

**THE HIGH COURT**

[2022] IEHC 686

[2020/961 JR]

**BETWEEN**

**NATASHA CUMMINS AND AIDEN SPENCER**

**APPLICANTS**

**AND**

**THE CORONER FOR CORK CITY**

**RESPONDENT**

**AND**

**UNIVERSITY HOSPITAL WATERFORD**

**NOTICE PARTY**

**JUDGMENT of Ms. Justice Bolger delivered on the 14th day of November, 2022**

1. The applicants seek an order of *certiorari* quashing the verdict of the coroner delivered on the 10 September 2020 in relation to the circumstances of and the cause of death of the late Tommy Spencer on 18 July 2018 at Cork University Hospital. For the reasons set out below I am refusing this application.

**Background**

2. The applicants are the parents of Tommy Spencer who was born at University Hospital Waterford on 14 July 2018 and sadly died at Cork University Maternity Hospital on 18 July 2018.
3. A jury inquest into Tommy's death was ordered by the respondent coroner and came on for hearing at Cork Courthouse on 10 September 2020 at 11am. Six witnesses gave evidence in person and were examined and cross examined by the coroner, senior counsel for the family and the solicitor for the hospital. Witness statements from seven other witnesses were read into the record and a number of documents were opened and put to the witnesses including clinical and practice guidelines and the CGT traces from Ms. Cummin's labour prior to Tommy's birth.
4. The jury retired at 4.35 pm and returned at 5pm with a verdict of natural causes and recommended that University Hospital Waterford "take a look at their current policy".
5. The applicant seeks an order of *certiorari* quashing the verdict of the coroner. Other declaratory reliefs had previously been sought and reliance had been placed on the lack of Ms Cummin's consent to the administration of oxytocin but those issues were not pursued at the hearing.

**The applicants' case**

6. The applicants' case can be summarised by paras. 11,12 and 13 of their statement of grounds as follows:

"11. A verdict of death by natural causes, simpliciter, or at least without establishing the circumstances in which the death occurred, was irrational or

unreasonable, and the evidence in the inquest was not adequate to support the finding.

12. The verdict was also affected or probably affected by the pressure of time in which to reach a verdict.

13. The Coroner did not properly charge the jury before retiring”.

7. The applicants’ pleadings set out the circumstances of Ms. Cummin’s labour during which oxytocin was administered to her. The applicants claim there was a failure to monitor hyperstimulation, relying on the CGT scans as evidence of that, and that the oxytocin should have been discontinued after the frequency of her contractions had caused what they claim was hyperstimulation. They submitted that the failure to monitor her hyperstimulation meant that no consideration was given to earlier intervention by way of a caesarean section. They criticised the adequacy of the coroner’s direction to the jury and submitted that a jury that was properly directed and given sufficient time and accommodation to reach a verdict based upon the evidence would have concluded that the death was caused by the care administered to Tommy *in utero*.
8. The applicants were critical of the time allowed by the coroner for the jury’s determinations and claimed that the coroner gave the jury the impression when they retired at 4.35 pm, that they had to deliver a verdict by 5 pm as the building was due to close and the inquest would not be resumed the next day, in spite of the applicants’ expectation that it would go into a second day.
9. The applicants criticised the coroner’s direction to the jury for not having identified what the applicants said were findings reasonably available to the jury including the following:
  - “d. Regardless of the level of consultation, whilst oxytocin was administered, the number and augmentation of contractions was not monitored either properly or at all, and was continued without further consultation and consent from Ms. Cummins.
  - e. Regardless of the level of monitoring, the continued administration of oxytocin was contrary to gynaecological or hospital guidelines in that the increased number and strength of contractions per reference period exceeded the required limits, and or, was not investigated further, and not acted upon by ceasing the use of oxytocin”.
10. The applicants criticised the coroner for not ensuring that the jury had access to readable copies of CGT and traces which were highly relevant documents recording maternal and foetal heartbeat that could verify that the contractions during the use of oxytocin were over and above the guidelines.
11. The applicant took issue with the coroner’s failure to exhibit his notes of the hearing and argued that the paucity of reviewable material meant that there was no evidence of any rational decision and demonstrated unfair procedures.

