

> "On the evidence I have read and heard, I have come to the conclusion that the death of Kathleen Parkinson was due to natural causes, and I am satisfied that any additional treatment that could have been provided to her in the short time she was at Darent Valley Hospital, would have been ineffective given the advanced stage of dying which she was at the time of her arrival at the hospital on the 9 January 2011."

160. At an earlier stage he had said this:

> "Dealing with the diagnosis and treatment of Mrs Parkinson I consider that the treatment provided by Dr Hijazi was appropriate given the limited time between Mrs Parkinson's arrival at the hospital and her subsequent unfortunate death. While tests and scans could have been conducted, from a practical point of view there would not have been sufficient time for this to have been carried out and concluded and treatment provided prior to her death to realistically have affected the outcome."

161. Without, we trust, dealing with this matter insensitively, we propose considering it shortly because of the status it possesses in the proceedings for the reasons we have given. We deal elsewhere (see paras. 168 onwards) with the issue of whether the Claimant's own actions contributed to the difficulty faced by Dr Hijazi in examining

Mrs Parkinson properly. However, the Senior Coroner concluded that it was "perfectly reasonable for Dr Hijazi to have concluded that with her agonal breathing and the results of the examination and tests available to him … Mrs Parkinson was in the course of dying." Dr Hijazi also said that his impression was one of sepsis.

162. The short point about the reasonableness of Dr Hijazi's view is that not merely was it his opinion of Mrs Parkinson's state when he saw her, but it was the independent view of two nurses who saw Mrs Parkinson at the time. Nurse Alison MacKay, an agency nurse, gave evidence that Mrs Parkinson was very ill when she came into the hospital and was exhibiting agonal breathing. Sister Elizabeth Taylor, a very experienced nurse, also considered the breathing to be agonal.

163. There was ample evidence, including the observations that were recorded (including the very low blood pressure and the low oxygen saturation of 58%), for the Senior Coroner to conclude that Mrs Parkinson was in an "advanced stage of dying" on her admission to hospital and that no treatment would have affected the outcome.

164. Equally, so far as the working diagnosis of sepsis was concerned, it was accepted as reasonable by Mr Manolis Gavalas, Consultant in Accident & Emergency Medicine at UCLH, who was invited by the Kent Police to offer a general opinion on the treatment provided by Dr Hijazi (as the A&E department doctor) and the rest of the A&E team. His reports had initially been critical of the care provided, but in questioning by Mr Hurst on behalf of Dr Hijazi he accepted that the working diagnosis of sepsis was within a responsible body of medical opinion and that he was not critical of the fact that Mrs Parkinson was not given anti-thrombolytic therapy.

165. It is clear from the acceptance of these matters that the calling of any other team of doctors would have had no impact on the outcome. We were pressed by Mr Rawlinson with submissions that the evidence demonstrated that there was confusion within the A&E Department about the respective relevance of the Manchester Triage System score (the 'MTS' score) and the Patient at Risk score (the 'PAR' score) with the result that no call was made to the Medical Emergency Team (the 'MET'). There was undoubtedly discussion about these matters in the evidence received by the Senior Coroner (see our analysis at paras. 105-119 above) although he made no specific reference to them in his Conclusion. That may have been because, as we have said, once it was accepted that Mrs Parkinson was dying, there was nothing that the MET could have done to change that course. Equally, however, part of the evidence received by the Senior Coroner, given by Mr Vincent Kika, a Consultant in the A&E Department, was that the MET is never called to the A&E Department. As we have already indicated, that was a position supported by Mr Gavalas (see para.110 above) from his personal experience. It follows from this that, on a fair analysis, there was almost certainly no confusion within the A&E Department about whether to call the MET (which consisted of one specialist registrar, one nurse and an anaesthetist): it was not a step which would ever have been taken and it would, in any event, have made no difference to the outcome.

