Neutral Citation Number: [2020] EWHC 1753 (Admin)

Case No: CO/2310/2019

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 03/07/20

Before :

LORD JUSTICE HICKINBOTTOM

MRS JUSTICE WHIPPLE
and
THE CHIEF CORONER OF ENGLAND & WALES
HIS HONOUR JUDGE LUCRAFT QC
sitting as a Judge of the High Court

- -

Between :

THE QUEEN ON THE APPLICATION OF ANTONIA IROKO

Claimant

- and -

(1) HM SENIOR CORONER FOR INNER LONDON SOUTH
(2) HM ASSISTANT CORONER FOR INNER LONDON SOUTH

Defendants

- and -

LEWISHAM AND GREENWICH NHS TRUST

Interested Party

- -
- -

Ben Keith (instructed by way of **Direct Access**) for the **Claimant**
None of the other parties either appearing or being represented

Hearing date: 25 June 2020

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Approved Judgment

Lord Justice Hickinbottom:

Introduction

1. Mrs Elizabeth Izagbuwa Iroko ("Mrs Iroko") died following a cardiac arrest on 13 December 2017 at the Queen Elizabeth Hospital, Woolwich ("QEH Woolwich") for which the Interested Party ("the NHS Trust") has responsibility. Her death was duly reported to the First Defendant ("the Senior Coroner"), and an inquest was opened.

2. On 21 February 2019, as a preliminary ruling, the Senior Coroner held that there was no evidence that any failure or dysfunction in the treatment of Mrs Iroko was systemic or due to a failure to put in place a regulatory framework; and thus the procedural obligation to conduct an inquest with the purpose of ascertaining in what circumstances Mrs Iroko came by her death, derived from article 2 of the European Convention on Human Rights ("article 2") and section 5(2) of the Coroners and Justice Act 2009 ("the 2009 Act"), did not apply.

3. The inquest took place on 6 March 2019 before the Second Defendant ("the Assistant Coroner"). In line with the pathologist's report, the Assistant Coroner concluded that Mrs Iroko died from acute intestinal obstruction as a result of a small bowel infarct associated with volvulus or intestinal twist, which in turn was probably related to adhesions consequential upon previous abdominal surgery of which they are a recognised complication.

4. In this claim, Ben Keith of Counsel on behalf of Mrs Iroko's daughter ("the Claimant") submits that three errors of law were committed during the inquest, as follows:

   Ground 1: The Senior Coroner erred in his decision that the procedural obligation of article 2 did not apply to this inquest.

   Ground 2: The Assistant Coroner erred in failing to explore the issue of neglect.

   Ground 3: The Assistant Coroner erred in failing to make a Prevention of Future Death Report in respect of this matter.

The Facts

5. As the Assistant Coroner noted (Inquest Transcript, pages 234 and 238), there are considerable differences between the factual evidence put forward by the various health professionals on the one hand, and that of Mrs Iroko's family on the other. In her statement dated 9 July 2019, made for this claim, the Claimant emphasises many instances of what she regards as inconsistences or holes in the former; and, indeed, the NHS Trust has acknowledged that mistakes were made. However, for the purposes of this claim, it is unnecessary to consider every aspect of the factual background; and I restrict my consideration of the evidence to that which is necessary for determination of the grounds of challenge, which are limited in scope.

6. Mrs Iroko was born on 14 September 1944. In 1971, she underwent an appendectomy and, in 1974, a hysterectomy, each of which left abdominal scars; but she generally enjoyed good health.

7. However, on the morning of 10 December 2017, Mrs Iroko accompanied by the Claimant attended the Urgent Care Centre ("UCC") at Queen Mary's Hospital, Sidcup, which is also managed by the NHS Trust. A UCC is not an Accident and Emergency Department ("A&E"), but rather a part of the hospital comprising triage nurses, general practitioners ("GPs") and nurse practitioners, where patients can obtain an urgent GP appointment.

8. Mrs Iroko was seen by Dr Ayesha Docrat, presenting with a history of vomiting, and abdominal bloating and pain, over the previous 12 hours since eating salmon. Although the "Patient Allergies" section of the clinical notes was left blank, there is a specific note by Dr Docrat in the history section (in capitals): "ALLERGY TO METRONIDAZOLE" (an antibiotic). Mrs Iroko's vital signs were normal, except that she had elevated blood pressure. Even unaided, she was fully mobile. On examination, her abdomen was soft and non-tender, and there was no rebound tenderness or guarding (i.e. tensing). There were no clinical signs of dehydration. A working diagnosis of gastroenteritis was made; and, before discharging her, Dr Docrat advised Mrs Iroko to drink liquids and Dioralyte (a rehydration treatment), and to be aware of the signs of dehydration (e.g. persistent vomiting, inability to drink fluids, drowsiness, reduced urine output). She was told she could take painkillers for the abdominal pain, and Imodium. Otherwise she was advised that, if signs of dehydration developed or the condition worsened, she should attend her local A&E.