12. The applicants contended that the verdict of Natural Causes was irrational and the most appropriate verdict was medical accident or medical negligence.
13. The coroner argues that the inquest is a fact finding exercise and that the criteria for finding unreasonableness or irrationality in the verdict is that of the *State (Keegan) v Stardust Victims Compensation Tribunal* [1986] IR 642 which does not include a proportionality review or the invoking of constitutional or Convention rights. The applicants must satisfy the court that the verdict flew in the face of fundamental reason and common sense and/or that there was no relevant material to support it. The coroner submits that the conduct of the inquest, the direction to the jury and the verdict were lawful and proper.

### **Decision**

14. The grounds on which the applicants base their challenge to the verdict can be categorised into the following three headings:
  - i. Irrationality/inadequacy of evidence.
  - ii. Insufficient time allowed for determination.
  - iii. The coroner's charge to the jury.
15. An assessment of each ground requires the court to examine the evidence, including the accounts of the oral and written evidence of the witnesses who appeared before the jury.
  - i. Irrationality/inadequacy of evidence**
16. The applicants contend that the evidence before the jury was not adequate to support the jury's finding that Tommy's death was caused by natural causes.
17. *Bingham v. Farrell* [2010] IEHC 74 is a case in which the coroner's verdict was sought to be quashed but the court held that the evidence given supported the verdict. Hedigan J. held that the applicant had not
  - "even come close to reaching the high bar involved in establishing irrationality. There was ample relevant evidence before the coroner upon which he could base his verdict and his verdict was based squarely upon that evidence.... It is not for this Court to assess that evidence – that is the role of the coroner." (at para. 25 of his judgment).
18. By contrast *State (McKeon) v. Scully* [1986] I.R. 524 was a decision where the evidence was found by this court to have not been adequate to support the coroner's finding of death by suicide. O'Hanlon J. held that the finding of suicide against the deceased was open to challenge
  - "on the grounds of inadequacy of evidence to support it, assuming it were within the powers and functions of the jury to make such a finding. The strict proof required in such circumstances under English law, where there is a clear authority

to find that the deceased committed suicide, has been stressed in a number of cases where the verdict was quashed subsequently on *certiorari*."

19. The applicants in this case were represented by senior counsel at the inquest. They were entitled and permitted to call witnesses, as they did, but they did not call any medical witnesses. They chose to rely on the CGT traces which they claimed showed inappropriate administration of oxytocin to Ms. Cummins during her labour at a time when her contractions had exceeded the five per fifteen minutes and they claimed this had caused hyperstimulation. Both of the applicants' propositions of inappropriate administration of oxytocin and evidence of hyperstimulation were heavily contested at the inquest by the medical witnesses who had attended on Ms. Cummins. The applicants' counsel put both propositions to a number of those witnesses. The note of the applicants' solicitor, Mr. Lohan, of the evidence (being the only contemporaneous note of the evidence put before this court) and significantly the witnesses' own statements and affidavits confirm their consistent disputing of the applicants' propositions.
20. The jury heard from Sara Bredin, midwife. When it was put to her by the applicants' senior counsel that oxytocin should have been reduced at a particular point, she confirmed that Ms. Cummins was "normal" and that everything was "ok". She was asked if oxytocin should have been reduced when Ms. Cummins was having eight to nine contractions to which she responded that she was complying with guidelines, she had applied her clinical judgment and that the CGT was reassuring. She described Ms. Cummins experiencing a sudden onset of pain at 19.33 hours, at which stage there was a suspicion of uterine eruption. In her written statement midwife Bredin said she commenced to care for Ms. Cummins at 08.00. There were repeated references throughout the day to her finding the CGT reassuring and the absence of any scar tenderness. At 19.30 midwife Bredin recorded Ms. Cummins experiencing sudden back pain and distress and noted foetal bradycardia as down to 80 btm.
21. Midwife Bredin also swore an affidavit in these proceedings in which she stated the following:
  - "4. Contrary to what the Statement Required to Ground Application for Judicial Review sets out, I say that the medical evidence, provided by way of Statements and direct evidence, at the inquest clarified that:
    - There was consent by the Plaintiff Mother to the use of oxytocin
    - There was continuous monitoring of the use of oxytocin
    - There was no evidence of hyperstimulation such that the use of oxytocin should have been discontinued any earlier than it was
  5. I also gave evidence, but not limited to, that I as the midwife in charge provided one-to-one care to the Plaintiff. I explained for the Jury the risks associated with VBAC delivery, the reasoning for the use of oxytocin, the causes of the uterine rupture".

