



Neutral Citation Number: [2021] EWHC 3354 (Admin)

Case No: CO/1958/2021

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 10/12/2021

Before:

LORD JUSTICE BEAN
MR JUSTICE JAY

Between:

MR THONG NGUYEN

Claimant

- and -

**HM ASSISTANT CORONER FOR INNER WEST
LONDON**

Defendant

- and -

**CHELSEA AND WESTMINSTER HOSPITAL NHS
FOUNDATION TRUST and others**

**Interested
Parties**

Leslie Thomas QC (instructed by Leigh Day) for the Claimant
Jason Beer QC (instructed by Westminster City Council Legal Services) for the Defendant
The Interested Parties were neither present nor represented

Hearing date: 1st December 2021

Approved Judgment

This judgment was handed down by the judge remotely by circulation to the parties' representatives by email and release to Bailii. The date and time for hand-down is deemed to be Friday 10th December 2021 at 10.00am.

MR JUSTICE JAY:

Introduction

1. This is an application by Mr Thong Nguyen (“the Claimant”) brought under s. 13 of the Coroners Act 1988 pursuant to the fiat of HM Solicitor General granted on 26th April 2021 for the quashing of the inquisition into the death of his son, Hayden Nguyen.
2. The inquest into Hayden’s death took place between 14 - 16th November 2017 before Dr Shirley Radcliffe, Assistant Coroner in the Coroner’s area for London (Inner West) Westminster (“the Assistant Coroner”). According to the Record of Inquest given on the final day of the hearing, Hayden died of natural causes. The medical cause of death was lymphocytic myocarditis (cause 1a) and disseminated enterovirus infection (cause 1b). The circumstances in which he died were recorded by the Assistant Coroner as follows:

“At 7:30pm on 24/08/16, Hayden attended the emergency department in Chelsea and Westminster Hospital. He was treated for sepsis with antibiotics and admitted. Following a worsening of his condition he was moved to the high dependency unit where he suffered a cardiac arrest at about 6am. Despite advanced life support resuscitation it was not possible to restore circulation and he was pronounced life extinct at 7:15am on 25/8/16.”

3. The challenge to this inquisition is brought on three distinct grounds:
 - (1) The Assistant Coroner’s decision not to hear evidence from an expert instructed by the Claimant, Dr Conway, was flawed, and/or a copy of Dr Conway’s report should have been sent to the expert instructed by the Assistant Coroner, Dr Martin, so that he could comment.
 - (2) There is new evidence that justifies re-opening the inquisition.
 - (3) The Assistant Coroner appeared to pre-determine the key issues.
4. The Claimant was represented by Mr Leslie Thomas QC who appeared remotely. The Assistant Coroner was represented by Mr Jason Beer QC to assist the Court on Grounds 1 and 3. She is neutral on Ground 2. None of the Interested Parties was present or represented.
5. This case has a long history and it arises out of tragic circumstances. Given our conclusion that there will have to be a fresh inquisition into Hayden’s death, I propose to set out the facts as neutrally as possible consistently with the need to do justice to the three Grounds that have been advanced. There have been various factual summaries in the expert evidence, but for present purposes I may rely primarily on the parties’ skeleton arguments.

Essential Factual Background

6. Hayden was born on 19th August 2016. The pregnancy and birth were, generally speaking, uneventful.

7. At 18:56 on 24th August Hayden, who had been suffering from fever for a number of days, was brought by his parents to Charing Cross Hospital. As that hospital does not have a paediatric department, on arrival there he was referred to the Chelsea and Westminster Hospital where he was admitted to the Paediatric Emergency Department at 19:33. He was summoned for an initial stage triage by a junior nurse five minutes later.
8. The junior nurse conducted an initial assessment of Hayden which revealed an axillary temperature of 39.4 degrees, a respiratory rate of 88 breaths per minute, capillary refill time of less than 2 seconds, oxygen saturation of between 95-98% and a heart rate of 190-208. Many of those observations were abnormal, and the nurse escalated Hayden's case to Dr Hester Yorke, Consultant in Paediatric Emergency Medicine, and Dr Felicity Taylor, Specialist Registrar.
9. Hayden was then examined by Dr Alina Grecu, Senior House Officer. She observed that Hayden appeared jaundiced but had no rash or mottled skin. Other observations were unremarkable. Mrs Nguyen told her that Hayden had been feeding well until that day. Owing to the history of fever, reduced feeding and Hayden's age, Dr Grecu discussed his case with Dr Taylor.
10. Dr Taylor reviewed Hayden in the presence of his parents. Mrs Nguyen confirmed the history recorded by the junior nurse. Upon examination, Hayden was alert and active. He had mild jaundice but his skin was of normal tone. According to Dr Taylor, there had been some improvement in Hayden's breathing and heart rate since triage.
11. Dr Taylor decided to implement a full septic screen of Hayden to be followed by intravenous antibiotics. The blood gas test performed at 20:38 revealed a mild metabolic acidosis of 7.28 and a lactate level of 4.0 (well above the normal threshold of 2.0). Initial blood tests at 20:57 showed a low platelet count of 57. Dr Taylor's interpretation was that the lactate level did not correlate with the clinical picture of a stable, well-perfused new-born: the blood gas test had been performed upon a sample obtained via a prolonged tourniquet of the right hand, and in her view was, therefore, a "squeezed sample" and unreliable. In her clinical judgment, a fluid bolus was not required.
12. Dr Taylor discussed Hayden's case with Dr Yorke. They agreed that in view of the clinical picture he did not require a fluid bolus at that stage but a further blood gas test should be performed upon his transfer to the ward. Hayden was given antibiotic treatment and a septic screen. A lumbar puncture was also carried out.
13. At approximately 21:00 Dr Jonathan Penny, Paediatric Consultant, started his shift in the Paediatric Emergency Department. Dr Grecu gave him an overview of the history and management of Hayden as well as the results of the blood samples. Her recollection is that they discussed whether Hayden should be given a fluid bolus and Dr Penny indicated that he would review him on the Mercury Ward and make a decision at that point. Dr Penny was not to see Hayden until 01:45 the following morning.
14. Hayden was not in fact admitted to the ward until about 23:00. Before then, observations at 21:50 and 22:45 showed a heart rate of 165 and 160 respectively, a respiratory rate of 80 and 78 respectively, and temperatures of 37.3 and 37.2

respectively. At 22:45 Hayden's blood pressure was recorded at 69/18, which is extremely low.