9. Just before 5am on 12 December 2017, again with the Claimant, Mrs Iroko attended QEH Woolwich, where she was initially seen by Dr Bolanin Adeniran. She complained of vomiting, abdominal bloating and generalised abdominal pains, and an inability to keep fluid down. Paracetamol had been ineffective as an analgesic. She had passed urine only twice during the previous 12 hours: she was unable to provide a urine sample at the hospital. However, she was not suffering from diarrhoea. Her vital signs were checked, and were normal except for her blood pressure which was high. It was recorded that Mrs Iroko was allergic to metronidazole.

10. Dr Adeniran referred her to A&E, where she was seen by Dr Seminapon Segbenu, a Senior Clinical Fellow in that department. Dr Segbenu again recorded that Mrs Iroko was allergic to metronidazole. He noted that her vital signs were stable although her heart rate was raised (100bpm), her abdomen was soft with mild generalised non-specific tenderness with no rebound tenderness or guarding, and bowel sounds were normal. Venous blood tests were essentially normal, but with slightly elevated urea, creatinine and lactate (2.1 mmol/L). Other tests were normal. Dr Segbenu prescribed intravenous saline, paracetamol, hyoscine butylbromide (Buscopan) (an antispasmodic) and cyclizine (an antiemetic). He was at the end of his (night) shift, and therefore he handed over the care of Mrs Iroko to Dr Arwa Shaikh, a Junior Clinical Fellow, on the morning shift. The A&E consultant on duty was Dr Matthew May, who also reviewed Mrs Iroko's records but did not see or examine her.

11. Mrs Iroko was by then stable and had been moved to a chair in the Clinical Diagnostic Unit ("CDU"). However, she was still complaining of abdominal pain, and so, just after 9am, Dr Shaikh prescribed Oramorph (a morphine-based painkiller), which appeared to help, although the family's evidence is that Mrs Iroko was still in considerable abdominal pain. Mrs Iroko's heart rate reduced. Dr Shaikh did not examine Mrs Iroko, and was unaware that she had abdominal surgical scars. During her period in the chair in CDU, the Claimant firmly recalls that her mother did not eat,

drink, get up from her chair or urinate. On the other hand, Dr May recalled seeing Mrs Iroko both drinking from a plastic cup, and walking independently: Dr Shaikh did not recall either. Dr May was aware that Mrs Iroko had had previous abdominal surgery (the appendectomy); but was unaware of the hysterectomy scar.

12. Shortly after 11am, Mrs Iroko was discharged with a diagnosis of gastroenteritis. At some stage, under the heading "DNR Resuscitation Status", an entry was made in the medical notes: "Do Not Resuscitate has **NOT** been agreed" (emphasis in the original), which I assume to be the default position.

13. Mrs Iroko returned home. However, the following evening, Mrs Iroko went into cardiac arrest, and the Claimant's brother (who was looking after his mother, the Claimant herself being at work) called for an ambulance. At 7.21pm, Michael Casizzi (an Advanced Paramedic Practitioner, who gave evidence at the inquest) received a call to attend Mr Iroko's home, where he arrived at 7.42pm. An ambulance was already there, and the crew had commenced cardiopulmonary resuscitation ("CPR"), intubated Mrs Iroko and administered adrenaline. The heart monitor, however, indicated that Mrs Iroko was asystolic, and she had no signs of life.

14. Mr Casizzi and the ambulance crew moved Mr Iroko to a larger bedroom, to enable better advanced life support. Mrs Iroko was re-intubated, a compression device was applied and further adrenaline (five times in all) was administered. At 8pm (i.e. at least 40 minutes after arrest), a pulse returned, although her heart wall motion was poor, her blood pressure low and she could not breathe independently. Adrenaline continued to be administered to maintain sufficient blood pressure for organ perfusion, and Mrs Iroko was placed onto a ventilator, before being transported to QEH Woolwich, in the ambulance, arriving there at 8.52pm. In his statement, Mr Casizzi said: "The patient remained unstable but with signs of life…". In his evidence to the Assistant Coroner, he explained that the only sign of life was, however, the adrenaline-induced pulse, and Mrs Iroko showed no respiratory effort (Transcript, page 219).

15. Mr Iroko arrived in the Resuscitation Room in A&E at about 9pm. Dr Christopher Foster (an Emergency Medicine Registrar) was in charge of the Resuscitation Team, which also included Dr Jennifer Berg. Dr Charlotte Davies was the A&E Consultant on duty.