The evidence of Dr. Botros, registrar

22. Mr. Lohan's notes record Dr. Botros stating the following in answer to the applicants' senior counsel putting to him that the guidelines states that oxytocin should be discontinued if contractions are more than five every fifteen minutes:

"The decision to stop is not just based on the CGT printout – you also need to carry out a physical examination – touch the patient's tummy and assess the situation by a physical examination and check resting between contractions."

23. When Dr. Botros was asked by counsel if he was saying that there was no hyperstimulation here he answered

"It can't be assessed only by reference to the CGT. I assume that she was seen by the midwife – they would have told me if anything was wrong."

24. In his written statement to the inquest, Dr. Botros referred to having performed both abdominal and vaginal examination at 19.36 hours and that abdominal examination revealed soft abdomen with no scar tenderness. He said he had the impression that Ms. Cummins was in need to deliver very soon. Shortly thereafter at 19.42 hours he had a strong suspicion of ruptured uterus. He said that diagnosis was confirmed when an emergency caesarean section was carried out on Ms. Cummins at 19.55 hours as the baby was in the abdominal cavity. He said that laparotomy revealed complete uterine rupture at the previous uterine scar.

The evidence of Dr. Asait, consultant obstetrician

25. Mr. Lohan's notes referred to Dr. Asait's comments on the CGT scans as: "They are not 100% real contractions". When asked to comment on the policy of Waterford Hospital to count the contractions every fifteen minutes, Dr. Asait stated in his evidence to the jury: "It's not just that – also required physical examination". Dr. Asait went on to say, "it wasn't clear if they were real contractions". When asked if he was suggesting the CGT was unreliable he said, "not 100%". He later said that he did not accept they were contractions but also said he was not in the room to see that. He went on to say, "if I was there I would have established if there was hyperstimulation". He said he could not confirm that a risk of UG could have been the prognosis. He was asked to comment on the proposition that hyperstimulation increases the risk of UR and that that is what happened to which he answered "yes".
26. In his written statement to the jury Dr. Asait described receiving a phone call at 19.36 hours confirming that Ms. Cummins was doing well, but that the CGT was showing foetal bradycardia. He stated, "her abdominal examination was unremarkable and there was no scar tenderness". He said he was contacted again by the registrar on call at 19.41 hours who had a strong suspicion that there was a uterine rupture. Dr. Asait therefore requested him to arrange a crash caesarean section as Ms. Cummin's baby needed urgent delivery.
27. Dr. Asait swore an affidavit in these proceedings in which he stated at para. 5:

"5. I further say that in regard to the issue of the discontinuation of oxytocin, I say that my evidence was that oxytocin should be discontinued if there were evidence of hyper-stimulation of the plaintiff's uterus. I did not give evidence that the first-named applicant's uterine contractions were not properly monitored or acted upon. I gave evidence that the midwife in charge charted giving one-to-one care, that proper contractions were present, that they were good, and that there was a good resting tone".

28. Ms. Cummins swore an affidavit in which she criticises the verdict given by the jury of death by natural causes and states, at para. 9, that:

"The right verdict that is true, fair, and honours Tommy's short life is that his fatal injuries were caused by the excessive and unmonitored use of oxytocin at the hospital, and by the absence of an early intervention, causing him to be born brain dead. The four days that followed is simply the rest of his life, and Aiden and I turning off the life support is not a natural cause any parent wants to experience. This is why Aiden and I want another inquest".