15. Upon admission to the Mercury Ward, Hayden was initially assessed by a Staff Nurse. She observed that his temperature ranged between 37.2 - 37.6, his heart beat was between 170 – 185 beats per minute, and his respiratory rate was 70- 76 beats per minute. He appeared jaundiced, mottled and was peripherally cold. The Staff Nurse reported her concerns to a colleague who assessed Hayden's Paediatric Early Warning Score ("PEWS") as between 3 and 5. Hayden's case was escalated. At about that time, the results of the lumbar puncture were received: these showed that Hayden's white cells were 12cmm.
16. At 23:55 Hayden was reviewed by Dr Chloe Norman, Senior House Officer. She observed that he appeared thin and jaundiced, was intermittently tachypnoeic (i.e. his breathing was rapid and shallow) and was mottled. By that stage a peripheral capillary refill time of 3-4 seconds had been observed. At Dr Norman's request, Dr Oluwakemi Bako, ST7 Paediatric Trainee, reviewed Hayden at about midnight on 25th August. She took a history, including the report from Hayden's parents that he had not fed properly since about 18:00, and observed that his heart rate was 170, his respiratory rate was 70 and his central capillary refill time was 2-3 seconds. Dr Bako's assessment was that Hayden had sepsis although he appeared clinically stable. She ordered the administration of saline bolus fluids, which began at 00:35, as well as repeat blood gas within an hour and repeat blood tests the following morning.
17. At that point, Hayden had a PEWS score of 4 and under Trust policy the on-call consultant should have been informed. He was not.
18. At approximately 01:20 Dr Norman was called to see Hayden because of nursing concerns. He remained tachypnoeic and tachycardiac. Upon examination, at around 01:30, Dr Norman observed that Hayden appeared alert. His capillary refill time was now 4 seconds peripherally, and his heart rate was 184. Dr Norman carried out blood gas tests at 01:32 and 01:34. These revealed metabolic acidosis of 7.17 and 7.06 and a lactate level of 7.1 and 7.5 respectively. Upon being made aware of these results, Dr Bako requested a second fluid bolus, administration of intravenous acyclovir (an antiviral), and chest and abdominal x-rays.
19. Dr Bako contacted Dr Jonathan Penny who reviewed Hayden at 01:45. He recommended that Hayden be commenced on Optiflow, that blood tests be repeated within the hour, and that Hayden be transferred to the Paediatric High Dependency Unit. He did not give specific instructions for monitoring.
20. A second fluid bolus was administered at 01:45 and intravenous acyclovir commenced at 02:10. A chest x-ray was conducted at 02:20 and revealed a distended abdomen. When a second cannula was inserted by Dr Bako into Hayden's left hand at about 02:30, it was noticed that his skin was becoming more mottled. His capillary refill time was 2-3 seconds. Hayden's PEWS score was now 5, with a respiratory rate of 74, heart rate of 184, increased work of breathing and decreased consciousness. Hayden was given a third fluid bolus at 02:45 after which time his capillary refill time improved.
21. At 03:00 Hayden was transferred to the Paediatric High Dependency Unit. At 03:15 the frequency of observations was set at hourly.

22. At 03:35 a Senior Staff Nurse observed that Hayden's breathing rate was intermittently fast, with moderate work of breathing. He appeared mildly pale/yellow in colour, his hands were warm, he had a strong cry and he appeared to be unsettled.
23. Hayden was commenced on Optiflow at 04:00. He was reviewed by the senior Staff Nurse at approximately 04:25. His breathing had become more laboured and his respiratory and heart rates more elevated. In view of nursing concerns, at approximately 04:40 Dr Bako was called to conduct a review of Hayden. She carried out a blood gas test at 04:45. This showed a metabolic acidosis of 6.69 and a lactate level of 15.92. Dr Bako contacted Dr Fiona Ramsden, Paediatric Anaesthetic Specialist Registrar, and directed that Dr Penny be informed of the deterioration in Hayden's condition.
24. At approximately 05:15 Hayden was reviewed by Dr Penny and Dr Ramsden. He had a heart rate of 170 – 175, a respiratory rate of 48 – 50, and oxygen saturation of 97%. Dr Ramsden observed clinical signs of laboured breathing and occasional grunting noises. It was agreed that Hayden was in a critical condition and required urgent, invasive ventilatory support. At 05:35 Dr Ramsden contacted Dr Alison Hare, Paediatric Anaesthetic Consultant, to request her immediate assistance in the intubation and ongoing resuscitation.
25. At approximately 05:45 it was noted that Hayden's blood pressure was extremely low. At about 06:00 he went into cardiac arrest and there was no further respiratory response. Dr Ramsden intubated Hayden at 06:15. Attempts to revive him failed and he was pronounced dead at 07:15. It is a clear inference from the foregoing narrative that the working hypothesis of the treating clinicians was that Hayden died from sepsis leading to shock and cardiac arrest.

The Investigation into Hayden's Death

26. Dr Fiona Wilcox, HM Senior Coroner, opened the investigation into Hayden's death on 2nd September 2016. A post-mortem was carried out on 5th September by a Paediatric Pathologist. In a report dated 24th October 2016, Dr Al-Adnani concluded that the cause of death was lymphocytic myocarditis and disseminated enterovirus infection. It is agreed that this is a rare condition with a poor prognosis.
27. Meanwhile, the Trust was carrying out its own investigation. Dr Anne Davies, Paediatric Service Director at West Middlesex University Hospital (part of the same NHS Trust as the Chelsea and Westminster Hospital), was commissioned to prepare a Serious Untoward Incident ("SUI") Report with the assistance of Dr Yemi Jegede, Consultant Paediatrician and Paediatric Intensivist.
28. The SUI report was completed on 29th October 2016 and "signed off" on 9th November 2016. The Trust received the post-mortem report on 7th November. Dr Davies' evidence before the Assistant Coroner was that she made a conscious decision not to look at the post-mortem report.
29. The SUI Report was critical of the Trust's clinicians. It identified the following failings in the standard of care afforded to Hayden:

- (1) Lack of appreciation of physiological and blood gas markers of shock in paediatric Emergency Department and on the wards by the senior resident paediatric medical and nursing teams.
 - (2) Minimisation of the significance of high lactate on initial blood gas in paediatric Emergency Department on handover of care to the ward, with an expressed preference for the sampling error explanation of a squeezed sample; a repeat gas as a specific task in paediatric Emergency Department with an early fluid bolus administration, with stabilisation of physiological parameters and an improving blood gas before a transfer to the ward was required.
 - (3) Failure to monitor appropriately the condition of the child with poor response to clearly expressed parental concern.
 - (4) Non-adherence to Trust Paediatric Observation policy for observation frequency and type of monitoring as well as non-escalation and incorrect calculation of PEWS.
 - (5) Anaesthetic assistance was not called despite the EWS score of 5, and a crash call was not considered nor initiated according to the guidance for this score at the appropriate time.
 - (6) Opportunities were not taken for detailed consultant-to-consultant discussion or professional challenge regarding the case management. The ownership of care was at times unclear.
 - (7) Lack of senior paediatric clinical leadership in terms of in-depth clinical assessment and the lack of decision making and vigorous escalation of care for a deteriorating infant.
 - (8) Failure to access external expert advice about a deteriorating infant in a timely way.
30. Some of these criticisms – as set out in the conclusions to the SUI Report - are more readily capable of correlation with specific events in the factual narrative than others. However, an examination of the italicised passages in the section of the SUI Report dealing with the unfolding sequence of events enables any gaps to be filled. For present purposes, the following additional matters may be highlighted. First, the incorrect calculation of the PEWS score was made at about 00:40 on 25th August. With a PEWS score of 4, the escalation plan within the explanatory rubric required informing the Consultant Paediatrician and carrying out 15-minute observations thereafter. Secondly, Dr Penny's response at 01:45 was criticised. As the SUI Report explained:

“Insufficient significance was given to the physiological parameters and blood gases of a deteriorating infant in septic shock. Blood pressure monitoring was insufficient. *Appropriate response would have been for intubation, further intravenous fluid resuscitation, call for anaesthetic support, consultation with other senior member of the team anaesthetic consultant Dr Fiona Ramsden and initial liaison with CATS regarding PICU transport and care, and preparation to support with inotropes.* There is no notes entry by Dr Penny to outline his decision-making in this regard. PEWS score by Nurse Gill for

decreased conscious level is at odds with the description of an active and alert baby.” [emphasis supplied]

Thirdly, with a PEWS score of 5 at 02:30 an anaesthetic review should have occurred, a 2222 crash call should have been initiated and there should have been no further delay in the transfer to the High Dependency Unit. Fourthly, at 03:15 no regular blood pressure checks and no cardiac monitoring were performed. The frequency of observations (only hourly) was at odds with the Trust’s PEWS policy.