16. Dr Foster had met the ambulance, and had received a handover report from the ambulance crew. Fluids were administered, but Mrs Iroko's blood pressure continued to fall. Small boluses of adrenaline were administered in an attempt to maintain a pulse. Dr Foster said that a blood sample was obtained by means of a femoral stab, and that sample was passed through a venous gas machine which indicated a "low" pH level (i.e. very high acid level). The lactate level was also very high indeed (20 mmol/L). Those readings, taken with the other clinical circumstances, led Dr Foster to be pessimistic about the outcome. In oral evidence at the inquest, he said that the venous gas machine indicated the pH level was "low", rather than as a specific pH figure, when the level was outside the range for human life; and that a lactate level as high as 6 would be predictive of significant mortality (Transcript, page 196). The venous gas machine recorded the time the sample was taken as "21.26", and the laboratory receipt time as "21.32", timings to which I will return.

17. Given that a further cardiac arrest was considered imminent as a result of the effects of the adrenaline wearing off, Dr Foster decided he should go to the Relatives Room to speak to Mrs Iroko's family who were there. The Claimant had not yet arrived; but her brother was there. Before leaving them, Dr Foster told the Resuscitation Team that, if Mrs Iroko arrested whilst he was away, they should attempt resuscitation by commencing cycles of CPR.

18. What was said between Dr Foster and the family is considerably disputed. There is no contemporaneous record. We do not have before us the evidence of the family members who were there; but Mr Keith said that the Claimant's brother's statement at the inquest said that Dr Foster told them that Mrs Iroko was "very ill", and was on a ventilator. Given the circumstances, it is inconceivable that Dr Foster did not discuss Mrs Iroko's condition and prognosis with the family. However, it is denied by them that any family member agreed that, if Mrs Iroko suffered a further cardiac arrest, CPR should not be attempted. As Mrs Iroko had previously enjoyed robust good health, and in any event it would be contrary to their religious beliefs, their evidence is that none of the family would ever have agreed to such a decision.

19. In his evidence about the conversation, given at the inquest, Dr Foster said that the family had a number of questions about Mrs Iroko's earlier visits to hospital, and he understood why that was their focus. He continued (Transcript, pages 197 and 204):

> "During that conversation with them I explained that the heart had stopped beating, um, and that the Paramedic had managed to restart it, but that she was still very unstable and that, um, I thought that the – if her heart – whilst we were supporting her as best we possibly could and resuscitating her, if her heart were to stop again, I didn't think that it would be appropriate for us, um, to perform further CPR, in the light of, err, her, sort of, clinical picture and the initial blood gas that we, that we performed. And it was – having had that conversation, I then went back into the resuscitation to find, actually, unfortunately, this lady had had a, a further cardiac arrest and my colleagues had, as we'd discussed, had restarted performing, um, the CPR. And so, I said, 'Actually, I've, I've spoken to the family and I've explained that I didn't think that it would be approp – appropriate, I mean, to do this, so we probably ought to stop. Does anyone have any disagreement with that?' And that'll be standard practice, in resuscitation, is just to check that the, the team all agree. Everyone did agree, so, having completed that cycle of CPR, we checked to see if there was a, a, a pulse detectable and there wasn't. And, um, yeah, it was unfortunate, I'm sorry to say, that, err, yeah, we established she had died.
>
> …
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> … Unfortunately, both her clinical state and her blood gas would've indicated that she was unlikely to do well. And at a – I think one of the things I said was probably the best case scenario is a prolonged period of, you know, essentially, a, a persistent vegetative state, but that wasn't the term I used. I, I

> said that, 'She would've been unable to – she would never regain consciousness and be the person you remember'... I believe were my exact words."

20. When it was suggested to him that the family's recollection of the conversation was very different, he said (at pages 206-207):

> "No, and I'm sorry that I, obviously, wasn't clear enough, err, in my discussion with, err, with the family. I expect something I will reflect on. But I say, I, I had spoken to my colleagues and the reason I left this patent was precisely to discuss this…".

21. Although Dr Foster said that he would have liked the family to have understood why it was the Resuscitation Team were making the decision they were making, he said that, even if the family had objected, that would not ultimately have made any difference to the clinical decision to stop attempts at resuscitating Mrs Iroko (page 208).

22. With regard to this conversation:

    i) In her evidence at the inquest, Dr Berg said that, once Mrs Iroko arrested (which was while Dr Foster was talking to the family), the team gave her further adrenaline and began CPR cycles; but, once Dr Foster had returned, the team decided that, if there was no spontaneous circulation after the next CPR cycle, they would stop – that was, she said, "very much a team decision". There was no pulse, and they did stop.

    ii) In her statement for the inquest, Dr Davies said that she had gone to the Resuscitation Room to review Mrs Iroko, when she was in arrest and Dr Foster was with the family. Dr Berg was "competently leading the arrest". Dr Davies said that: "[Dr Foster] returned to the resuscitation department quickly after a discussion with [Mrs] Iroko's family – as a result of which, resuscitation stopped".

    iii) There was an internal investigation into the care and treatment of Mrs Iroko, consequent upon a complaint by the family, that investigation being led by Dr Duncan Brookes (an A&E Consultant). During the course of this complaint, there was disclosure of medical records which noted a DNR decision; which, for the reasons I have already outlined, greatly distressed the family. It is unclear precisely when this notation was added to the record. In the initial complaint response letter dated 21 February 2018, the NHS Trust said:

    > "Dr Brooke reports that, during this time (i.e. the time in the Resuscitation Room), your mother showed no signs of any spontaneous movement, and approximately fifteen minutes after arrival she sustained a further cardiac arrest, and following discussion with the family, it was agreed not to continue with any further attempts of resuscitation."