166. The final matter to consider in this overall context of a challenge to these two findings is the alleged failure to conclude (and thus record) the time of death. We have already observed (see para. 158) that the precise time of death was, in the circumstances, irrelevant to the cause of death. On that basis, there was no need for the Senior Coroner to resolve the difference that might at first sight appear from the

contemporaneous records: Dr Hijazi recorded death at 07.08 (when he felt no pulse) and the medical registrar on call (who attended following the recommendation of Mr Kika after the issues involving the Claimant had arisen) who recorded death at 07.40 in a record timed at 07.50. The registrar could not have recorded death at 07.08 because he was not there at the time and his record is probably simply a reflection of the time he attended. However, the issue is irrelevant for the reasons we have given.

167. Recording the time of death is particularly fact and context-specific. In our judgment, the record made by the Senior Coroner was acceptable in the circumstances of this case.

Ground 4: The Senior Coroner was wrong to find that Dr Hijazi was prevented from examining Mrs Parkinson at 06:50 by the Claimant's behaviour.

168. In his conclusion the Senior Coroner made a number of findings of fact about the conduct of the Claimant. He expressed his findings in these terms:

> "It was apparent to Dr Hijazi the doctor who saw Mrs Parkinson that she was in agonal breathing and given the other recorded findings he formed the view that she was sadly dying. It is clear that Gerard Parkinson did not accept this and he wanted his mother treated, and when that had been declined by Dr Hijazi I confirm that Mr Parkinson had become extremely angry and I am satisfied that he did make threats towards the doctor and was obstructive. I also accept from the evidence of Dr Hijazi that he was extremely concerned and considered security to deal with the situation. I find that as a result of the way the doctor was treated by Mr Parkinson this did result in him not being able to carry out a full examination of Mrs Parkinson, which given the evidence I have considered, I consider to be understandable."

169. Mr Rawlinson takes issue with this criticism of the Claimant and submits it was unfair and inconsistent with much of the evidence before the Senior Coroner. In support of his submissions on this ground he makes a number of submissions. He says that the allegation only surfaced a matter of days before the inquest began and did so in a statement from Dr. Hijazi dated 5 May 2016. He also submits that the evidence of the family was to the effect that they wished for an examination and treatment and that there was no obstruction. He submits that a finding that the Claimant prevented Dr. Hijazi from examining Mrs Parkinson was perverse in all the circumstances.

170. Mr Rawlinson also submits that the actions of the Claimant were not formally within the scope of the Inquest and that the finding was unnecessary, gratuitous, unsupported by other evidence and a finding that leaves a strong sense of grievance on the part of the Claimant who was effectively told by the Senior Coroner that he had a hand in his own mother's death.

171. In the course of this lengthy Inquest the Senior Coroner heard evidence from all of the key personnel in close proximity to Mrs Parkinson: Dr Hijazi, the nursing staff as well as the Claimant and Jennifer Higgins. In his Conclusion the Senior Coroner set out his summary of the evidence on this particular topic. The topic was a key feature of the Inquest and a factual issue that the Senior Coroner considered that he had to resolve. When summarising the evidence of Dr Hijazi, he did so in these terms:

> "He tried to engage with her son and his partner and found them extremely difficult. Mr Parkinson was very, very angry, distressed and aggressive and he was urging him to do something and he could not understand that his mother was dying. He explained to Mr Parkinson that his mother was dying and there was not much he could do. He did mention 91 but this was not a main factor in the decision not to do anything. He considered that she was in the last moments of life and doing anything at that stage would not have been beneficial to her. He considered the agonal breathing was a terminable event and further investigation was not necessary. He felt threatened by Mr Parkinson who was abrupt and aggressive towards him. DNR was discussed and the doctor informed Sister Taylor of the position. The doctor had left at about 6:55am and when he came back it was 7:08am and checked Mrs Parkinson's pulse. He found that there was none. He spoke to his consultant Dr Kika and he suggested the medical registrar on call should be involved with the certifying of the death. Dr Hijazi said that Mr Parkinson was extremely hostile and was very, very angry and aggressive and saying that the doctor should do something and Mr Parkinson had pushed him and accused him of killing his mother. The doctor asked Sister Taylor to speak with Mr Parkinson. The doctor had considered calling security but as this was the last moments of Mrs Parkinson's life he thought that it was better for Mr Parkinson to remain with her. The doctor had never ever felt threatened by relatives to this extreme before. The doctor was unable to certify Mrs Parkinson's death because he was concerned and worried about his own personal safety. Mr Parkinson told him that he hoped my head would be crushed in a road accident. He found Mr Parkinson difficult to communicate with and so he had left."