31. In SUI Report gave the following “Overview of Findings”:

“On arrival in hospital the clinical presentation of the patient was an infant with fever and signs of abnormal physiology in the neonatal period indicating shock. There were opportunities for the pathophysiology to be reversed by early intravenous fluid resuscitation with on-going assessment of the efficacy of treatments given ... via close continuous bedside monitoring ...”

The reference to “shock” is to septic shock, and we know that Hayden did not have sepsis. Whether or not his pathophysiology might have been reversed by early intravenous fluid resuscitation is open to debate. I will be returning to this topic.

32. Dr Taylor, Dr Alexander (the Service Director of Acute Paediatrics), Dr Penny and Dr Yorke all made detailed written comments criticising various aspects of the SUI Report. The family had been given a copy of the report before those comments were provided, and it would be fair to point out that the clinicians should have been given the opportunity to comment on the report in draft before it was promulgated.
33. The Senior Coroner commissioned a report from Dr Robin Martin, Consultant Paediatric and Adult Congenital Cardiologist based at the Bristol Congenital Heart Centre. He was asked to opine on the reasonableness and quality of Hayden’s care, and whether death could on the balance of probabilities been prevented. In his report dated 20th May 2017 he said:

“As I am not a general paediatrician it is not appropriate for me to comment in detail on the content of the [SUI] report but I do have some sympathy for the responses from [the treating doctors].”

34. There was some discussion during the hearing as to whether Dr Martin was effectively saying that he was not the right expert to address the quality of care issues. Mr Jason Beer QC for the Defendant submitted that he was qualified to do so, although he was approaching the management of Hayden’s care from the viewpoint of a Paediatric Cardiologist and not from that of the general paediatricians working at the hospital that night. In my opinion, Mr Martin was fully qualified to understand all the technical issues, but he came at them from an overly specialised perspective. He was not the right expert to instruct on standard of care as opposed to causation issues, which explains the reticence with which he expressed himself in the opinion section of his report. He was aware that the performance of general paediatricians was under scrutiny, and that did not fall squarely within his province. However, his reticence was not entirely consistent. He did point out that some of the criticisms in the SUI report made must be invalidated

in the light of the post-mortem report. He did largely exonerate Dr Penny and opined that he would not have expected the treating team to have diagnosed myocarditis with this presentation. On the other hand, he did acknowledge that the lactate reading of 7.5 was “very worrying” and that there was a case for referral to the CATS team.

35. Dr Martin had more to say on the issue of causation. In his opinion, many children with this condition deteriorate rapidly, and that even if Hayden had been referred for intensive care support at 01:45 it is unlikely that he would have survived. He did not believe that “any of the alleged failures of care [in the SUI] or any delay in referral for Intensive care support caused or significantly contributed to Hayden’s death”.
36. On 31st July 2017 the SUI Panel reconvened at the request of the Senior Coroner to review the findings and recommendations of the SUI report in the light of the clinicians’ comments and Dr Martin’s report. In its addendum report, the Panel recognised that, even had aspects of Hayden’s care not been “sub-optimal”, his death would probably not have been averted. The failings in the standard of care were reduced to four, viz.:
 - (1) Failure to monitor appropriately the condition of the child with poor response to clearly expressed parental concern.
 - (2) Non-adherence to Trust Paediatric observation policy for observation frequency and type of monitoring as well as non-escalation and incorrect calculation of PEWS.
 - (3) Anaesthetic assistance was not called for a PEWS score of 5 and a crash call was not initiated according to guidance for this score at the appropriate time.
 - (4) Opportunities were not taken by the consultant paediatrician for discussion and advice from PICU retrieval team (CATS) about a deteriorating infant in a timely way.
37. The parents’ solicitors, Leigh Day, commissioned a report from Dr Steven Conway, Consultant Paediatrician with a particular interest in paediatric infectious disease. He had retired from the NHS and held an honorary contract at Leeds Teaching Hospitals Trust. In his report dated 8th August 2017 he was severely critical of the care provided. He concluded that there was a persistent failure to recognise the severity of Hayden’s condition. In particular, Dr Grecu and Dr Taylor should have diagnosed probable compensated shock in the light of the blood gas results, and should have administered bolus fluid. He considered that Dr Bako “failed completely to assess the severity of Hayden’s illness” and that in the context of the assessment in the Emergency Department, the results of continued monitoring, and the nursing observations on arrival in the ward Hayden should have been transferred straight to the High Dependency Unit. In his view, a repeat blood gas should have been ordered immediately. Furthermore, in Dr Conway’s opinion Dr Penny should have reviewed Hayden earlier. At 01:45 Dr Penny should have directed that Hayden be transferred to intensive care and that he should have been ventilated and intubated. Dr Conway also considered that Dr Penny should have contacted a Paediatric Intensive Care Unit and the CATS retrieval point.
38. Paras 21 and 22 of the skeleton argument of Mr Leslie Thomas QC for the Claimant suggest that Dr Conway agreed with the conclusion of the SUI report in almost all respects. To a certain extent, Mr Thomas is caught in a cleft stick. On the one hand, his

client's overall case in terms of its underlying merits is stronger if two sets of experts are saying the same thing; on the other hand, his client's case on Ground 1 is stronger if Dr Conway is adding materially to the conclusions of the SUI report. An additional consideration is that the addendum report had significantly reduced the number of overall criticisms, and it is not entirely clear how far criticism (4) (see §36 above) now went. Even so, when Dr Davies came to give evidence before the Assistant Coroner, she agreed that the conclusions of the addendum report were "pretty much the same" as the earlier report.

39. Dr Conway qualified his report in two respects. First, he deferred to expert Emergency Department opinion in relation to the adequacy or otherwise of Dr Yorke's assessment of Hayden at approximately 21:00 on 24th August. In my view, this is a minor point. Secondly, and more importantly, he deferred to expert Intensivist and Paediatric Cardiology opinion on the issue of causation. Dr Conway had already seen Dr Martin's opinion on this topic.
40. In his letter to Leigh Day dated 20th July 2017 (although this pre-dates the report, the inference must be that the solicitors had seen a draft), Dr Conway addressed the comments of the treating clinicians on the SUI report, in particular Dr Penny's. Mr Thomas placed particular reliance on this letter, but in my view it does not take his argument any further forward. Dr Conway was heavily critical of Dr Penny's management of Hayden's care at 01:45 and thereafter. Specifically:

"In his summary Dr Penny argues that Hayden did not die of sepsis and therefore the criticisms levelled at the care given need to be reconsidered. There is no way round the fact, however, that Hayden required earlier referral to Intensive Care and proper Intensive Care Support including ventilation, inotrope support and fluid balance monitoring."

and:

"Although intubation and aggressive fluid resuscitation may have caused their own complications, had they been done in a controlled manner with proper expert care available on a balance of probabilities any complications could have been successfully dealt with. The opinion of a Paediatric Intensivist would [be] useful I think."

41. In the light of Mr Thomas' submissions, I have the following observations to make about Dr Conway's letter. First, it was not put before the Assistant Coroner when she decided at the pre-inquest review that Dr Conway would not be called to give evidence. It follows that it cannot be relied on in support of Ground 1. Secondly, the extent to which the now known fact (sc. that Hayden died of myocarditis not sepsis) impacts on the assessment of the care given by the treating clinicians is not straightforward, given that on my understanding it is not being said that myocarditis should have been diagnosed. The true diagnosis is clearly relevant to the issue of medical causation, but an accurate evaluation of the quality of care depends on whether the patient's presenting symptoms and signs were properly assessed and treated. The correct diagnosis may not matter, regardless of whether it lies within the differential diagnosis. Thirdly, I do not read the extracts I have set out as expressing any view on causation. Indeed, in the

second extract, and in the context of the slightly different issue of whether intubation might have led to complications, Dr Conway's lack of direct expertise is apparent.