    The Claimant responded on 28 March 2018:

> "My family and I are extremely concerned and distressed at the statement in the letter which states after further discussion and agreement with the family it was decided not to continue with any further attempts of resuscitation of our mother, this discussion never took place and we never agreed not to resuscitate our mother, this has come as a complete shock to us all, we were not told she had sustained a cardiac arrest and had not been resuscitated, this is extremely distressing and has had a devastating impact on us all, we were told she passed away. Who provided consent not to resuscitate?"

To which the NHS Trust in its turn, replied by letter of 18 May 2018:

> "The decision not to provide further resuscitation was taken by Dr Davis [this seems to be an error, for Dr Foster], Resuscitation Team Leader, following discussion with the rest of the team. Dr Brooke apologises if this was not discussed with you and our family as previously stated. During resuscitation attempts, any family who are present are kept as up to date as is possible. It was this that 'further discussion' mentioned in your previous complain response referred to."

23. Mrs Iroko was declared dead at 9.20pm.

Ground 1: Article 2

24. Article 2 provides that the right to life shall be protected by law. This imposes upon the state substantive positive obligations not to take life without justification and, in some circumstances, to protect life; and the consequential procedural obligation to establish a framework of laws, procedures and means of enforcement to protect life.

25. This procedural obligation requires the state to initiate an investigation into a death for which it may bear responsibility. In R v HM Coroner for the Western District of Somerset ex parte Middleton [2004] UKHL 10: [2004] 2 AC 182, the House of Lords held that the limited terms of section 11(5)(b)(ii) of the Coroners Act 1988 now reproduced in section 5(1) of the 2009 Act (the requirement that an inquest determine "how… the deceased came by his or her death"), as interpreted in R v HM Coroner for North Humberside ex parte Jamieson [1995] QB 1 at pages 24G-25F as being restricted to "by what means" rather than "in what broad circumstances", meant that the requirements of the procedural obligation of article 2 would not be met by an inquest. Consequently, where that obligation applied, "how" in section 11(5)(b)(ii) should be construed to mean "not simply 'by what means' but 'by what means and in what circumstances'" (Middleton at [35]).

26. That conclusion was expressly imported into the statutory framework by the insertion of a (new) section 5(2) of the 2009 Act. Section 5 of the 2009 Act now 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) the particulars (if any) required by the 1953 Act to be registered concerning the death.
>
> (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 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 questions mentioned in subsections (1)(a) and (b) (read with subsection (2) where applicable);
>
> (b) the particulars mentioned in subsection (1)(c)."

Section 10(2) of the 2009 Act prohibits framing a determination under section 5 "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."

27. The application of these principles to cases in which death has occurred as the result of medical mishap has been the subject of much consideration; but, as confirmed recently by Lord Burnett of Maldon CJ (giving the judgment of the court) in R (Maguire) v HM Senior Coroner for Blackpool and Fylde [2020] EWCA Civ 738 at [27] (and as Mr Keith accepted), following Lopes de Sousa Fernandes v Portugal (ECtHR Application No 56080/13) (2018) 66 EHRR 28 and R (Parkinson) v HM Senior Coroner for Inner London South [2018] EWHC 1501 (Admin); [2018] 1 WLR 106, it is now well-settled.

28. The correct approach is that set out by the Grand Chamber in Fernandes, which was helpfully summarised by the Lord Chief Justice in Maguire at [22]-[26], as follows:

> "22. [The Grand Chamber in Fernandes] confirmed that in cases involving alleged medical negligence the state's positive obligations were regulatory, 'including necessary measures to ensure implementation, including supervision and enforcement' (paragraph 189). It continued by noting that in 'very exceptional circumstances' a state may be responsible under the substantive limb of article 2. It enumerated those circumstances between paragraphs 191 and 196.
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> 23. First, 'a specific situation where an individual patient'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' (paragraph 191).
>
> 24. Secondly 'where a systemic or structural dysfunction in hospital services results in a patient being deprived of access to life-saving treatment and the authorities knew or ought to have known about the risk and failed to undertake the necessary measures to prevent the risk from materialising, thus putting the patients' lives, including the life of the particular patient concerned, in danger' (paragraph 192).
>
> 25. The Grand Chamber devised a strict test to determine whether the exceptional circumstances were satisfied in any given case. It identified four cumulative factors: (a) The acts or omissions of the health care providers 'must go beyond mere error or medical negligence, in so far as the health care professionals, 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' (paragraph 194); (b) The dysfunction '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' (paragraph 195); (c) There must be "a link between the dysfunction complained of and the harm which the patient sustained (paragraph 196); (d) 'The dysfunction in issue must have resulted from the failure of the state to meet its obligations to provide a regulatory framework …' (paragraph 196).
>
> 26. At paragraphs 214 and 215 the Grand Chamber restated the Convention jurisprudence on the procedural obligation arising in medical cases. The state is required to set up an effective and independent judicial system to enable the cause of death of individuals in the care of the medical profession, whether private or public sector, to be determined and those responsible (in a culpable sense) to be held accountable. Between paragraphs 222 and 228 the Grand Chamber explained that it considered that the disciplinary, criminal and civil proceedings were ineffective. As a result there was a breach of the procedural obligation applicable in cases involving alleged medical negligence."