29. It does not seem to me from the evidence put before the jury from Mr. Lohan's notes, the witness statements and the affidavits sworn by the witnesses who gave evidence, that there was any evidence to support Ms. Cummins' claims of excessive and unwarranted use of oxytocin and the absence of an early intervention. Rather it seems that her claims were put to the witnesses and to the jury through her counsel. There is an obvious and fundamental difference between evidence given and propositions made.

30. The respondent coroner swore an affidavit in which he set out, *inter alia*, his account of the conduct of the inquest. He confirmed at para. 15 that he was relying on his own recollection and his contemporaneous notes. He did not exhibit those notes and I return to that issue further below. He set out what he explained to the jury in his opening of the inquest as to the issues which were to be dealt with which he identified as establishing the following:

- (a) The identification of the deceased;
- (b) When he died;
- (c) Where he died;
- (d) How he died.

31. At para. 20 he set out what he had advised the jury when dealing with the fourth question i.e., how the deceased died which he described as a two-fold process in that:

"(a) the particular cause of death had to be established and that this is done in the main by testimony from the pathologist who was to read out the deceased's post mortem report and then answer questions thereon; and

(b) by enquiry into the immediate circumstances leading up to the death of the deceased”.

32. At para. 23 the coroner set out the evidence given during the hearing as including the following

“a. that the use of Oxytocin for an expectant mother with the first named Applicant’s previous history would be inappropriate where it was used to *induce* labour but that it was safe and part of protocol where it was used to *speed up* the labour process when labour was already commenced;

b. that, in the first named Applicant’s case, labour had fully commenced before the use of Oxytocin began as the first named Applicant was over three centimetres dilated at that point;

c. that the proposition that Oxytocin had been continued beyond its recommended timeline was incorrect and did not apply to the care of the first named Applicant;

d. that whilst hyperstimulation can occur, it only occurs over a prolonged period where the number of contractions has exceeded 5 every 15 minutes;

e. that where there were more than 5 contractions for every 15 minutes, these were of short duration in each period recorded and furthermore did not give rise to or represent hyperstimulation;

f. that when assessing this situation, three factors must be borne in mind namely: (i) CTG readings, (ii) clinical observations; and (iii) medical examination of the patient and that CTG findings alone would not be relied by attending medical professionals;

g. that where there were excessive contractions, the dose of Oxytocin was adjusted and the excessive contractions stopped.

h. that the use of Oxytocin is an inexact science where infusion starts at a very slow rate, which is slowly increased and if there is a reaction to this, the rate of infusion is dropped and that this practice was followed in the case of the first named Applicant and each time the Oxytocin was reduced the contractions lessened; and

i. that, at all times, the first named Applicant was on the minimum dosage of Oxytocin and that she did not on any occasion exceed this dose” (coroner’s emphasis).

33. He then identified at para. 24 the direction he had given to the jury as follows:

“After all witness testimony had been heard and all parties had asked the questions which they wished to ask, the evidence concluded. Senior Counsel for the

Applicants then addressed the Jury and I then gave my direction to the Jury. This consisted of the following:-

- (a) I advised the Jury that they should reach their verdict on the balance of probabilities;
- (b) I stated that there were four possible verdicts open to them;
  - (i) **An open verdict** – this was available to the Jury if they felt having heard all the evidence, they were not in a position to reach a conclusion as to the cause of death.
  - (ii) **A narrative verdict** – the Jury could reach a narrative verdict if, in all the circumstances having heard the evidence that it was appropriate to record the verdict in narrative form as a description as to when the First Named Applicant attended the hospital, the length of time she spent in hospital, the time and place where the deceased was pronounced dead.
  - (iii) **Medical misadventure/accident** – I put this in simple terms to the Jury that if they felt there was a systematic failure or a failure in treatment then this verdict was open to them.
  - (iv) **Natural causes** – I told the Jury in essence that if they were satisfied that this was an event which occurred due to unfortunately a natural condition and was not due to human failure to intervene or having intervened incorrectly that this verdict was open to them”.