42. In submissions filed for the purpose of the pre-Inquest review, Leigh Day invited the Assistant Coroner "to adopt Dr Conway as an expert". Aside from his robust conclusions, the contention was made that Dr Martin was not the appropriate expert in this case and had expressed himself in guarded terms in his report (see §33-34 above). The Trust submitted that Dr Conway should not be called: he had not expressed a view on causation, and his "opinion is limited to the standard of care only". It was suggested that Dr Conway's report be shared with Dr Martin to ascertain if it "has altered his opinion on causation in any way".
43. The pre-Inquest review took place on 30th August 2017. Oral submissions were made, and the Assistant Coroner gave a ruling that has not been transcribed. She acceded to the family's separate submission that Dr Jegede be called to give evidence at the Inquest. According to her witness statement filed for the purposes of these proceedings, she decided not to call Dr Conway because the findings and criticisms made in his report did not differ materially from those contained in the SUI report (and both Dr Davies and Dr Jegede would be giving evidence in connection with that report) and Dr Conway had not expressed a view on causation. Mr Beer accepted that these two reasons had to be taken together and that the second taken in isolation could not support the decision. In line with the Trust's suggestion, the Assistant Coroner directed that Dr Conway's report be made available to Dr Martin, but unfortunately that did not happen.
44. The Inquest took place on 14th, 15th and 16th November 2017. I have read the entirety of the transcripts. The Assistant Coroner heard evidence from virtually all the treating clinicians, four nurses, as well as Dr Martin, Dr Davies and Dr Jegede. As is standard practice, the Assistant Coroner examined the witnesses before permitting Mr Jones (for the family), Mr Reddington (for the Trust) and Miss Vickers (for Dr Penny) to question them. Generally speaking, before Dr Davies gave her evidence, the Assistant Coroner asked a mixture of non-leading and leading questions which, without more, is unobjectionable. It is obvious that a preponderance of leading questions would not constitute the proper discharge of a Coroner's duty to undertake sufficient inquiry, but that is not what happened. Furthermore, some of the leading questions were summaries of the evidence that had already been given, and as a general observation that too is unobjectionable.
45. When examining Dr Penny, the Assistant Coroner asked a question which demonstrated that she was concerned that he had not seen Hayden before 01:45 on 25th August and it was only then that he was informed of the worsening acidosis. The Assistant Coroner did not probe Dr Penny about his plan for the management of Hayden at that time, although she did ask him how quickly he thought Hayden would be transferred to the High Dependency Unit (we know that he was not in fact transferred until about 03:00). Further, Dr Penny was asked questions about the adequacy of the response once Hayden's PEWS score was 5. Dr Penny also conceded that with the earlier PEWS score of 4 he should have been informed of Hayden's condition.
46. The Assistant Coroner permitted counsel to question Dr Penny as they saw fit.
47. On the second day of the hearing Dr Martin gave his evidence. The Assistant Coroner did not probe him particularly in relation to his evidence that on the balance of

probabilities earlier escalation would not have saved Hayden, and that his death could not have been prevented by any different clinical care. Mr Jones took the opportunity to question Dr Martin on this topic, but for whatever reason he did not put Dr Conway's opinions to him. Nor was it put to Dr Martin that he was not qualified to address standard of care issues: the reason for that omission may well have been that almost all his oral evidence was directed to the issue of causation.

48. Mr Reddington asked Dr Martin about the risks of intubation. Mr Thomas relies on the answer he gave:

“He would have had a risk of cardiac arrest now that he we know what his condition was, that is true. It is completely outside of my expertise in that I am not the person offering that treatment, so it's ...”

I will be returning to Mr Thomas' submission directed to Dr Martin's lack of expertise, but it is difficult to avoid the comment that in the first sentence of this citation Dr Martin was seeking to have it both ways.

49. Dr Davies then gave evidence. She confirmed that she had heard all the evidence given at the Inquest. At a fairly early stage in her questioning of Dr Davies, the Assistant Coroner asked this:

“Have you taken any consideration of the fact that all the clinicians and to some extent the nursing staff have said that this didn't look like a baby with a lactate of 4? That this baby handled well, that clinically, this baby did not look as if it was in septic shock? Which indeed it wasn't, we know. So, what about the fact that the clinician with the child on the day, having seen the child, has some flexibility or some decision-making as to whether it would be appropriate to fluid resuscitate a child who looks as well as they did, despite the fact ... yes, the boxes had been ticked and it should day, the result ticked the box, how do you factor that in?”

50. This is more than one question. It also comes close to suggesting that very considerable respect should be given to the impressions of the treating clinicians. Dr Davies' answer has not been properly transcribed.

51. The Assistant Coroner also asked Dr Davies about the failure to repeat the blood gas test:

“Okay. The doctors' evidence was that they weren't too concerned about it because we quite often get clumping in a sample and there wasn't any clinical evidence of a problem. Would you accept that, rather than having them do an immediate repeat?”

Dr Davies: That's one explanation (inaudible words)”

52. The transcript does not provide us with any indication of the tone of the questioning. However, the phrasing of the question comes close to suggesting that the Assistant Coroner was trying to get the witness to agree with the proposition that was being put to her. The suggestion that there was not any clinical evidence of a problem is slightly tendentious in that it appears to elevate clinical impressions and appearances over the objective findings.

53. The Assistant Coroner then asked Dr Davies to comment on Dr Penny's evidence that it was not necessary to intubate Hayden at 01:45. That, of course, was one of the key issues in the case. The Assistant Coroner sought to summarise Dr Penny's evidence on this topic (one would question the need, given that Dr Davies had heard it), and said:

“His view as the man there with the patient is that they wouldn't really want to start incubating this baby.

It doesn't look as though it's on the point of peri-respiratory arrest or indeed the requirement for massive further interventions. Then we heard from Dr Martin, that actually with what we know now, that might have precipitated a cardiac arrest at that point, removing the last bit of reserve for this baby. Had you given any weight to the fact that the clinician at the time with the baby was taking all factors into consideration, as opposed to rigidly sticking to the guidelines on fluid resuscitation?

Dr Davies: Yes, I had.”

54. Again, the question, with its use of the adverb “rigidly”, comes close to suggesting that Dr Penny had indeed taken all relevant factors into consideration. It might have been better to leave this question to Miss Vickers.

55. The Assistant Coroner also asked about the SUI report's criticism that the ownership of Hayden's care, at consultant level, was at times unclear. The Assistant Coroner said this:

“The ownership of care was at times unclear. I'm not sure how that ... I think it was clear, it was just that the procedure was that rather than wake up the on-resident consultant, the Registrar approached Dr Penny in part because he was at the scene but also because he was amenable and helpful if you did approach him with these matters, yes?

Dr Davies: Yes.

Coroner: so the ownership of care, it wasn't actually that there wasn't Consultant overview of this child and it didn't actually create any difficulties in the care?

Dr Davies: No.”

56. Although it was open to Dr Davies to reject the propositions that were being put to her, the Assistant Coroner's opinion comes through quite strongly. I think that the real issue

here, and it will be for the new Inquest to consider, is whether there was sufficient Consultant hands-on involvement in Hayden's care at all material times. That is not quite the same question as whether there was sufficient Consultant "ownership" in the sense of their being present in the hospital and available if required.