172. With the evidence of the Claimant, he set out the following summary:

> Mr Parkinson asked what was wrong with his mother and the doctor replied "*I don't know*." He did not carry out an examination of his mother, he considered the doctor's attitude as he expressed it as being venomous. His mother called out for help, she was agitated and restless, breathing fast and moving around vigorously. Mr Parkinson asked the doctor when he was walking away "*is she dying?"* and he said the doctor had responded "*I don't know if she is but if she is we don't do anything she is 91."* In the view of Mr Parkinson his mother was not in agonal breathing, Mr Parkinson was totally shocked at the

> attitude of the doctor, he spoke to Jennifer and said to her "*he is murdering her, what are we going to do?"* Mr Parkinson did not consider his behaviour was obstructive he just wanted his mother examined, diagnosed and treated. He did accept that by the end of the encounter he may have sworn, he said the doctor went away and returned after ten minutes and he had suggested to the doctor that adrenaline should be administered. He said the doctor was aggressive and hostile and shouted *"she is 91 let her die in peace*." It was accepted by Mr Parkinson that he did say that the doctor was murdering his mother. He had spoken over the telephone to his sister Ruth and when his mother had stopped breathing Mr Parkinson gave mouth to mouth resuscitation to his mother. He said the first time that Dr Hijazi had used a stethoscope was when his mother was certified dead".
>
> And
>
> "He was cross examined at length by Mr Hurst on behalf of Dr Hijazi but maintained that his evidence was accurate. He accepted that his mother had a degree of dementia, he did not accept that his mother used a zimmer frame. He said that she may have been prescribed one but that she would only have used it when leaving hospital. He maintained that Dr Hijazi had been criminally responsible and he denied making racist remarks. He did not accept that there was no clinical justification to carry out CPR. He denied having any contact with security he maintained that his mother was alive until 7:40am and that his mother had been neglected by Dr Hijazi and that he was solely responsible for her death. He did not accept that his mother had agonal breathing at any point. He said that no one else examined his mother before she was declared to have died."

173. We have been referred to references in the statements before the Senior Coroner and in the transcript of the Inquest where this topic was covered. The witnesses included the Claimant and Dr. Hijazi, as well as Jennifer Higgins, Sister Taylor and Nurse Mackay. We have set out the summary given by the Senior Coroner and we have read all the passages in the statements and the transcript on this issue.

174. As well as the Claimant and Dr. Hijazi it is instructive to see how the issue was covered by the others in the course of the Inquest. For example, at p.268 of the Inquest Transcript Sister Taylor was asked about this by Mr Payne:

> "Mr Payne: Now, did you see, well was Mr Parkinson in any way aggressive or did he shout at you or in any way abusive you?
>
> Sister Taylor: To me personally, no.
>
> Mr Payne: What about to Dr Hijazi?

Sister Taylor: Yes he did.

Mr Payne: At that stage or afterwards?

Sister Taylor: It is difficult to put that into the context of exactly when. But as I have put in my notes, he was very agitated, he was clearly very unhappy, he was upset and I was trying to explain to him why we'd made the decisions we had and he just accused Dr Hijazi of murdering her."

When Senior Staff Nurse Mackay attended on day 9 of the Inquest, the following exchange took place:

"Mr Payne: Did he seem distraught, angry, calm?

Ms McKay: No, angry.

Coroner: Sorry I didn't hear that?

Ms McKay: Angry.

Coroner: He was angry?

Ms McKay: Mmm.

Mr Payne: And did he seem angry from the outset or did, is it something that developed during the half hour that you spent with Mrs Parkinson?

Ms McKay: No, it was something that developed.

Mr Payne: And what did you put that anger down to? Why do you think he became angry? Well let me ask you, sorry, did he ever say to you why he became angry?

Ms McKay: No, not to me, no he didn't speak to me.

Mr Payne: And are you able to say why you thought he became angry.