29. Thus, as succinctly described by Singh LJ in Parkinson (at [90]), in this context, there is an essential distinction between "ordinary negligence cases" (in respect of which the procedural obligation upon the state under article 2 does not apply) and cases of systemic failure (in which it does); and care needs to be taken to ensure that what are in truth allegations of individual fault are not "dressed up" as systemic failures (R (Humberstone) v Legal Services Commission [2010] EWCA Civ 1479; [2011] 1 WLR 1460 at [71] per Smith LJ).

30. In this case, both the Senior Coroner and the Assistant Coroner considered whether the procedural obligation of article 2 applied. In response to a request by the family that an article 2 inquest be held, the Senior Coroner wrote to the parties saying that, while he accepted that there may have been failings in the care Mrs Iroko received, he did not consider there were any grounds for there being an arguable breach of article 2 rights. If the family had any further submissions, he invited them to be made urgently, particularly addressing the criteria set out in Fernandes and Parkinson. No further submissions were received; and, on 21 February 2019, having briefly set out the law as derived from those two authorities, the Senior Coroner ruled:

> "Whilst it is a proper part of the scope of the inquest to explore the systems in the Trust, there is no evidence that any failure or dysfunction is systemic or due to a failure to put in place a regulatory framework. The Senior Coroner rules that the inquest will be held as Jamieson."

31. At the inquest hearing itself, the Assistant Coroner thus began by explaining that "this is not an article 2 inquest" (Transcript, page 5); and Counsel for the family (not, then, Mr Keith) said that, although there was a duty to keep the position under review, he was not at that stage advocating that this should be an article 2 inquest (page 6). The Assistant Coroner confirmed that, in her view, this was not an article 2 inquest (page 7). No further submissions were made on that issue during the hearing, despite the Assistant Coroner properly inviting such submissions at the end of the evidence to which Counsel for the family responded: "No" (page 226).

32. Mr Keith submitted that the coroners were wrong not hold an article 2 inquest in this case. The NHS Trust's policy on DNR (Do Not Attempt Cardiopulmonary Resuscitation Policy 1 April 2015, reviewed March 2018 ("the DNR Policy")) states that, for patients without capacity, "the views of the relatives and carers MUST be obtained…" (emphasis in the original). Mr Keith submitted that the (false) claim that a DNR decision had been discussed with Mrs Iroko's family, and the fact that this decision was acted upon either on the basis of results from a patently faulty venous gas machine or results not taken at the time, met the threshold of an act which goes beyond mere error or negligence; and involved denying Mrs Iroko treatment knowing that her life would be at risk if treatment were not given, or at least a systemic failure. Leaving aside the possibility that timings on the venous gas machine results were correct and thus the sample was taken and tested after death – a suggestion not supported by the evidence nor pursued by Mr Keith in his oral submissions – he submitted that, just as the clock on the machine had erroneous readings, the substantive result readings might also have been wrong. There was no evidence to corroborate Dr Foster's assertion that, when the pH was very low, the machine did not give an exact figure for it but merely recorded that it was "low".

33. Mr Keith submitted that the failure properly to check and maintain the machine was or could have been systemic. Furthermore, there was no contemporaneous note of the discussion between Dr Foster and the family, despite the DNR Policy having specific forms with a section headed "Summary of communication with the patient's relatives or friends", which ought to have set out to whom Dr Foster spoke and what he and they had said. This too reflected, or might have reflected, a systemic failure in respect of medical note taking.

34. It is submitted that whether these were systemic failings ought to have been an issue for the inquest.

35. In support of the premise that they were likely to have been systemic, the Claimant relies upon the statements of Dr Gurdave Gill dated 14 January 2020 and Ms Teri Turner in a letter dated 6 February 2020. Dr Gill is a GP. QEH Woolwich is the nearest main acute hospital to his surgery. He asserts that the closing of A&E at Queen Mary's Hospital, Sidcup, has resulted in the "increasing pressure on services leading to poor clinical assessments, failure to admit sick people and premature patient discharge from wards" (paragraph 3). He refers to three specific examples of patients, each of whom he considers, as a result of mis- or late diagnosis, to have had a poor outcome as a result of "overstretched services at [QEH Woolwich]…" (paragraphs 3-8); and provides links to newspaper articles on that same subject (paragraph 9). Ms Turner refers to her mother's care at the hospital which, she considers, was negligent and left her mother with a number of very serious, chronic conditions including brain damage. The Claimant has also conducted a survey of experience of members of the "QE Patient Forum" who have been patients (or who have known patients) at QEH Woolwich in the period 2001-19, upon which she relies.