57. The Assistant Coroner concluded her questioning of Dr Davies at the end of proceedings on the second day. At the commencement of the hearing on the third day, she gave a summary covering three pages of the transcript, "putting it all together with all the evidence we have heard" for the benefit of Dr Jegede, who had not been attending the hearing on the first and second days. Most of the summary is unobjectionable, although during the course of it the Assistant Coroner appeared to endorse Dr Penny's reasons for not intubating Hayden at 01:45. Then she said:

"So, really I feel that the SI findings do not quite reflect the clinical picture nor, indeed, do they reflect the considerable input by senior members of staff at all times in his care while he was in their care. So, is there anything you want to say at this point or shall I allow the lawyers to ask some questions?"

Dr Davies: No, thank you."

58. Dr Davies was asked a number of questions by Mr Jones for the family and the Assistant Coroner did not impede his flow.
59. Dr Davies was then very thoroughly cross-examined by Miss Vickers. Counsel was successful in extracting a considerable number of concessions from her. I list just some of these:
- (1) It was a "grave error" to sign off the SUI report without considering the post-mortem report. She apologised to the family for this.
 - (2) She agreed "in retrospect" that she ought to have given the treating clinicians the opportunity to comment before completing her report.
 - (3) She accepted, again in retrospect, that it was a "fundamental flaw" of the SUI report that it did not evaluate the treatment decisions "from the view of what was available to the clinicians at the time they were making their decisions".
 - (4) She accepted that she had been wrong to say that there should have been an escalation at 22:45 on the basis of a blood pressure reading.
 - (5) She accepted that she had made no reference to Hayden's actual management in the context of his PEWS scores.
 - (6) She accepted that it would not have been appropriate to make a 2222 call at 02:30 when Dr Bako was with the patient putting in a cannula.
 - (7) She accepted that she had gone too far in criticising Dr Penny for not calling the anaesthetist at 01:45.
 - (8) She then accepted that her criticism of Dr Penny's management was no longer justified (this included the failure not to intubate Hayden at 01:45).

(9) She proposed that a further SUI report be written whose “contents will reflect all the matters”.

60. On hearing Dr Davies’ last concession, the Assistant Coroner interjected:

“These reports, do they go up to NHS England? This is at NHS England? Which is quite shocking really that that is on the record and clearly it is not reflecting the evidence. I hope that it will be made very clear to NHS England that the previous reports should be removed from the record.”

61. The final witness was Dr Jegede. The Assistant Coroner did not have many questions for her, remarking that the family had requested her attendance. Mr Jones asked a number of questions but did not touch on the causation issues that had been fully covered by Dr Martin. However, the following exchange between Mr Jones and Dr Jegede should be noted:

“Mr Jones: So, in other words at 01:45, Hayden should have been intubated?”

Dr Jegede: I am not saying Hayden should have been because obviously the team on the ground have been assessing him since he came in and they’re feeling was that this was on the right path ...”

Mr Jones may not have been expecting this answer.

62. Dr Jegede did agree that a lactate of 7.5 was worrying (from her perspective, a lactate of 2 would be worrying), but Mr Jones did not explore her answer on this key point. The Assistant Coroner then asked Dr Jegede a series of questions about the risks of intubation. It would be fair to say that Dr Jegede’s view was that the risks of intubating and not intubating were finely balanced.

63. At the conclusion of Dr Jegede’s evidence, the Assistant Coroner proceeded directly to sum up the case and deliver her verdict. It is unnecessary to summarise her conclusions because these had been – and this is Mr Thomas’ point on Ground 3 – largely prefigured. The Assistant Coroner did add this comment on the SUI addendum report and Dr Davies’ evidence:

“And so the addendum has taken out some of the original criticisms. In the evidence during the course of the inquest it would seem that there was actually very little that is left of the criticisms in the SUI that actually Dr Davies, the lead investigator, still stands by. And Dr Davies has accepted that with reflection and hindsight that a considerable amount of her criticisms in her report are unfounded and she has said she will apologise to the parents, she has, in court, apologised to the medical staff.”

64. In my judgment, this was a reasonably fair assessment of where Dr Davies’ evidence reposed after her questioning by the Assistant Coroner and, in particular, what

amounted to her cross-examination by Miss Vickers. My reading of the transcript is that she apologised in court to the parents for not waiting to read the post-mortem conclusions, and that she largely retracted her criticisms of the treating clinicians, wholly retracting her criticism of Dr Penny.

Subsequent Events

65. Mr Thomas' skeleton argument refers to a number of matters on which it is unnecessary, and possibly inappropriate, to comment. I shall focus on those matters which seem to me to be key.
66. Leigh Day obtained a report dated 27th November 2018 from Dr Stephen Playfor, Consultant Paediatric Intensivist, based at the Royal Manchester Children's Hospital. Given that Dr Playfor's evidence will be adduced at the new Inquest, I shall confine myself to the bare minimum.
67. Dr Playfor's conclusions on the standard of care issue may be encapsulated as follows:
 - (1) Hayden did not receive the care that he ought to have done, and Dr Playfor agreed with Dr Conway's conclusions.
 - (2) The blood gas test demonstrating an elevated lactate level at 20:38 on 24th August should "without question" have been repeated within an hour at most.
 - (3) If Hayden had received appropriate treatment "with aggressive intravenous fluid resuscitation, intubation, mechanical ventilation and the administration of inotropic agents following admission at any time prior to 01:32 on 25th August 2016 then his blood lactate level would have been less than 7.5 when remeasured".
 - (4) At or before midnight on 24th August Hayden met the diagnostic criteria for "severe sepsis" (by implication, it does not matter for this purpose that he was suffering from something else): the Paediatric Consultant should have been called, and if less aggressive measures failed, he should have been intubated.
 - (5) It is probable that multiple intravenous fluid boluses would have brought about only partial improvement, in which event Hayden would and should have been intubated, ventilated and administered inotropic agents.
 - (6) Had this occurred even after 02:00 (it is not entirely clear from Dr Playfor's report what was the latest effective time for intubation etc.), it is probable that his condition would have been stabilised to the degree that he could have been transferred to a Paediatric Intensive Care Unit and would have survived. By 05:00 it was certainly too late.
68. Leigh Day also obtained a report dated 4th January 2019 from Professor Michael Burch, Consultant Paediatric Cardiologist based at Great Ormond Street Hospital. I can take this report quite briefly, without diminishing its potential value. Based on a literature review and his clinical experience, Professor Burch is of the opinion that over 50% of children with neonatal enterovirus myocarditis survive with appropriate intensive care. My only comment is that the Coroner would be likely to ask Professor Burch the question at what point, in terms of the timeline, Hayden's prospects of survival fell from

above 50% to below that figure. I take it that he agrees with Dr Playfor that by 05:00 it was too late.

69. In two letters sent in September 2019, the Trust’s solicitors, Weightmans LLP, admitted liability for Hayden’s death. The civil claim for damages brought on behalf of Hayden’s estate has been settled on a full liability basis.