Ms McKay Well, that would be me making assumptions, I, I don't know because I didn't have a conversation with him.

Mr Payne: Fair enough. And how did you know that he was becoming angry, if you didn't speak to him?

Ms McKay: Because I heard him being verbally aggressive to Dr Hijazi.

Mr Payne: You have just said that you remember hearing Mr Parkinson being aggressive to Dr Hijazi, how close to Dr

Hijazi and Mr Parkinson were you when the conversation you describe was taking place.

Ms McKay: How close was I?

Mr Payne: Yes.

Ms McKay: Not that far away, a few feet maybe.

Mr Payne: And were there raised voices, or was it at a conversational level?

Ms McKay: No, raised voices.

Mr Payne: And where there raised voices, was, how was Dr Hijazi responding to Mr Parkinson.

Ms McKay: In a normal fashion, in a polite fashion.

Mr Payne: And do you remember what Dr Hijazi was saying to Mr Parkinson?

Ms McKay: I don't remember the exact words, but whatever he said it wasn't raised, he hadn't raised his voice.

Mr Payne: And do you remember the, do you remember what Mr Parkinson was saying to Dr Hijazi?

Ms McKay: I don't remember the actual words, but it was the tone.

Mr Payne: Do you remember the thrust of the conversation they were having?

Ms McKay: No, no.

Mr Payne: And how would you describe the atmosphere at that time?

Mrs McKay: It was very tense, it wasn't nice, it was hostile it just didn't feel right and that's why I think I remember the majority of us, well not majority, but that time."

175. Jennifer Higgins attended on day 7 of the Inquest. At p.306 of the transcript she was asked about the behaviour of the Claimant:

"Mr Payne: Now when Dr Hijazi came you've explained, and I don't want to upset you again, did he, how would you describe Mr Parkinson, Gerard's behaviour?

> Ms Higgins: He was pleading, he was pleading with Dr Hijazi to help his mother. He was asking him not in an aggressive, there was only one person aggressive in that hospital that day and it was Dr Hijazi, trust me. He was begging him to help his mum and it was heart breaking to watch."

176. We have considered those passages alongside the exchanges concerning the Claimant and Dr. Hijazi, with care. From a review of the transcript, it is clear that the issue whether the Claimant obstructed Dr. Hijazi's examination was fully explored through questions from counsel to the Inquest, counsel for Dr. Hijazi as well as by Mr Rawlinson on behalf of the Claimant.. Mr Rawlinson was able to put questions as to the timing of the witness statement from Dr. Hijazi dealing with obstruction, as well as what he says are inconsistences in the accounts given by Dr. Hijazi. His questions on these topics were thorough. By way of example at p.413 of the transcript there was the following exchange:

> "Dr Hijazi: Again, I tried, I explained to him that it wouldn't help, he's I, you know do something, he kept asking me, begging me to do something. I said whatever I'm going to do is not going to help, OK. I don't think Mr Parkinson was in a state of mind that I could rationalise any sensible discussion with him at all.
>
> Mr Rawlinson: And there we have it. Dr Hijazi, you have just said he was begging you for help. This isn't a man who was obstructing you from doing your job, this is a man begging you for help. Now would you like to withdraw the allegation that he obstructed you from carrying out any observations of Mrs Parkinson now?
>
> Dr Hijazi: No, I would not because he pushed me, he swore at me, he was angry, he was not accepting.
>
> Mr Rawlinson: When did he push you?
>
> Dr Hijazi: I couldn't remember whether it was first or second time, but I remember him pushing me, I remember him swearing at me, I remember him shouting very loudly.
>
> Mr Rawlinson: He was shouting that you weren't helping his mum and you were murdering his mum. It may have been most unpleasant, most unpleasant, but he didn't lay hands on you did he?
>
> Dr Hijazi: Sorry?
>
> Mr Rawlinson: He did not lay hands on you.
>
> Dr Hijazi: He did."

