Neutral Citation Number: [2020] EWHC 781 (Admin)

Claim No: CO/3179/2019

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

Cardiff Civil and Family Justice Centre
2 Park Street, Cardiff, CF10 1ET

Date: 07/04/2020

Before :

LORD JUSTICE DINGEMANS
MR JUSTICE GRIFFITHS
THE CHIEF CORONER FOR ENGLAND AND WALES
(HIS HONOUR JUDGE LUCRAFT QC)

- - - - - - - - - - - - - - - - - - - -

Between :

THE QUEEN on the application of CAROLE SMITH	**Claimant**
- and -	
HM ASSISTANT CORONER FOR NORTH WEST WALES	**Defendant**
-and-	
BETSI CADWALADR UNIVERSITY HEALTH BOARD	**Interested Party**

- - - - - - - - - - - - - - - - - - - -
- - - - - - - - - - - - - - - - - - - -

Paul Kingsley Clark (instructed by **Broudie Jackson Canter**) for the **Claimant**
David Pojur (instructed by **Gwynedd Council Legal Services**) for the **Defendant**
Sara Sutherland (instructed by **NHS Wales Share Services Partnership, Legal & Risk Services**) for the **Interested Party**

Hearing date: 17 March 2020

- - - - - - - - - - - - - - - - - - - -

Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

MR JUSTICE GRIFFITHS

Mr Justice Griffiths :

1. This is the judgment of the Court on an application for judicial review of a Coroner's decision and Record of Inquest following an inquest held at the Council Chamber, Caernarfon. The inquest was in relation to the sad death of Ms Leah Victoria Smith, described by the Coroner as "clearly, a much-loved daughter and partner". The deceased has been referred to in the proceedings, by permission and at the request of her family, by her first name, Leah, and we will continue to do that in this judgment.

2. The proceedings are brought by Leah's mother. The Defendant is the Coroner, who is represented, but takes a neutral stance. Fuller argument in response to the claim has been presented by the Interested Party, which is the health board responsible for Leah's health care at the time of her death.

The issues

3. Five issues are raised in the Claimant's Statement of Facts and Grounds for Judicial Review, which claim:-

    i) The decision erred in law as to the threshold for causation of death.

    ii) The decision erred in law as to the standard of proof for causation of death.

    iii) The decision was irrational in its failure to accept the evidence of an expert, Dr Maganty, about causation of death.

    iv) The decision and Record of Inquest were not compliant with the requirements of an investigation under Article 2 of the European Convention on Human Rights.

    v) The decision was irrational in failing to make a finding of neglect.

4. Permission to apply for judicial review was granted by Swift J on Grounds 1-4 and refused on Ground 5. Ground 5 was pursued as a "rolled up" hearing before us, both renewing the application for permission and arguing it on its merits.

Chronology of Leah's treatment and death

5. Leah was born in 1989 and died at the age of 27 on 2 May 2017. The medical notes showed the following history in the weeks leading up to her death. This history is relevant to Issues 1-3 (on causation) and Issue 5 (neglect).

6. In March 2017, Leah had a urinary tract infection. She was seen by her GP who prescribed trimethoprim (an antibiotic). At the same time, she was noted by her partner, Simon, and the GP as suffering from a sudden onset of paranoid delusions.

7. On 20 March 2017 Leah collapsed at the GP surgery and was immediately referred to the emergency department. There she was medically reviewed and referred to mental health liaison, because of her paranoid beliefs. The clinical notes from psychiatric liaison that evening (20 March) include: "no thoughts of harming herself, partner Simon and her dog walks are protective factors… rapid deterioration in mental state over the last 2 to 3 days… odd head movements noted…"

8. On 29 March she was seen by a medical registrar who noted "impression acute psychosis query schizophrenia, no medical issues at the moment." On the same day she was reviewed by a psychiatric liaison nurse who "suggested treatment with lorazepam mg and 3.75 zopiclone tablets for 2 days if needed. Impression epilepsy. Okay to discharge from psychiatric point of view… refer to a community mental health team, urgent outpatient."

9. Lorazepam is used to treat anxiety and sleeping problems and zopiclone is also for sleeping problems.

10. On 31 March she was seen out of hours "presenting with paranoid ideation acute". She was still going to work and her relationship with her supportive partner of 4 years was noted. The notes said she "has had thoughts of harming herself, no plans." There was a discussion with the psychiatric Senior House Officer on call, Dr Mehr, "who queried possible epilepsy and advised discharge and urgent referral to CMHT (Community Mental Health Team) for further assessment. Also prescription of lorazepam 1mg for 2 days and zopiclone 3.75mg to 2 days." A later note the same day was "no risk to self or others identified. MHM clinical assessment tool completed. Case discussed with local consultant, Dr Majek, referred to home treatment team, agreed risperidone 0.5mg twice daily for one week, then increase to 0.5mg daily and 1mg at night. Liaison with community mental health team allocation of care manager."