Legal Framework

Coronial Inquests Generally

70. This Inquest was governed by s. 5(1) and (3) of the Coroners and Justice Act 2009 as explained by the Court of Appeal in *R v HM Coroner for North Humberside and Scunthorpe, ex parte Jamieson* [1995] QB 1. The function of the Inquest was, therefore, to determine “how, when and where the deceased came by his death” (see s.11). “How”, read in conjunction with rule 36(1)(b) of the Coroners Rules 1984, is narrowly construed to mean “by what means” and not “in what broad circumstances”.
71. *Jamieson* also provides guidance on the meaning of “neglect” in the context of a possible verdict open to the Coroner in a case such as this. Although a matter of fact and degree, “neglect” means “a gross failure” and something usually more serious than “negligence” in the context of determining civil liability. “Neglect” also requires the establishment of a causal link between any gross failure and the death at issue.
72. Finally, *Jamieson* is authority for the proposition that a Coroner must “fully, fairly and fearlessly” investigate the death, and “fails in [her] duty if the investigation is superficial, slipshod or perfunctory.”

Applications to this Court

73. Section 13 of the 1988 Act, as amended, provides in material part:

“13 Order to hold investigation

(1) This section applies where, on an application by or under the authority of the Attorney-General, the High Court is satisfied as respects a coroner (“the coroner concerned”) either —

(a)...; or

(b) where an inquest or an investigation has been held by him, that (whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise) it is necessary or desirable in the interests of justice that an investigation (or as the case may be, another investigation) should be held.

(2) The High Court may—

(a) order an investigation under Part 1 of the Coroners and Justice Act 2009 to be held into the death either—

- (i) by the coroner concerned; or
- (ii) by a senior coroner, area coroner or assistant coroner in the same coroner area;
- (b) order the coroner concerned to pay such costs of and incidental to the application as to the court may appear just; and
- (c) where an inquest has been held, quash any inquisition on, or determination or finding made at that inquest.”

74. This provision has attracted considerable judicial scrutiny but for present purposes it is possible to focus on the following key points. There is little between the parties as to how this Court should be approaching its functions under s. 13 in the circumstances of the present case.
75. First, although it is quite clear that members of the deceased’s family can put forward expert witnesses for the Coroner to consider calling, she has a wide discretion whether or not to call a witness reviewable on *Wednesbury* principles: see *Mack v HM Coroner for Birmingham* [2011] EWCA Civ 712, per Toulson LJ at para 9. This must be seen in the context of the Coroner’s duty to call sufficient witnesses to undertake a proper inquiry: see *R (Ahmed) v South and East Cumbria Coroner* [2009] EWHC 1653 (Admin), per Irwin J at para 35. For the purposes of Ground 1, if I were satisfied that the Assistant Coroner’s decision not to call Dr Conway was *Wednesbury* unreasonable, it would follow that there would be an “irregularity of proceedings” or an “insufficiency of inquiry” for the purposes of s. 13(1)(b).
76. Secondly, the “discovery of new facts or evidence” for the purposes of s. 13(1)(b) has been interpreted in a broadly similar way to *Ladd v Marshall*, although with greater judicial flexibility and subject to the important qualification that there is no requirement that the further evidence could not with reasonable diligence have been obtained at the first trial or hearing. That is a factor which weighs more generally in the balance; it is not a precondition to admission. The leading case remains the decision of this Court in *Re Fletcher* [1992] 156 J.P.N. 460, where Beldam LJ held as follows:
- “In my judgment evidence will qualify as new evidence if it was not available at the time of the original inquest, would have been admissible had it been available, is credible and relevant to an issue of significance in the inquisition. It must also be shown that it might have made a material difference to the verdict recorded at the original inquest.”
77. Thus, on a strict application of this passage, in the circumstances of this case it would have to be demonstrated that the new evidence might lead to a Coroner finding neglect (with its two elements of “gross failure” and causation) as opposed to death by natural causes. In subsequent cases it has been held that the possibility of a different conclusion is not an essential component of the test for new evidence, although it will often be a factor of central importance (see *R (Sutovic) v HM Coroner for North London* [2006] EWHC 1095, per Moses LJ at para 55). The case of *Farrell v HM Coroner for North East Hampshire* [2021] EWHC 778 shows that sometimes there will be an additional factor which means that it is in the interests of justice to have a fresh inquest even where

there is no realistic prospect of a different conclusion. Given the nature of the further evidence that has been obtained, it was unnecessary for Mr Thomas to submit that Beldam LJ's test is too stringent.

78. The parties have drawn our attention to a number of cases where further evidence (whether it is truly "new" evidence is often the point at issue) has either been admitted or refused by this Court. In my view, none of these cases raise a point of principle; each turns on its particular facts.
79. Thirdly, it is not sufficient for the purposes of s. 13(1)(b) for a Claimant to satisfy one or more of the criteria set out in the parenthesis: it must also be established that it is "necessary or desirable in the interests of justice" that another investigation should be held. This is an extremely broad test, and requires the Court to take a global and holistic view of whether the first Inquest should be allowed to stand in the light of the proven irregularity or new evidence.
80. Guidance on the exercise of discretion under s. 13(1)(b) of the 1988 Act may be found in *Howlett v Devon Coroner* [2006] EWHC 2570 (Admin), in which Maurice Kay LJ held at para 13 as follows:

"... we have derived great assistance from the judgment of Moses LJ in *Sutovic v HM Coroner for North London* [2006] EWHC 1095 (Admin) and the earlier decision of this court in the case of *Talbarn* [1998] EWHC (Admin) 38. The following propositions of law are not in doubt: among the material considerations in a case under section 13 are the possibility, and not just the probability, of a different verdict; the number of shortcomings in the original inquest; the need to investigate matters raised by new evidence which had not been investigated at the original inquest; the lapse of time since death, which generally is a factor against ordering a fresh inquest, although not always; and the fact that a new inquest can be ordered, even where it appears to the court that there is a high probability that the original verdict would remain unchanged."

81. In *McDonnell v HM Assistant Coroner for West London* [2016] EWHC 3078 (Admin), Beatson LJ held, in the context of a challenge to the Coroner's conclusion that codeine contributed to the deceased's death, that:

"In a case such as this where the cause of death was complex and there was a range of medical opinion given in evidence, the possibility of a different verdict in a further inquest cannot be excluded: a different coroner might take a different view of the evidence. But that possibility does not mean that it is in the interests of justice to hold a new inquest. If it did, that would be so whenever there was complex and disputed medical evidence and finality could hardly ever be achieved."

Apparent Bias

82. It is unnecessary to summarise the test for apparent bias as set out in very familiar House of Lords authority.
83. Mr Beer's skeleton argument refers to two authorities which do merit direct citation.
84. In *R (Pounder) v HM Deputy Coroner for the North and South Districts of Durham and Darlington* [2010] EWHC 328 (Admin), Burnett J (as he then was) summarised the appropriate test to be applied in coronial context, as follows (at para 12):

“Where an allegation of apparent bias is made, the test to be applied is “whether the fair-minded and informed observer, having considered the facts, would conclude that there was a real possibility that the tribunal was biased”...The fair-minded and informed observer is neither unduly sensitive nor suspicious yet he is not complacent. He is assumed to have taken the trouble to acquire knowledge of all relevant information before coming to a conclusion...The fair-minded and informed observer is also expected to be aware of the law and the functions of those who play a part in its administration...When applying the test, any Court will take account of an explanation given by the tribunal and assume that the hypothetical observer is also aware of that explanation...in most cases the answer regarding apparent bias would be obvious. However, ...if there were real ground for doubt, the doubt should be resolved in favour of recusal.”