36. I understand the distress which the Claimant and her siblings felt when they saw that a DNR direction was recorded in their mother's medical records, which was contrary to their deeply held personal and religious beliefs, in circumstances in which they did not agree to such a direction and did not consider that they had been consulted about it adequately, or indeed at all. However, despite his able efforts, Mr Keith has fallen very far short of persuading me that the coroners erred in not holding an article 2 inquest.

37. Although for the reasons I give below this is not determinative, I am unpersuaded that, so far as Mrs Iroko's death is concerned, the DNR direction was a material circumstance.

38. The DNR Policy concerns decisions (ultimately, themselves clinical: see paragraph 6.5) not to attempt CPR if and when a patient suffers a cardiac arrest; and it makes clear that it complements the NHS Trust Resuscitation Policy (paragraph 2). By the time Dr Foster had returned to the Resuscitation Room having spoken to family members, Mrs Iroko was in cardiac arrest and attempts at CPR were underway. We do not have the Resuscitation Policy before us; but it is uncontroversial that a decision to cease further attempts at CPR is a clinical decision, taken by the lead medic on the Resuscitation Team having consulted the other members of that team. Without descending into factual detail which would be both unnecessary and inappropriate for this court, as I read his evidence, Dr Foster has never said that the family members expressly agreed to a DNR direction: he said that he had told them of the grave nature of Mrs Iroko's condition and that, in the light of all the circumstances (including the blood gas results), he did not consider it would be clinically appropriate for further CPR to be performed if there were a further cardiac arrest, to which the family members made no comment. I understand that the family members do not accept that that was the nature of the conversation.

39. In any event, having at least informed Mrs Iroko's family members of her grave condition, on his return to the Resuscitation Room, Dr Foster found Mrs Iroko already in cardiac arrest with further adrenaline having been given and further attempts at

CPR being administered. Having consulted his colleagues (who all agreed), Dr Foster took the clinical decision to cease further attempts at CPR. Mr Keith frankly and properly accepted that he could put his argument no higher than this: that Dr Foster's indication to the Resuscitation Team that the family agreed to (or, at least, did not object to) a DNR decision materially contributed to the decision to cease attempts at CPR. As I have already indicated, Dr Foster expressly denied that to have been the case (see paragraph 21 above).

40. However, as I have indicated, it is unnecessary for this court to involve itself in the resolution of these evidential matters; because, in any event, there was here no systemic failure that could prompt an article 2 inquest. The DNR Policy was clear that, in taking a DNR decision, clinicians are required to take into account the views of family members. Insofar as Dr Foster took such a decision without properly obtaining those views and/or suggested to his team that the family approved of such a course, that was no more than an individual error on his part in the face of systemic requirements.

41. Mr Keith seeks support for the proposition that the way in which the DNR discussion was held and recorded, and the decision to stop further attempts at CPR was made, was the result of systemic failings, from the general failure in Mrs Iroko's case properly to make medical records, and in particular (i) the failure properly to record the DNR discussion and decision, and (ii) the errors in the recording of the venous gas results. However, (i) as Mr Keith emphasised, the DNR Policy requires the recording of any discussion of a DNR direction on a future cardiac arrest with family members, and of any such direction: any error is patently directly contrary to the requirements of the regulatory framework; and (ii) there is no evidence that the error in the timings on the venous gas record reflects other (substantive) errors in the readings, or that any errors (in timing or otherwise) resulted from a systemic failure in (e.g.) maintenance. The argument that any working regulatory framework would ensure that machines could be relied upon at all times to be in fully working order is to dress up any act which might be potentially negligent as a systemic failing.

42. In addition to the lack of proper notes relating to the DNR decision and the venous machine readings, the following specific examples of alleged deficient note taking are relied upon:

    i) Dr Docrat failed to record that Mrs Iroko was allergic to metronidazole. However, this criticism is unfair: as I have indicated (see paragraph 8 above), although Dr Docrat did not record Mrs Iroko's allergy in the "Patient Allergies" section of the clinical notes, there is a specific note in the history section (in capitals): "ALLERGY TO METRONIDAZOLE". Dr Adeniran dealt with Mrs Iroko's allergy in his note in the same way, and no criticism appears to be made of him.