11. Risperidone is an anti-psychotic drug.

12. Leah was also assessed by a social worker, who noted "Leah's partner is self-employed and is able to take time off to look after Leah who is currently needing constant support and reassurance. There was no evidence of risk to self. Leah denied any suicidal ideation of self-harm… Discussed with Dr Majek for GP to prescribe risperidone. Discussed referral to home treatment, Leah agreed to this but remains fixed in her thinking. Also discussed the possibility of hospital admission if there is any further deterioration…."

13. On 2 April 2017 she was visited at home. A locum consultant, Dr Ezah, was spoken to about an outpatient appointment. Leah later became very distressed at her mother's house and her partner was told a prescription for diazepam would be arranged after consultation with Dr Ezah.

14. Diazepam is used to treat anxiety.

15. On 3 April 2017, Dr Ezah being off sick, another doctor gave a 7 day prescription for lorazepam (1mg) and zopiclone (3.75mg at night) and asked for an urgent review by a consultant. Dr Mehr being on annual leave, an appointment on his return on 11 April was suggested.

16. Leah was visited on 5 April 2017. The notes say she was less anxious and had decreased paranoia. On 6 April 2017 the notes say "Leah uses lorazepam to good effect when needed". She was visited at home on 7 April 2017 and appeared to have improved. A note on 12 April recorded "she is no longer taking zopiclone 3.75mg on a regular basis". However, she was still mentally ill and concerns were repeatedly noted that she had not had any medical review by a consultant in the previous two weeks, due to a lack of medical cover. On 13 April an increase in her risperidone prescription to 1mg was

discussed by telephone with Dr Mehr. The GP agreed to prescribe accordingly. An outpatient appointment with Dr Mehr was fixed for 18 April.

17. At a home visit on 17 April Leah's mental health had become worse, but she denied thoughts of self-harm.

18. However, Leah took an overdose of co-codamol (paracetamol and codeine) later in the day (17 April 2017), in the context of paranoid delusional thinking.

19. Leah was admitted to hospital. She was scored at the top end of 'medium' on a suicide intent scale at the hospital. An on-call psychiatrist was consulted. It was decided to discharge her to the Home Treatment Team and increase her risperidone prescription to 2mg a day.

20. Leah was discharged from hospital on 19 April. She was seen at home and it was agreed that someone would always be with her in the next few days.

21. On 20 April she was shaking badly and still presenting with paranoid ideation. She was on risperidone 2mg daily (up from 1mg) and "not experiencing any side effects". When seen on 21 April, she "looked a little tired but conversed well". A diazepam prescription was available for collection. On 22 April she had "very noticeable tremor" in "whole body", said to be "getting worse with increasing risperidone". On 23 April the note is "tremor much reduced, she reports she feels better in mood, seemed to be smiling spontaneously." On 24 April concern was expressed about "absence of medical review". A doctor suggested "risperidone to be stopped immediately commence on olanzapine 5mg and mirtazapine 15mg nightly" but action on this was deferred until Leah was seen by a psychiatrist.

22. Olanzapine is an anti-psychotic medicine. Mirtazapine is an anti-depressant.

23. On 25 April 2017 Leah was seen for the first, and only, time face-to-face by a psychiatrist in consultation. This was Dr Mehr. He took detailed notes. These include "sometimes fears not worth living"; "Her mood and verbal communication have deteriorated". His conclusion was:-

> "Impression – first episode of psychosis. Plan – refer to early intervention team, start mirtazapine 15mg nocte [nightly], reduce the dose of risperidone by 1mg every 3 days and stop, start olanzapine 5mg nocte [nightly] after the 1mg risperidone bd [twice daily] stops. Review if required by the home treatment team."

24. She was seen and given her medication on 26 April.

25. On 28 April 2017 Leah hanged herself. She was taken by air ambulance to hospital. Efforts to revive her there failed, and she died on 2 May 2017.

The inquest and the evidence

26. A coronial investigation was opened, by the Coroner's predecessor in office, on 4 May 2017.

27. A post mortem examination was carried out by Dr Mared Owen-Casey on 4 May 2017 (less than 36 hours after death). She produced a Post Mortem Report dated 9 June 2017 which is short and uncontroversial. Her "Provisional Anatomical Diagnosis" was:-

> "1. Feint ligature mark around neck anteriorly;
> 2. Mildly oedematous brain;
> 3. Pulmonary oedema;
> 4. Probable bronchopneumonia;
> 5. Possible pus in right kidney."