177. It is clear that the issue of the attitude of the Claimant and whether there had been obstruction of Dr Hijazi's examination was one where the evidence before the Senior Coroner was in conflict. It was an issue that had to be addressed: not to have done so would have been odd in the circumstances of the sequence of events at the hospital that morning. In making an assessment of the evidence the Senior Coroner was clearly entitled to consider all of the material before him and to decide upon the evidence he found to be credible and that which he did not consider to be credible or reliable. Although it was open to the Senior Coroner to have come to a different view on this evidence, and others might not have come to the view that this coroner did, in our judgement, it cannot be said that the conclusion the Senior Coroner reached on the evidence was not one that he was entitled to make, nor was it irrational. The Senior Coroner made an assessment on the evidence before him that cannot, in our judgment be described as perverse.

178. Before leaving this topic we should say that we do not accept the point set out in the Skeleton Argument that this finding should leave a strong sense of grievance on the part of the Claimant in the sense that it is said he was being told by the Senior Coroner that he had a hand in his own mother's death. That is not how we read the finding of facts. The Senior Coroner was clearly of the view that the death was from natural causes and that Mrs Parkinson was in the process of dying when she arrived at the hospital.

Conclusion

179. For the reasons we have set out this claim for judicial review is dismissed.

Costs

180. After the draft judgment in this case was circulated to the parties on a confidential basis in the usual manner, the parties were invited to make written submissions on consequential matters. The Defendant and both Interested Parties have made applications for their costs against the Claimant. The Claimant resists those applications and all the parties have filed written submissions on the issue of costs. They are also agreed that this issue can be determined by the Court on the papers without the need for a further hearing.

181. It is common ground that costs lie in the discretion of the Court and that the usual order is that costs should follow the event. However, the Claimant submits that there should be no order as to costs in this case. The Claimant makes distinct submissions in respect of (1) the Defendant and (2) the two Interested Parties.

182. The Claimant first relies upon the fact that permission was granted by Mostyn J to bring this claim for judicial review on all grounds. However, that is a general feature of claims for judicial review which reach the stage of a substantive hearing. It is not a

reason for not making the usual order as to costs in favour of the successful party or parties.

183. Secondly, it is submitted that the claim raised an important series of issues of general importance. However, this was not brought as a public interest case. It was brought, as is commonly the case, to defend the private interests of the Claimant. In any event, we are not persuaded that this is a case in which the general importance of the issues would have justified making no order as to costs.

184. Thirdly, the Claimant submits that, in the course of its judgment, the Court has made some criticism of the Senior Coroner's expression of his findings, in particular at para. 157 above. However, this does not detract from the fact that the claim for judicial review has failed on all grounds and does not persuade us to take a different view from the normal position on costs.

185. Finally in relation to the Defendant, it is submitted that the Senior Coroner engaged in this claim on the basis of seeking to assist the Court and otherwise to be neutral. It is submitted that, if the claim had succeeded, the Defendant might well have been justified in submitting that there should be no order as to costs against him. We are not persuaded by this submission.

186. In the circumstances of this particular case, we consider that it was important and necessary for the Defendant to defend his decision and to take an active part in these proceedings. A detailed critique of the Defendant's position was launched by Mr Rawlinson, both on the law and on the facts. We have derived particular assistance from the submissions of Ms Leek, who took the lead on issues of law. Since the Defendant has been successful in resisting the challenge to his decision, we consider that the normal order as to costs should follow.

187. The position of the Interested Parties is not necessarily the same. The Court will often make only one order as to costs in judicial review proceedings (or analogous proceedings such as those under the planning legislation): see e.g. *Bolton Metropolitan District Council v Secretary of State for the Environment* [1995] 1 WLR 1176, at 1178G-1179A (Lord Lloyd of Berwick); and Fordham, Judicial Review Handbook (6th ed., 2012), para. 18.1.7. However, in the particular circumstances of this case, we are persuaded that both of the Interested Parties should be awarded their costs. They each had separate interests which needed to be protected by separate representation in these proceedings. Furthermore, their submissions have been particularly helpful to the Court in resolving the factual issues in this case, as will be apparent from our judgment.

188. We have considered carefully whether costs should be awarded in principle in full to each of the successful parties. We have concluded that they should. It is difficult to see how any just reduction could properly be made. However, we consider that there should be a detailed (rather than summary) assessment of costs in this case if the parties are unable to agree the quantum of costs.