34. The hospital solicitor, Mr. Groarke, who attended the hearing, also swore an affidavit in these proceedings at which he stated the following at para. 4, 5, 6 and 7 of his affidavit:

“4. I say that in regard to the issue of the consent of the first-named applicant... that no Medical witnesses gave evidence that the consent for the use of Oxytocin of the first-named applicant was “assumed”. Further, I say that no Medical Witness gave evidence that the oxytocin should have been discontinued any earlier than it was.

5. I say that my recollection of the evidence given by the hospital’s midwives obstetricians accords with the summary of evidence contained at paragraph 23 of the affidavit of the respondent sworn 9 March 2021.

6. I further say that at the conclusion of evidence from all of the witnesses at the Inquest, the respondent invited Senior Counsel representing the applicants to make submissions about the verdict and recommendations to the jury that he felt should be considered by the jury. In his submission, the Senior Counsel raised issues about the first-named applicant’s consent to her treatment, the use of oxytocin, involvement of senior staff, and documentation and notes of advices given to the first-named applicant. The Senior Counsel also submitted that the jury should consider making recommendations to the Notice Party about its policies for the use of oxytocin, record-keeping, and updating policy guidelines for VBAC deliveries.



7. I say that at the conclusion of the Family's Senior Counsel's evidence, your deponent, on invitation from the respondent, also made a submission. In my submission, I stated that the applicant's Senior Counsel had set out a narrative that was not reflected in the evidence given by the treating midwives and obstetricians and the pathology report. I submitted that the jury should be guided by the statements submitted and by the evidence and answers given by each of the obstetricians and midwives involved. I then submitted that the recommendations being put forward by the senior counsel had already been adequately set out in the policies produced by him from University Hospital Waterford, and, as such, there was no requirement for any recommendations".

35. Mr. Lohan, the applicant's solicitor, swore a second affidavit in order to reply to the affidavit sworn by the coroner, Dr. Botros, midwife Bedwin, Mr. Groarke solicitor and Dr. Asaait. Mr. Lohan disagreed with the coroner's recollection about the circumstances in which the jury gave their verdict at 17.00 hours having retired to consider their verdict at 16.35 hours. He did not specifically challenge the coroner's evidence about what he had said in his opening and his direction to the jury, but he did say at para. 17:

"I say that as Mr Comyn has provided no supporting documentation and there is significant divergence with my recollection and notes, then it will be necessary to cross examine Mr Comyn at the hearing of this matter".

36. Mr. Lohan went on to make a single response to Mr. Groarke's affidavit as follows:

"I say that Mr Groarke also fails to exhibit any documents or notes to support his affidavit and there will be need to cross examine him also".

37. Mr. Lohan states at para. 20 of his affidavit as follows:

"I say, and as will be explained at the hearing, that these CTG scans show that the first named applicant had repeatedly exceeded 5 contractions every 15 minutes and was suffering from hyper stimulation".

A statement to the effect that CGT scans showed that Ms. Cummins was suffering from hyperstimulation in circumstances where it was disputed by the medical witnesses that gave evidence, is evidence that one would normally expect from a medical witness and not from a solicitor.

#### Disputed versions of the evidence given to the jury

38. The applicant, through their counsel at the inquest, put propositions to the medical witnesses and to the jury, and subsequently to this court, to the effect that there had been an inappropriate administration of oxytocin that had caused Ms. Cummins to experience hyperstimulation that had caused her uterine rupture that had caused the death of baby Tommy. It seems that the basis for these propositions was the CGT scan. The medical witnesses strongly disputed those propositions and repeatedly confirmed that there was no inappropriate administration of oxytocin, that Ms. Cummins did not

experience hyperstimulation and that all the indicators, including the CGT scans and the other factors they relied on in ascertaining Ms. Cummins condition i.e., their clinical judgment, the absence of scar tenderness and a physical examination, were reassuring. This evidence was reflected in the coroner's version of the evidence given and supported by the affidavit of Mr. Groarke, the hospital solicitor. It was purportedly challenged by Mr. Lohan in his affidavit but without specifying any basis for same and on the basis that both deponents would be cross examined at the hearing of these proceedings.