28. A Serious Incident Review was carried out by the Interested Party. It made the following findings:-

> "Care and Service Delivery Problems
> 1. Absence of medical review led to no formal diagnosis.
> 2. Over-cautious use of antipsychotic medication.
> 3. Non-prescription of antidepressants for nearly a month.
> 4. Discharge from emergency department early hours of the morning, on one occasion without informing her partner.
>
> Root cause
> 1. Inadequate medical cover for home treatment team patients in the West.
>
> Actions
> 1. Home treatment team consultant has been recruited to cover the geographical area of Anglesey and Gwynedd August 2017.
> 2. Reflect on discharge of vulnerable patients from emergency department.
> 3. Share report with emergency department colleagues to reflect on discharge from emergency department for vulnerable patients. Completed August 2017."

29. On 12 October 2017, the coroner then acting decided that a duty to investigate was engaged by Article 2 of the European Convention on Human Rights. She formulated a list of 9 issues to be included in the inquest, which included "Availability of / Access to a Consultant Psychiatrist", "Diagnosis", "Medication/Dosage" and "Staffing, in particular adequate provision of consultant psychiatrists". She decided that an expert witness was required, "given the complexity of the issues and the engagement of Article 2".

30. The expert commissioned to provide this evidence was Dr Dinesh Maganty ("Dr Maganty"). Dr Maganty is a Consultant Forensic Psychiatrist. He produced a report on 22 February 2018 ("Dr Maganty's Report").

31. Dr Maganty's Report set out the history from the clinical records and reviewed other documents and witness statements. Since it was produced before the inquest, it could not, of course, take account of the evidence that was, in due course, given to the inquest by those responsible for Leah's care in the period before she died, although Dr Maganty did refer to witness statements which had already been served.

32. Dr Maganty's Report criticised the medical care given to Ms Smith in the period before her death. He said there was "a singular lack of availability/access to a consultant psychiatrist". He criticised the way in which Leah had been seen as an out-patient or by way of home treatment by a team which did not include a consultant psychiatrist. He noted that Leah had not received a formal diagnosis of the causes of her psychosis. He postulated "a diagnosis of a psychotic depression" but Dr Maganty said it was "not clear… what precipitated this depression… the underlying cause… could be organic or functional." He noted the possibility of epilepsy and also highlighted the urinary tract infection. He said "These would have required further investigation". He identified a delay in prescribing anti-depressant medication. He also observed that the doses of anti-psychotic medication (risperidone) were sub-therapeutic throughout. He criticised a lack of continuity of care.

33. Dr Maganty's Report reached the following conclusion:-

> "Considering all the above, i.e. failure of provision of basic medical care, in my opinion, on the balance of probabilities, the death of Miss Leah Smith was not only predictable but was entirely preventable. If she had received appropriate antidepressant medication at an early stage, therapeutic doses of an appropriate antipsychotic at an early stage and received inpatient admissions/home treatment care as per good practice guidance with appropriate treatment at an early stage, on the balance of probabilities, it is likely that she would have made a good recovery."

34. The final hearing took place between 7-14 May 2019. A number of witness statements were read and other witnesses were questioned by the Coroner and cross-examined. The Claimant and the Interested Party made written and oral submissions through their respective Counsel.

35. The witnesses questioned and cross-examined included Dr Maganty (on 10 May), Dr Tunde Akinkummi (after Dr Maganty) and Dr Majid Mehr (on 13 May). The oral evidence of these witnesses is particularly relevant to Issues 1-3 (causation) and Issue 5 (neglect), and we have examined the transcripts of what they said to the Coroner at the hearing.

Dr Maganty's evidence

36. Dr Maganty accepted that there were never, in Leah's case, grounds to detain her in hospital. He did not, therefore, criticise her being treated at home. He also emphasised that "nothing that I say should be read as criticism of a particular practitioner". He also said: "For that matter, I do not think I would criticise the senior management".

37. He accepted that the Home Treatment Team had access to a consultant psychiatrist. However, he said it is "standard practice" that the patient "is seen face-to-face by the psychiatrist and they make an assessment and a diagnosis and prescribe treatment." He said that this should have happened within 24 hours of referral to the Home Treatment Team.

38. He stressed that he had not himself seen Leah, but he confirmed his suggested diagnosis of "severe depressive episode with psychosis". As to the cause of that, he said: "I cannot say… what the diagnosis is, i.e. what is the cause for this psychosis with depression, because I did not see the patient." The Coroner asked him, in view of that answer, how he had been able to conclude in his Report "The death of Miss Leah Smith was not only predictable but entirely preventable". His answer was "it's entirely a treatable condition that she had, whatever the condition may be… So if you can treat that illness and illness is causing the death, then you can prevent the death".