    ii) Dr Docrat said that she had copied the triage nurse's notes, but there are differences in the two notes, e.g. "crampy abdominal pain" and "vomiting when drinking" appear in the doctor's notes but not those of the nurse. However, it is difficult to see how any legitimate complaint can be made that a doctor's notes of a patient's reportage are more detailed than those earlier recorded by a triage nurse. Whilst Dr Docrat said that she had copied the triage nurse's notes, she herself of course saw and examined Mrs Iroko.

iii) Dr Segbenu's notes had no date, time or place. That is so.

iv) Dr Segbenu failed to note that Mrs Iroko had two abdominal scars. It is submitted that this is important, because the scars were indicative of previous abdominal surgery, in respect of which adhesions (and, thus, small intestinal blockages) are a well-recognised complication. Dr May was aware of the appendectomy scar, but not the second scar.

v) Dr Segbenu denied Mrs Iroko had no bloating, although the Claimant produced a photograph taken in Dr Segbenu's room of her mother's extended abdomen. This is a difference in evidence; but, as I understand it, the important clinical signs noted by Dr Segbenu were that the abdomen was soft with no rebound tenderness or guarding, and bowel sounds were normal (see paragraph 10 above).

vi) Dr Segbenu recorded that Mrs Iroko had had two days of vomiting, whilst Dr Adeniran had immediately before recorded three days.

vii) Dr Adeniran had recorded that Mrs Iroko had complained of vomiting, and pain, bloating and tenderness in the abdomen, whilst Dr Segbenu himself recorded only the vomiting.

43. These criticisms, some of which may have force, looked at on their own or in combination with the other evidence relied upon, are clearly insufficient to support the proposition that there were systemic failings in medical note taking or otherwise, such that an article 2 inquest was required.

44. In addition, as I have indicated, the Claimant relies upon the evidence of Dr Gill and Ms Turner. However, whilst the four individual cases to which they refer are each profoundly sad, the evidence of Dr Gill and Ms Turner can offer no assistance in determining whether any systemic failure caused or contributed to Mrs Iroko's death. None of the examples focuses upon inadequate medical record keeping, or DNR decisions; and, in any event, they are insufficient alone or together even to suggest any form of systemic failing(s). Nor, in my view, does the QE Patients Survey offer any support to this claim. There were 646 members of the Forum, only 16% of whom responded to the survey. Of those members who responded, about three-quarters of said that they had joined the QE Patients Forum because they had experience of a "negative experience" of QEH Woolwich between 2001 and 2019. This must be a very tiny proportion of the patients who attended the hospital in that period. There is no analysis of what, if any, statistical force the survey may have.

45. Of course, as she expressly recognised, the Assistant Coroner had an obligation to keep under review whether, as a result of the evidence as a whole, should properly be an article 2 inquest; and, although no substantial representations were made to her that it should, as Mr Keith submitted, whether an article 2 inquest is required is a matter of law. However, looking at the evidence as a whole, in my view, the Senior Coroner and the Assistant Coroner were right to conclude that an article 2 inquest was neither required nor appropriate in this case; and the reticence of Counsel for the family at the inquest to submit that it fell within section 5(2) of the 2009 Act was both understandable and right.

Ground 2: Neglect

46. Mr Keith submitted that the Assistant Coroner erred in not considering the issue of neglect.

47. The issue was expressly raised at the inquest by Counsel for the family, who primarily relied upon the following (Transcript, page 227), both of which relate to 12 December 2017:

    i) the failure to monitor urine output, repeat venous gas analysis, and note and document previous abdominal operations; and

    ii) the decision to discharge Mrs Iroko on 12 December 2017 (a) on the basis of a resolution of abdominal pain, less than two hours after the administration of Oramorph, (b) without any record of Mrs Iroko eating, drinking or ambulating, and (c) without a further abdominal examination.

48. The Assistant Coroner declined to make a finding of neglect. However, she had before her the expert evidence of Mr Vivek Datta (a Consultant Colorectal and General Surgeon instructed by the Senior Coroner) who considered that, on the basis of the history of intermittent abdominal pain and the previous abdominal surgery reflected by the two abdominal scars, Mrs Iroko ought not to have been discharged on 12 December 2017 without an abdominal x-ray which would have confirmed the presence of the obstruction in the small bowel which could and would have then been surgically removed. On the basis of that evidence, the Assistant Coroner did find that "there seems to have been a failure to give weight to the history of the abdominal surgery that [Mrs Iroko] had had, in diagnosing her problem" (Transcript, page 238).

49. Mr Keith submitted that the NHS Trust failed to provide Mrs Iroko with basic medical attention, in the following specific regards. These are somewhat wider than those relied upon before the Assistant Coroner, (i) and (ii) being new.

    i) There was a systemic failure to make adequate medical notes, as described above.

    ii) The care and treatment of Mrs Iroko led to her suffering additional harm, namely (a) she suffered drag marks across her back having been dragged across the floor following her first cardiac arrest, (b) Dr Segbenu prescribed her cyclizine, which exacerbated her pain and (c) Mrs Iroko was made to walk to the CDU without a wheelchair, despite being in considerable pain.

    iii) Dr Shaikh and Dr May erred in discharging Mrs Iroko on 12 December 2017 on the (false and undocumented) basis that Mrs Iroko had been walking around, eating and drinking whilst in the CDU.

    iv) Having given Oramorph, Dr Shaikh did not conduct any further examination of Mrs Iroko before discharging her, in less but still some pain, two hours later.