39. The apparent earlier intention of the applicants to cross examine the coroner and Mr. Groarke at the time Mr. Lohan swore his replying affidavit on 2 November 2021 was one that was properly open to them and in accordance with the decision of the Supreme Court in *RAS Medical Ltd trading as Parkwest Clinic v. The Royal College of Surgeons in Ireland* [2019] 1 I.R. 63. Clarke C.J. stated at para. 90 of that decision:

"Just as it is inappropriate to argue in a trial conducted on oral evidence that the evidence of a witness should not be accepted, either on grounds of lack of credibility or unreliability, without having given that witness a fair opportunity to answer any issues arising in that context, so also is it impermissible to ask a decider of fact (such as the trial judge in this case) to determine contested questions of fact on the basis of affidavit evidence or documentation alone.

He went on to say at para. 92:

"But it is frankly not appropriate for parties to enter into controversy as to the facts contained either in affidavit evidence or in documents which are admitted before the court without successful challenge, without exploring the necessity for at least some oral evidence. If it is suggested that there are facts which are material to the final determination of the proceeding and in respect of which there is potentially conflicting evidence to be found in such affidavits or documentation, then it is incumbent on the party who bears the onus of proof in establishing the contested facts in its favour to use appropriate procedural measures to ensure that the potentially conflicting evidence is challenged. Where, for example, two individuals have given conflicting affidavit evidence and where it is considered that a resolution of the dispute between those witnesses is necessary to the proper disposition of the case, then there has to be cross-examination and the onus in that regard rests on the party on whom the onus of proof lay to establish the contested fact.

40. It appears that the applicants decided not to proceed with cross examination of the coroner and Mr. Groarke. That decision exposed them to being unable to ask this court to determine what they seemed to view as contested evidence on the basis of the affidavit evidence. The medical witnesses' evidence is consistently contrary to the propositions put forward by the applicants, through their counsel, to the inquest about inappropriate use of oxytocin and Ms. Cummins having experienced hyperstimulation. It is clear that there was ample evidence before the jury in the form of the medical witness's written statement and their oral evidence, which the applicants were permitted to cross examine through their counsel, for the jury to choose not to accept the applicants' case that there

had been inappropriate administration of oxytocin and that there was evidence of Ms. Cummins having experienced hyperstimulation. In circumstances where the applicants' propositions were not accepted and the evidence of the medical witnesses was, there was an evidential basis for the jury to reach a verdict of death by natural causes. In those circumstances the applicants fall well short of the high bar on any applicant seeking *certiorari* on grounds of irrationality as per the test set out in *State (Keegan & Lysaght) v. Stardust Victims Compensation Tribunal* [1986] I.R. 642 and *O'Keeffe v. An Bord Pleanála* [1993] 1 I.R. 39.

41. I am satisfied that there was relevant evidence before the jury on which the verdict they delivered could be lawfully based. Much of the applicants' case on what they claimed was the inadequacy of the evidence to ground the verdict reached, was premised on the jury having heard evidence of inappropriate administration of oxytocin and hyperstimulation. I am satisfied that no such evidence (which would be essentially medical) was put before the jury. I do not accept that the CGT scans constituted such evidence particularly in circumstances where there was medical evidence showing that the CGT scans confirmed contractions at a particular rate as well as clear medical evidence that oxytocin was appropriately administered and that the basis on which a diagnosis of hyperstimulation would be made (namely clinical judgment, physical examination and scar tenderness) were all reassuring to Ms Cummins' medical attendants and did not, in their view, constitute evidence of hyperstimulation.
42. The propositions made by the applicants to the jury that there was inappropriate administration of oxytocin and evidence of hyperstimulation that was not acted upon in a timely manner, was not accepted by the jury. That is clear from the verdict they delivered, and I am satisfied that on the basis of the evidence they heard, the jury was entitled to reach that decision and to deliver the verdict that it did.
43. This is clearly a case falling within the type of situation that arose in *Bingham v. Farrell* rather than that of *McKeon v. Scully*.