39. The Coroner (C) then asked: "…there is a difference, isn't there, between treating and curing?" Dr Maganty (M) agreed, and this passage of evidence then followed:-

> "M: There is a difference between treating and curing, and that's why, as I say in paragraph 11, the opinion expressed is on the balance of probabilities. That is, the death of Miss Leah Smith was not only predictable but preventable. And patients with psychotic depression… in the vast majority of cases patients make a good recovery. And 99, over 99% of them do not go on to kill themselves in the coming few years, as it were.
>
> C: Just pause there for a moment. Where do you get that 99% from, Doctor?
>
> M: The five-year mortality rate of those who have been treated for psychosis is less than 0.1%. The first episode psychosis. Those who do not have illicit substance use and who have a supportive family.
>
> C: … But people do still undertake those acts, or commit suicide whilst they are being medicated for those type of illnesses, don't they?
>
> M: I entirely agree. Patients do suffer self-inflicted deaths whilst they have been treated for these illnesses, but that's why the opinion is expressed on the balance of probabilities. Therefore, you cannot say that for certain that it would be prevented, but the vast majority of patients who receive treatment don't go on to suffer self-inflicted deaths."

40. Under further questioning by the Coroner, Dr Maganty said that, if Leah had been seen face-to-face by a consultant psychiatrist at the outset (instead of psychiatrists being consulted via the Home Treatment Team), medication would "not necessarily" have been delayed until a cause for her psychosis had been established, and it was uncertain what medication would have followed.

41. Dr Maganty was cross examined about the fact that Leah was seen face-to-face by a consultant psychiatrist 3 days before she died (that is, by Dr Mehr, who had not yet given evidence). Dr Maganty emphasised that, at that point, the dosage of anti-psychotic medication was sub-therapeutic, and suggested that "if she had been assessed within 24 hours, weeks earlier, you would have had an opportunity to provide

effectively give olanzapine, it may well be olanzapine; and Dr Mehr saw the patient, and that's a big advantage".

42. However, when Dr Mehr gave his evidence (which we will summarise more fully below), he did not agree that the prescription he gave on 25 April, with the benefit of prescribing and observation in the period before his consultation, is what should have been prescribed at the outset, without that benefit. From the transcripts we have seen, no witness appears to have supported Dr Maganty's opinion that a face-to-face consultation at the outset should or probably would have resulted in different diagnosis or prescription of medication from that which was actually provided on the basis of the observations of the Home Treatment Team. Dr Maganty himself emphasised "I haven't seen the patient" and he accepted that his own statements had "an element of hindsight bias." He accepted that "it is sensible and cautious to start with low levels of medication".

Dr Akinkummi's evidence

43. Dr Akinkummi was a Consultant Forensic Psychiatrist who was a locum on Friday 21 April and Monday 24 April. He was the doctor who suggested "risperidone to be stopped immediately commence on olanzapine 5mg and mirtazapine 15mg nightly" on 24 April, based on a diagnosis of psychotic depression. In evidence to the Coroner, he explained that his suggested diagnosis and proposed prescription was based on the symptoms described to him, although he did not conduct a face-to-face consultation with Leah. He said that this was "not unusual at all."

Dr Mehr's evidence

44. Dr Mehr MD PhD had been a practising psychiatrist since 2011 and he was the doctor who saw Leah face-to-face at a consultation on 25 April 2017, 3 days before Leah's final suicide attempt. This was the consultation at which he prescribed "*start mirtazapine 15mg nocte* [nightly]*, reduce the dose of risperidone by 1mg every 3 days and stop, start olanzapine 5mg nocte* [nightly] *after the 1mg risperidone bd* [twice daily] *stops*." His evidence was that the consultation lasted more than an hour.

45. Dr Mehr's evidence was that, in answer to specific questioning from him, Leah had "denied any thoughts of deliberate self-harm, suicide or harming others." He said there was no reason to admit her to hospital because "patient denies having low mood, patient is receiving medicine without any problem, she has a family around her, especially a partner that has quit his job to take care of her." He said:

> "The risk is always there. What we can, only can say, the risk is low, medium or high. Everybody has a risk of these issues when they come to mental health, so the risk was there, but it was low, and the risk from what I had in my assessment, the risk could be managed under Home Treatment Team."

46. Dr Mehr's evidence was that at the consultation he reached "a working diagnosis". This was "first episode psychosis and depression" (which is the diagnosis supported by Dr Maganty). This led to his prescription of mirtazapine (for depression and to improve sleep) and olanzapine (for psychosis). He explained that he prescribed the replacement of risperidone (which was also for psychosis) with olanzapine because Leah's mental

state had become worse after the risperidone dosage had been increased, and a lower risperidone dose would not address her paranoid thoughts. Although body movements are a side effect of risperidone, this was not the reason for taking her off risperidone, because, at the hour-long consultation, "She showed no signs of abnormal physical movements, that means tremor, shaking, ticks or extrapyramidal side effects." Although he agreed with Dr Maganty's opinion that side effects of antipsychotic medication, "including stiffness and shaking", cause stress and increase the risk of suicide in a patient, Dr Mehr said, from his observation, "she didn't have extrapyramidal side effects", and he was in any case taking her off the risperidone. His evidence, however, supported the decision of a previous doctor to start with a prescription of risperidone, saying: "…I think it was a normal practice to start risperidone on a case at this age, first episode psychosis. So whoever prescribed the risperidone did what everybody else as a psychiatrist would have done."