50. As defined in Jamieson at page 25 (and now set out in paragraphs 74-85 of Chief Coroner's Guidance No 17 (Conclusions: Short-form and Narrative)), neglect in this

context requires more than even gross negligence: it means a gross failure to provide basic medical attention although "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".

51. I do not consider that, on the findings of the Assistant Coroner to which she was entitled to come on the evidence, there was any gross failure to provide basic medical attention to Mrs Iroko or any failure to provide her with any medical attention that she, as a dependent person, obviously needed. Indeed, in my view, this case falls some considerable way short of that high threshold.

52. I have already dealt with (i): in my view, there was no (and, certainly, no material) systemic failure in relation to medical record keeping.

53. I can deal with (ii) shortly. As to (a), as the Claimant accepts, it is clear that the marks on Mrs Iroko's back were caused when she was in cardiac arrest in her own house, and moved by the ambulance crew to a bedroom where there was better room to perform optimal CPR. There is no support for the assertion that the marks reflected additional and unjustified harm to Mrs Iroko. (b) The Claimant relies upon the fact that, on 12 December 2017, Dr Segbenu prescribed Mrs Iroko cyclizine when she was not properly passing stools or urine, in circumstances in which constipation is a noted potential side-effect of the drug and the medical literature indicates that a patients should tell the prescriber if they "have problems peeing or emptying your bladder". However, despite the references to the drug literature, there is no evidence that cyclizine was wrongly prescribed in Mr Iroko's case, or that Dr Segbenu did not take into account her reportage of symptoms when prescribing it. There is certainly no evidence that, as alleged, the prescription caused Mrs Iroko any additional harm. (c) Whilst it is unfortunate that there was no wheelchair available for Mrs Iroko, there is no evidence that her walk to the CDU chair caused her any additional abdominal pain.

54. For those reasons, in my view, it is understandable why, in submitting that there should be a finding of neglect, Counsel for the family did not rely on (i) or (ii) at the inquest.

55. In respect of (iii) and (iv) upon which the family did rely at the inquest, viewed in isolation or together, the Assistant Coroner was clearly entitled (and, in my respectful view, right) not to make a finding of neglect: even if the discharge of Mrs Iroko on 12 December 2017 was in all the circumstances clinically negligent as Mr Datta's evidence suggested (about which I express no view), it clearly fell outside the applicable, narrow definition of neglect.

Ground 3: Prevention of Future Deaths Report

56. Where an inquest gives rise to "a concern that circumstances creating a risk of other deaths will occur, or will continue to exist in the future", and if the coroner considers that action in respect of that risk needs to be taken, paragraph 7 of Schedule 5 to the 2009 Act and regulation 28 of the Coroners (Investigations) Regulations 2013 (SI 2013 No 1629) require the coroner to issue a report to any relevant person, organisation, local authority or government department or agency setting out the concerns and a request that appropriate action be taken (a "Prevention of Death", or "PFD" report).

57. Mr Keith submitted that the Assistant Coroner erred in not making a PFD report in this case; although he frankly accepted that whether there was such an error would likely be determined by the outcome of Grounds 1 and 2.

58. I can deal with the issue shortly. Whether the duty to issue a PFD report arises is highly fact-specific, and involves an exercise of judgment by the coroner. Given the other conclusions of the inquest (including the conclusions in relation to article 2 and neglect which, for the reasons I have given, the coroners were entitled to draw), the Assistant Coroner did not arguably err in not issuing a PFD report.

Conclusion

59. As I have already indicated, I understand the grief and distress of the Claimant and her siblings in respect of the loss of their mother. Mrs Iroko appeared to be a good health prior to her symptoms which first appeared on 9 December 2017 and, despite several visits to hospital, her health rapidly declined and she died only four days later. Whatever the cause, that would inevitably have been distressing for the family. That distress has been compounded by errors within the hospital, some of which have been accepted by the NHS Trust and some recognised by the coroners themselves. Particularly distressing for the family members was to find a DNR direction in the medical records to which they never agreed.

60. However, this court's role is narrow. For the reasons I have given, in my judgment, neither coroner erred as it is alleged. Indeed, although I understand the Claimant is disappointed with the conclusions of the inquest, I consider both the Senior Coroner and the Assistant Coroner conducted the inquest, not only lawfully, but with commendable professional skill and sensitivity.

61. Subject to my Lady and my Lord, I would consequently dismiss this claim.

Mrs Justice Whipple :

62. I agree.

The Chief Coroner of England & Wales (His Honour Judge Lucraft QC) :

63. I also agree.