85. In *Arab Monetary Fund v Hashim* (1993) 6 Admin LR 348, Sir Thomas Bingham MR held at 356A-C

“In some jurisdictions the forensic tradition is that judges sit mute, listening to advocates without interruption, asking no question, voicing no opinion, until they break their silence to give judgment. That is a perfectly respectable tradition, but it is not ours. Practice naturally varies from judge to judge, and obvious differences exist between factual issues at first instance and legal issues on appeal. But on the whole the English tradition sanctions and even encourages a measure of disclosure by the judge of his current thinking. It certainly does not sanction the premature expression of factual conclusions or anything which may prematurely indicate a closed mind. But a judge does not act amiss if, in relation to some feature of a party's case which strikes him as inherently improbable, he indicates the need for unusually compelling evidence to persuade him of the fact. An expression of scepticism is not suggestive of bias unless the judge conveys an unwillingness to be persuaded of a factual proposition whatever the evidence may be.”

Ground 1

86. Mr Thomas accepted that it was incumbent on him to demonstrate a *Wednesbury* error by the Assistant Coroner in relation to her decision not to call Dr Conway as an expert witness.
87. He submitted that there was an inextricable link between the two limbs of “neglect”, and that on the facts of this case the standard of care issues determined the causation

issue. Dr Martin was qualified to address the second question and not the first, but he went behind some of the findings and conclusions of the SUI report. Dr Martin was critical of the SUI report because it reached certain conclusions without the benefit of the post-mortem report. A similar criticism could not be made of Dr Conway; and, in any event, the latter *was* clearly qualified to address the question that Dr Martin was not.

88. In any event, there was a lacuna in Dr Martin's report on the key question of whether Hayden should have been intubated at 01:45. That lacuna was filled by Dr Conway's evidence. Moreover, when Dr Martin came to give his evidence to the Coroner, he said in terms that he was not qualified to express a view on whether intubation might have caused harm (see §48 above).
89. Mr Thomas submitted that had Dr Conway given evidence to the Assistant Coroner, or had his report been made available to Dr Martin as it clearly should have been, the latter might well have revised his views on causation. These views had been given in the absence of a proper context.
90. In answer to my question, Mr Thomas reinforced his submission that Dr Martin was not qualified to address the standard of care issue. Hayden was not treated by paediatric cardiologists. In answer to a further question, Mr Thomas submitted that when it became clear during the Inquest that Dr Martin was unable to answer the question about intubation, the Assistant Coroner should then have sought evidence from Dr Conway on this and other topics.
91. Mr Beer's essential submission was that the Claimant cannot establish a *Wednesbury* error in these circumstances. Even without Dr Conway, the Assistant Coroner was receiving an extensive range of evidence over three days. The Assistant Coroner was entitled to conclude that Dr Conway's report duplicated the findings of the SUI panel; and, in any event, she directed that Dr Conway's report be sent to Dr Martin for him to consider.
92. Despite Mr Thomas' powerful and attractive oral argument, I cannot accept that the Assistant Coroner fell into *Wednesbury* error in reaching what was essentially a case management decision: that Dr Conway would not be called to give oral evidence, but his report should be made available to Dr Martin for consideration.
93. In my judgment, the focus must be on the Assistant Coroner's decision-making at the pre-Inquest hearing on 30th August 2017. What happened at the Inquest itself is not relevant on ordinary principles, and Mr Thomas has not pleaded a case along the lines that Dr Martin's oral evidence to the Assistant Coroner should have caused her to reconsider her decision not to call Dr Conway. In any event, Dr Martin was not conceding that he was not qualified to give evidence on the issue of causation; he was merely saying that he could not comment on the much narrower issue of whether intubating Hayden at 01:45 would have carried its own risks. It was entirely obvious, with respect, that the issue of medical causation fell squarely within Dr Martin's expertise. Further, counsel for the family did not at any stage ask the Assistant Coroner to revisit her decision that Dr Conway would not be called.
94. It is clear from the Assistant Coroner's witness statement that her reasons for not calling Dr Conway were that he duplicated the opinion evidence of the SUI panel and could

not contribute to the issue of causation. In my view, the second aspect of her decision is unimpeachable, although Mr Beer fairly accepted that it could not stand alone. As for the first, I do not think that the issue is entirely clear-cut. Initially, I was quite attracted by the point that the SUI panel had retracted some of its criticisms, and it could therefore be argued that Dr Conway went further in his strictures than did the addendum report. Mr Thomas did not advance a submission along these lines, and on reflection I am fully satisfied that it was open to the Assistant Coroner to interpret the expert evidence before her in the way in which she did. There are two slightly stronger points. The first is that the SUI panel had rather exposed itself to forensic attack by promulgating its report without sight of the post-mortem findings. The second is that there is some force in Mr Thomas' submission that Dr Martin was the wrong expert to address standard of care failings, and yet his report and evidence was being received by the Assistant Coroner on the premise that he was appropriately qualified. Dr Conway was the right expert, and his views could likely assist Dr Martin on the related question of causation.

95. I consider that Dr Conway was a potentially important witness and that this Inquest would have proceeded in a fairer and more balanced fashion had he been called. However, I cannot elevate this consideration to the level of *Wednesbury* error. At the time her decision was made, the Assistant Coroner was aware that she would be hearing a considerable body of lay and expert evidence in this undoubtedly complex case. Her initial assessment that Dr Conway's evidence duplicated that of the SUI panel was not, as I have said, perverse. Even more importantly, the Assistant Coroner could not have anticipated the evidence that was in fact given, including the way in which Dr Davies' evidence was substantially dismantled by Miss Vickers in cross-examination. She was entitled to believe that she would be receiving sufficient evidence from both sides of the debate to enable her investigatory duty under the 2009 Act to be discharged.
96. The contention that Dr Martin was not qualified to opine on standard of care issues was capable of cutting both ways. On the one hand, his evidence served to undermine the SUI report; on the other, he was accepting that he was not the expert best placed to comment on it.
97. Furthermore, the Assistant Coroner's decision was more nuanced than has been characterised by Mr Thomas. Although Dr Conway was not going to be called, she directed that his report be provided to Dr Martin. One possible outcome might have been that Dr Martin would have agreed with it. The fact that, owing to administrative error, Dr Conway's report was not in fact sent to Dr Martin does not retrospectively invalidate the Assistant Coroner's decision, nor does it generate some other "irregularity of procedure" within the meaning of s. 13(1)(b) such as to have induced her to conduct an inquiry which did not satisfy the statutory pre-requisites.
98. It is not clear why Mr Jones did not ask questions of Dr Martin about Dr Conway's conclusions. If he had ascertained in advance that the Assistant Coroner's direction had not been complied with, that failing could have been rectified on the day. There would have been time within the context of a three-day Inquest for Dr Martin to have prepared an addendum report if necessary; or, at the very least, to have absorbed and considered Dr Conway's conclusions before being asked questions about them. If the correct explanation were that the issue was overlooked, that could not form a basis of complaint.

99. I return to an observation I made earlier: the greater the force in Mr Thomas' submission that Dr Martin was out on a limb in the context of all the expert evidence in this case, including the SUI report and Dr Conway's evidence, the weaker the Claimant's case must be on Ground 1. In oral argument Mr Thomas submitted quite forcefully that Dr Conway's view was the same as the SUI report, and (he added) that opinion has now been supported by other expert witnesses.
100. For all these reasons, I am not persuaded that the Assistant Coroner's decision made at the pre-Inquest hearing was perverse. However, the absence of separate support for the SUI report from an expert such as Dr Conway meant that once Dr Davies' evidence had been undermined wholesale by Miss Vickers, the family were left with next to no support for the case they were advancing. That, in the particular circumstances of this case, is a factor relevant to Ground 2.