47. Dr Mehr told the Coroner that the follow up after his consultation with Leah on 25 April was "an open follow up", which meant that "at any time Leah could be seen if required"; "…if Home Treatment Team had any concern they could contact me and Leah could be seen at any time." He said "In fact I made that note in my records because I had very, very low threshold to admit this lady… if Home Treatment Team wants this patient to be reviewed I will review her urgently."

The Coroner's decision: the Reasons and the Record

48. This was an inquest conducted by the Coroner sitting alone and without a jury.

49. At the end of the inquest, the Coroner delivered her decision in two parts.

    i) First, she delivered a carefully structured and reasoned narrative and consideration of the issues ("the Reasons"). The Reasons set out and explained the conclusions the Coroner had reached on the evidence. She delivered the Reasons orally but also made them available in writing. The Reasons cover 14 pages of transcript, the transcript not differing materially from the written version which was circulated.

    ii) Second, she completed and delivered her Record of Inquest ("the Record") which was in the standard, brief, form required by sections 5 and 10 of the Coroners and Justice Act 2009 and Form 2 of the Schedule to the Coroners (Inquests) Rules 2013/1616.

50. We will refer to relevant parts of the Reasons when considering each of the issues, below.

51. Turning to the Record:-

    i) Part 1 stated Leah's name, and is not controversial.

    ii) Part 2 recorded the "*Medical cause of death*", which was "Multi-organ failure" and "Self suspension". This is also uncontroversial.

    iii) Part 3 answered the question *"How, when and where, and, for investigations where section 5(2) of the Coroners and Justice Act 2009 applies* [i.e. in the case

of a European Convention on Human Rights investigation], *in what circumstances the deceased came by his or her death"*, in the following terms:-

> "On 28/4/17 the deceased was found hanging by the neck from a bannister at her home address. She was taken to hospital where she was placed on life support. Tests revealed no brain activity was evident and she sadly passed away on 2/5/17. The deceased had a short history of mental health issues with an attempted overdose a week prior to her death. She was receiving antipsychotic medication and was under the care of the Mental Health Services at the time of her death."

iv) Part 4 contained the *"Conclusion of the Coroner as to the death"*, which was:-

> "The deceased hung herself with a ligature on 28/4/17. This act caused her death. At the time she took this action it is likely that she was suffering from an episode of psychosis of unknown origin."

v) Part 5 contained the details to be entered on Leah's death certificate, which are uncontroversial.

The relief claimed

52. The relief claimed in these proceedings is, in the Statement of Facts and Grounds for Judicial Review, somewhat imprecise. It is:

> "Replacement of all or part of sections 3 and/or 4 of the Record of Inquest with a narrative that refers to the failings in care provided by the [Interested Party] to Ms Smith."

53. This was helpfully clarified in the course of the hearing before us, when Counsel for the Claimant explained that his case was that the Reasons should have been more fully reflected in the Record (Issue 4); that the Reasons and the expanded Record ought to have reflected a different conclusion on causation from the one reached by the Coroner in the Reasons (Issues 1, 2 and 3); and that the Reasons and the expanded Record ought to have included a finding of neglect (Issue 5). He conceded that a new conclusion on causation might require a new inquest (as, it seems to us, it must), but indicated that, if necessary, the Claimant would ask for a new inquest rather than accept the Coroner's existing decision on causation. In the course of the hearing, he produced a draft of his proposed wording for Parts 3 and 4 of the Record.

Issues 1 and 2: The threshold and the standard of proof for causation of death

54. Issues 1 and 2 are conveniently considered together. They are that the Coroner's decision erred in law (1) as to the threshold for causation of death and (2) as to the standard of proof for causation of death.

55. The law on both these issues is succinctly stated in *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] 4 WLR 157 per Sir Brian Leveson P and Kerr J at para 41:-

> "…the threshold for causation of death is not the same thing as the standard of proof required to prove causation of death. In cases such as this, the latter is proof on the balance of probabilities. It is agreed that the threshold that must be reached for causation of death to be established, is that the event or conduct said to have caused the death must have "more than minimally, negligibly or trivially contributed to the death" (see e.g. *R. (Dawson) v. HM Coroner for East Riding and Kingston upon Hull Coroners District* [2001] Inquest LR 233, [2001] EWHC Admin 352 , per Jackson J at paragraphs 65-67). Putting these two concepts together, the question is whether, on the balance of probabilities, the conduct in question more than minimally, negligibly or trivially contributed to death."

56. Some passages of the Reasons, taken in isolation, suggest that the Coroner was applying a test of "certainty", which would have been wrong in law. We have in mind her saying "There is no certainty in this case" and "words such as, 'reasonably confident, if, on balance of probabilities' do not provide any certainty".

57. However, it is not in our view fair or correct to pick out isolated phrases in this way. Taken as a whole, the Reasons show that, after these initial phrases, which formed part of a relatively general and reflective discussion of the evidence, the Coroner quickly settled on correct formulations of the question she had to answer as a matter of law, before she answered it.

58. She said "I am not satisfied on the balance of probabilities that if all of these things had happened, when they should have happened, that it could be said it was more likely than not that Leah's death on 2 May could have been prevented." Counsel for the Claimant accepted that this was the right question for the Coroner to answer.

59. She referred to *R (Chidlow) v HM Senior Coroner for Blackpool and Fylde* [2019] EWHC 581 (Admin), a case in which the Divisional Court quoted the *Tainton* summary of the law on the threshold and standard of proof required for causation of death verbatim (as we have above): see para 36 of *Chidlow*.

60. *Chidlow* goes on to examine the role of statistics in coronial findings about causation in individual cases (at paras 38-52). The review in *Chidlow* includes the observation of Croom-Johnson LJ in *Hotson v East Berkshire Area Health Authority* [1987] 1 AC 750 at 769B "To be a figure in a statistic does not by itself give him a cause of action." It also quotes Clerk & Lindsell on Torts (22nd edition, 2017) at paragraph 2-30, saying: "Care has to be exercised when relying on statistics as a means of establishing causation. The court must look at the claimant's individual circumstances rather than at the general statistics." When summarising the principles, *Chidlow* says (at para 52.3 of the judgment):

> "…general statistical evidence alone is, however, unlikely to be sufficient. For example, even where the rate is over 50%, a raw

> survival rate for the group into which (without the relevant event or omission) the deceased is said to fall is unlikely to be sufficient because, without evidence supporting the proposition derived from the population data, a jury could not safely conclude that he or she would have fallen into the category of survivors. As Croom-Johnson LJ put it, being a figure in a statistic does not of itself prove causation."

61. In referring to *Chidlow*, therefore, the Coroner was indicating that she had the correct principles very much in mind. She demonstrated this when she said, pointing out the narrowness of the difference between being treated after a face-to-face consultation as advised by Dr Maganty, and being treated, as Leah was, after referrals from the Home Treatment Team followed by a later in-person consultation with Dr Mehr,

> "Taking all of the evidence together this is my finding. I cannot say on the balance of probability that the fact that Leah did not see a consultant psychiatrist in person until 25 April had any evidential causative effect on the actions that she undertook on 28 April that caused her death, and I, therefore, do not find on a balance of probabilities that her death was preventable."

62. We ourselves note that Dr Maganty's use of statistics was couched in very general terms, which made it particularly difficult to use them confidently in Leah's case, when deciding the *Tainton* question, in her particular case, of "whether, on the balance of probabilities, the conduct in question more than minimally, negligibly or trivially contributed to death."

63. We also think it is important to distinguish between cases about what ought to be left to a jury (the question in *Chidlow*) and cases about what verdict or conclusion is open to the jury or, as in this case, the Coroner sitting alone, once seized of the question. In the passage we have just quoted beginning "Taking all of the evidence together this is my finding…" the Coroner was entering into her actual finding of fact (the jury question, if there had been a jury), which was that it did not have "any evidential causative effect". We see no basis in her reasoning, either of fact or law, for overturning that conclusion.

Issue 3: Was the decision irrational in its failure to accept the evidence of an expert, Dr Maganty, about causation of death?

64. In support of Issue 3, argument for the Claimant was based on the Coroner's failure to accept the passage in Dr Maganty's Report which we have quoted at paragraph 33 above and, particularly, his opinion that "on the balance of probabilities, the death of Miss Leah Smith was not only predictable but was entirely preventable" and that, with appropriate care, "on the balance of probabilities, it is likely that she would have made a good recovery."

65. Before a Pre Inquest Review Hearing on 10 April 2019, the Interested Party said in written submissions:

> "There is a report from Dr Maganty and the Trust accepts what is said by him and his conclusions. The Trust has already taken

> action to resolve many of those criticisms and has and is implementing processes and procedures to see that this does not happen again.
>
> It is respectfully submitted that in those circumstances, there is no need for Dr Maganty to attend. Furthermore, the Trust would respectfully suggest there is no need to call all the witnesses currently listed to attend; many provide evidence that is not in dispute and will not take the matter further."

66. The Claimant has strongly emphasised this statement, that the Interested Party accepted "what was said" by Dr Maganty "and its conclusions". However, it was a statement made in the context of a suggestion that Dr Maganty (and some other witnesses) should not be required to give evidence at the final hearing. That is not what happened. Dr Maganty did give evidence. He was questioned by the Coroner and cross-examined, in the way we have summarised. Moreover, other witnesses gave evidence and were questioned and cross-examined, and their evidence was relevant to the opinions that had been expressed by Dr Maganty, as we have also summarised. In those circumstances, it was for the Coroner to decide what conclusions to draw from the evidence, and she was not bound to accept what Dr Maganty had said at an earlier stage.