Ground 2

101. As I have said, Mr Beer was neutral on Ground 2. He drew our attention to relevant authority and was of considerable assistance in that respect, as indeed in others.
102. In my judgment, the various criteria laid down in *Re Fletcher* have been satisfied in this case. First, the evidence of Dr Playfor and Professor Burch was not available at the time of the original Inquest. Secondly, and without wishing to go any further than is absolutely necessary, I would hold that this evidence is both credible and relevant to an issue of significance. Thirdly, it might have made a material difference to the verdict recorded. If accepted by a Coroner, it might lead not merely to a different factual narrative but to a verdict of neglect.
103. The more difficult question in this case is whether it is necessary or desirable in the interests of justice to hold a new Inquest into Hayden's death. "Desirable" imports a lower threshold than "necessary".
104. The factors militating against the holding of another investigation are as follows. First, the Assistant Coroner heard from a significant number of witnesses over three days and her investigation was neither superficial nor perfunctory. Secondly, it had been open to the Claimant's advisors to instruct Dr Playfor or a similar expert in time for the November 2017 Inquest. Dr Conway had said in terms that he deferred to the opinion of a paediatric intensivist. Thirdly, the fact that Dr Davies metaphorically crumbled in the witness box does not necessarily lead to the conclusion that it is desirable in the interests of justice for a further investigation to take place.
105. The factors militating in favour of holding another investigation are as follows. First, the forensic weaknesses in the SUI report would be significantly weakened if there were evidence, as there now is, that earlier invasive procedures would on the balance of probabilities have led to Hayden's survival. Secondly, although I would not go so far as to hold that the Assistant Coroner demonstrated apparent bias in her conduct of these proceedings, some of her questioning of Dr Davies came close to the borderline between robustness and unacceptability. Thirdly, the Trust has now admitted liability in civil proceedings, at the very least calling into question the Assistant Coroner's narrative conclusions in this case. Fourthly, even if the administrative error which led to Dr Conway's report not being made available to Dr Martin does not generate a free-standing ground of challenge, it is relevant to the separate issue of whether it would be

desirable in the interests of justice for Dr Martin to have the opportunity to take on board his views and, indeed, the similar views of Dr Playfor. Fifthly, the further evidence lends new insights into the issue of causation which it would be desirable to balance against the opinion of Dr Martin. Finally, in a case of this sensitivity and importance to the family, and taking into account the interests of the Trust, the treating clinicians and the public, it is desirable that the Coroner receive further evidence from apparently independent sources on the issues of standard of care and causation. No doubt that evidence will be thoroughly tested before the Coroner, but it deserves to be considered.

106. On balance, I have come to the conclusion that it would be desirable in the interests of justice for a further investigation to be held in this case. Ground 2 therefore succeeds.

Ground 3

107. Mr Thomas invited us to consider the cumulative effect of a number of matters. He focused on the Assistant Coroner's handling of a number of the witnesses, and submitted that too many of her questions were not in fact questions at all but amounted to speeches, and that too many were "particularly robust" and crossed the line from probing into advocacy. Mr Thomas submitted that the Assistant Coroner's questioning of Dr Davies was unfair and unduly pressurising, and appeared to be seeking to persuade her to resile from her criticisms in the SUI report. He submitted that the Assistant Coroner's view of the merits of the case was too often betrayed: that she was too "pro-doctor" (in the sense that the clinical judgments of the treating clinicians should not be called into question), and that she had a closed mind to the findings and conclusions in the SUI report.
108. Mr Thomas further submitted that it was concerning that the Assistant Coroner felt able to say, before Dr Davies' evidence had concluded, that the SUI report did not match the clinical picture. The clinical picture represented no more than the clinical impressions of the treating doctors, and these did not match the objective findings of the various test results.
109. Finally, Mr Thomas submitted that it is concerning that the Assistant Coroner proceeded to expound her conclusions extempore immediately at the conclusion of Dr Jegede's evidence. During the course of her summing-up the Assistant Coroner made no reference to that evidence.
110. Rightly in my judgment, Mr Thomas does not seek to identify one factor as more important than any other. He invites the Court to read the transcripts and assess on which side of the line this case falls.
111. I have sought to set out several extracts from the transcripts in order to give the flavour of some of the Assistant Coroner's questioning in this case. Here, I am focusing primarily on the questioning of Dr Davies. It cannot be denied that some of the questions were too assertive, amounted to the setting out of propositions rather than questions, and/or involved several questions and not one, making it difficult for the witness to answer. Furthermore, there is some force in the submission that the Assistant Coroner was already sceptical of the correctness of the SUI report before Dr Davies began to testify. That might have made it difficult for Dr Davies to stand up for herself.

112. On the other hand, the Assistant Coroner’s questioning of Dr Davies must be considered in context. She had already heard from the treating clinicians and from Dr Martin; the two SUI panel witnesses were the last on the list of witnesses. The Assistant Coroner had already, it appears, formed firm provisional views about this case, but that does not amount to bias. Dr Davies had exposed herself forensically by not waiting for the post-mortem report and (although the responsibility for this is less clear) in not insisting that the treating clinicians be given the opportunity to comment before the report was finalised. Further, it cannot be ignored in this context that Dr Davies succumbed to Miss Vickers’ questioning without any assistance from the Assistant Coroner. Mr Thomas did not make submissions about this, and he did not suggest for example that the witness had already been “softened up” by the Assistant Coroner before Miss Vickers started. I have, however, taken that possibility into account.
113. The Assistant Coroner’s remark – “really I feel that the SI findings do not quite reflect the clinical picture” (§57 above) – was unwise, and her later remark about it being “quite shocking really” that this SUI report went to NHS England (§60 above) was close to being intemperate. However, by the time this last remark was uttered, Dr Davies had effectively withdrawn her report.
114. I do not consider that the Assistant Coroner’s decision to deliver her narrative conclusions and verdict immediately after hearing from Dr Jegede raises any particular concern. Whether she needed time to reflect and assemble her notes was a matter for her.
115. The present case is quite close to the line, but adopting the cumulative approach urged on the Court by Mr Thomas, I am unable to conclude that the Assistant Coroner demonstrated apparent bias during her conduct of this Inquest. Ground 3 therefore fails.

Conclusion

116. This application succeeds on Ground 2 but not on Grounds 1 and 3.
117. If my Lord agrees, the inquisition into the death of Hayden Nguyen held in November 2017 must be quashed and a further inquisition will be ordered. That should take place, if practicable, before the Senior Coroner.

LORD JUSTICE BEAN

118. I agree.

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Case Number: CO/1958/2021

DIVISIONAL COURT (Bean LJ and Jay J)

BETWEEN

IN THE MATTER OF THE INQUEST INTO THE DEATH OF HAYDEN NGUYEN
MR THONG NGUYEN

Claimant

-and-

HM ASSISTANT CORONER FOR INNER WEST LONDON

Defendant

-and-

(1) CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

(2) DR JONATHAN PENNY

(3) DR HESTER YORKE

(4) DR OLUWAKEMI BAKO

(5) DR FELICITY TAYLOR

(6) DR CHLOE NORMAN

(7) DR ALINA GRECU

Interested Parties

ORDER

IT IS ORDERED pursuant to Section 13(2) of the Coroners Act 1988 that:

- 1) The findings and determination of the Inquest into the death of Hayden Nguyen, which took place on 14 to 16 November 2017, be quashed.
- 2) There be an investigation under Part 1 of the Coroners and Justice Act 2009 into the death of Hayden Nguyen by a Senior Coroner, Area Coroner or Assistant Coroner for Inner West London with no prior involvement in the investigation into the death of Hayden Nguyen.
- 3) There be no order as to costs.

Dated this 10th day of December 2021