67. An inquest is, as the name suggests, an inquisitorial process. The Coroner was not bound to accept the evidence of Dr Maganty, even if it stood alone. In fact, it did not stand alone. It was given before the evidence of the treating psychiatrists had been given, which undermined some of Dr Maganty's assumptions (such as that if Dr Mehr had been consulted initially, he would have prescribed olanzapine rather than risperidone, whereas Dr Mehr's subsequent evidence was that "everybody" would have started with risperidone in a case, at Leah's age, of first-episode psychosis).

68. Dr Maganty's Report and, even more, his evidence in person subsequently, suggested that he was giving his opinion that "the death of Miss Leah Smith was not only predictable but was entirely preventable" with great confidence but based on a relatively insecure evidential foundation. When tested, his evidence on causation appeared to be little more than an assertion. He was at pains not to criticise the individual specialists or even the general management. He approved Leah being treated at home, where she was well supported, rather than being confined to hospital. His criticisms of the lack of cover were well-founded, as the Coroner decided, and she accepted and adopted many of them, but it did not follow that they caused Leah's death. Despite the lack of a face-to-face consultation until relatively late in the history (3 days before the final act of suicide), there was, as our summary earlier shows, constant and careful monitoring and review of Leah's condition, and apparently appropriate treatment which was modified in the light of the observations being made. This weakened the credibility of Dr Maganty's trenchant conclusions about causation.

69. The face-to-face consultation of Dr Mehr, when it did take place on 25 April, was over an hour long, and he agreed with what had been done until that moment. His own assessment, based partly on what Leah told him, was that she was a low suicide risk. He emphasised that this did not mean she was at no risk of suicide. It is tragic that Leah did go on to commit suicide so soon afterwards. But Dr Mehr did not have what Dr Maganty frankly admitted was his own "hindsight bias".

70. We reject the suggestion that Dr Maganty, although he was unshakeable in his opinion, was entitled to have his opinion accepted by the Coroner. She did a good job of exploring and taking into account all the evidence, as we can see from the transcripts of the hearing as well as from her Reasons. The conclusion she reached was rational and securely based on the whole of her careful evidential enquiry.

Issue 4: Was the Decision and Record of Inquest compliant with an investigation under Article 2 of the European Convention on Human Rights?

71. The Claimant did not challenge the investigation at the hearing, which was remarkably thorough, and entertained points raised by the Claimant which went well beyond the immediate cause of death.

72. No complaint was made that the hearing failed to comply with the requirements of an Article 2 investigation which, as *Middleton* [2004] 2 AC 182 at para 35 shows, only expands the scope of the inquest to add "in what circumstances" the death occurred, as well as "by what means". Nor did the Claimant argue that, having explored the circumstances at the hearing, the Coroner failed to reflect the broader criticisms suggested in the argument and evidence in her Reasons. The Coroner discussed them in her Reasons, and she accepted many of them.

73. The argument under Issue 4 was, rather, that the criticisms accepted by the Coroner in her Reasons ought to have been included in the Record.

74. Since it was clear that the Claimant was seeking a significant redrafting of Parts 3 and 4 of the Record, by this Court if possible, and since it was accepted that the Record is, by its nature and in accordance with the Chief Coroner's Guidance, to be concise, we invited Counsel for the Claimant to produce a draft of what he sought by way of a replacement. This he did in the course of the hearing. What he described as "tentatively offered as an appropriate wording for sections 3 and 4 of the Record" was as follows ("the Draft");-

> "On 28 April 2017 the deceased, Leah Smith, was found hanging by the neck from a bannister at her home address. She was taken to hospital where she was placed on life support. Tests revealed no brain activity, and she sadly passed away on 2 May 2017. The deceased had a short history of mental health issues with an attempted overdose a week prior to her death.
>
> On 28 March 2017, she collapsed and was taken to hospital. She was referred (via the 'Community Mental Health Team'), to the 'Home Treatment Team' of the Betsi Cadwaladr University Health Board. She received inadequate care, below the level of basic medical care that a patient can expect to receive from a modern mental health service. Despite an urgent referral, she received no in-person consultation from a psychiatrist until 25 April. In the absence of such consultation, there was no opportunity to reach a proper diagnosis despite florid psychotic symptomatology, suggestive of psychotic depression. Medication (both anti-psychotic and anti-depressant) given during much of this time was at a sub-therapeutic dose, which

> risked side-effects. Furthermore, there was no appropriate monitoring of her medication. There were multiple opportunities prior to 25 March, for consultant psychiatrists to have seen Ms. Smith, and no adequate reason for this not to have occurred. [DEPENDING ON CAUSATION]: Whilst it may not be possible to say, with certainty, that given proper care Ms. Smith would not have died, the failures are likely – that is to say, on a balance of probabilities – to have had a more than minimal or trivial effect, in causative terms."

75. The first paragraph of the Draft is a verbatim reproduction of the existing Part 3 of the Record, with the omission of its final sentence. The focus of this Issue is, therefore, on the second paragraph of the Draft.

76. All the matters which the second paragraph of the Draft proposes for inclusion in the Record as a narrative Conclusion were addressed, frequently using critical language, by the Coroner in her Reasons. Except where the Claimant disagrees with the Coroner's conclusions (on causation and on neglect), the Draft is based on the Reasons.

77. Both the Reasons and the Record were delivered in public. Both, therefore, were part of the public record. The argument that more of what appeared in the Reasons should have been repeated in the Record has the appearance of an argument of form over substance and we would reject it on that ground alone.

78. However, there are more fundamental objections to the second paragraph of the Draft. It reads more like a Statement of Case than the Conclusion (formerly known as the verdict) of a coroner's inquest. We cannot approve language of this sort for either Part 3 or Part 4 of the Record. By section 5(3) of the Coroners and Justice Act 2009, a coroner (and a jury, if there is one) is prohibited from expressing any opinion on any matter except who the deceased was (Part 1), how, when and where the deceased came by her death (including the circumstances, in a Convention case) (Parts 3 and 4) and the particulars required for the death certificate (Parts 2 and 5).

79. As the Court of Appeal said in *R (Jamieson) v HM Coroner for North Humberside and Scunthorpe* [1995] QB 1 at 24B: "It is not the function of a coroner or his jury to determine, or appear to determine, any question of criminal or civil liability, to apportion guilt or attribute blame". A verdict (now a Conclusion) "must be factual, expressing no judgment or opinion, and it is not the jury's function to prepare detailed factual statements" (at 24G).

80. It was recognised by the House of Lords in *R (Middleton) v HM Coroner for West Somerset* [2004] 2 AC 182 that in a Convention case (such as this one, in which Article 2 was engaged) "an inquest ought ordinarily to culminate in an expression, however brief, of the jury's conclusion on the disputed factual issues at the heart of the case" (para 20), and this broadens the enquiry, as we have said, to include "in what circumstances" as well as "by what means" the death occurred (para 35). But any narrative verdict is still expected to summarise factual conclusions "briefly" (para 36) and "The prohibition in rule 36(2) of the expression of opinion on matters not comprised within sub-rule (1) must continue to be respected" (para 37). What *Middleton* envisages is "conclusions of fact as opposed to expressions of opinion… Nor must the verdict appear to determine any question of civil liability" (para 37): both these points have

been quoted and reiterated more recently by the Supreme Court in *R (Smith) v Oxfordshire Assistant Deputy Coroner* [2011] 1 AC 1 per Lord Brown of Eaton-under-Heywood at para 153.

81. It was neither necessary nor convenient for the points in the second paragraph of the Draft to be added to the Record. In our judgment, it would have been wrong to put them there. They would have compromised the essential brevity and simplicity required of a Conclusion answering the question "How, when and where, and [this being an Article 2 case] in what circumstances the deceased came by his or her death." It was correct for the points in the Draft to be placed in the Reasons, where the Coroner placed them, and not in the Conclusion.

82. If the case raises issues from which lessons may be learned, the appropriate vehicle for conveying those lessons is not the Conclusion, narrative or otherwise, but a rule 43 report: *Smith* at para 154. In the present case, there had already been a Serious Incident Review, which we have referred to above. This had identified 4 specific "Care and Service Delivery Problems", identified the "Root Cause" of those problems, and formulated the 3 "Actions" which should follow to address them. The Coroner was assured by the Interested Party that "The Trust has already taken action to resolve many of [Dr Maganty's] criticisms and has and is implementing processes and procedures to see that this does not happen again" (para 3 of its Submissions dated 9 April 2019). The Coroner did not make a rule 43 report in this case, and it was not suggested to her, or to us, that she ought to have done so.

Issue 5: Was the decision irrational in failing to make a finding of neglect?

83. We agree with Swift J, who refused permission to appeal on this ground on the papers. This point is not reasonably arguable.

84. The issue of neglect was one of fact. The Coroner considered it, and, for the reasons she gave, rejected it on the evidence. She was fully entitled to do so. A finding of neglect is exceptional, particularly in suicide cases, and requires proof, not only that it was causative of death, but that it is in the nature of "gross failure" or "gross neglect": *Jamieson* [1995] QB 1, 25 at paras (8), (9) and (11).

85. The Claimant conceded that, unless the alleged neglect was causative of the death, a finding of neglect could not be included. We have upheld the Coroner's findings about causation.

Conclusion

86. The application for judicial review is, therefore, dismissed. We will invite the parties to make written submissions on the question of costs.