**ii. Insufficient time allowed for determination**

44. A very specific plea is made at paras. 25 and 26 of the applicant's statement of grounds as follows: -

"25. The Coroner announced in the presence of the jury or gave the impression to or directed the jury that there was pressure of time to deliver a verdict, that the building in which the inquest was being held was shortly to close, and that there were no prospects of continuing an adjourned inquest the next day or in the foreseeable future.

26. Due to time pressure by the coroner, in relation to the need to vacate the building by 5 pm, a verdict was given within 25 minutes of the jury retiring to consider their verdict, which was, objectively in the circumstances, not sufficient time to consider all the evidence, and may predictably have [been] caused by the pressure of time the jury were under".

45. This allegation is not referred to or supported by the grounding affidavits sworn by Ms. Cummins and Mr. Lohan. The allegations are denied by the respondent in their statement of opposition and in his affidavit grounding the statement of opposition the Coroner said that he did mention in open court at around 16.00 hours that the building in which the inquest was taking place was due to close at 17.00. He said he did not attach any particular importance to it nor was the Coroner's address specifically to the jury but rather was addressed to all the people present in court including the applicants' representatives and the applicants themselves. He says there was no submission or application from any party as to the period of time allowed for the conduct of the inquest or the time within which the jury had to consider their verdict. He said the jury were not told by him that they had to come back with a verdict at any particular point in time and that they were each available to continue with their deliberations on the following day, and that he was available to continue on the following day if that had been necessary. Mr. Lohan swore a second affidavit in reply to the Coroner's affidavit in which he stated that he disagreed with the Coroner's recollection that the jury or counsel was not rushed and stated that it was his recollection that there was a distinct pressure to have the matter determined by 17.00 hours. He also disagreed that the Coroner informed jurors and the applicants that the inquest could continue the next day. He gave the following evidence on affidavit: -

"I do not recall now if it was said in open court or not, we were informed by Mr. Comyn, the registrar and or the attending garda that the inquest could proceed but not the next day in the court building and it would have to be adjourned to an as yet unspecified or unknown date and location if it was not completed that day".

This version of events was denied by the Coroner in his second affidavit in which he confirmed that he did not state to Mr. Lohan or any other person that the inquest could not proceed the following day and he said there was no reason for him to make such a statement, as arrangements were in place to continue the inquest the following day in the same place if this had proved to be necessary. He also said that he made inquiries of the registrar sitting with him at the hearing and of two members of An Garda Síochána who were present and was satisfied that none of them had stated to Mr. Lohan or any other person that the inquest could not proceed the following day.

46. The applicants' case in relation to the insufficiency of the time allowed for the jury's determination commenced with a definite claim at paras. 25 and 26 of the statement of grounds that the Coroner made an announcement or gave the impression or directed the jury that there was pressure on time to deliver a verdict because the building was about to close and there was no prospect of continuing the inquest to the next day and that as a direct result of that, the verdict was given within twenty five minutes. This allegation was not grounded on affidavit. By the time evidence was put on affidavit in relation to this point, it had changed to the deponent's inability to recall whether the information was given in open court or not, or to whom the information was given and whether it was given by the Coroner, the registrar or the attending garda. In spite of the vagueness of the detail as to who says what and where it was said, the deponent was apparently in a

position to state definitively on affidavit that he disagreed with the Coroner's recollection that the jury or counsel was not rushed and instead set out his recollection that there was "a distinct pressure" to have the matter determined by 17.00 hours.

47. There is a clear conflict in the evidence in relation to this aspect of the plaintiff's claim. Given the vague and inconsistent nature of the allegations made on behalf of the applicants and the basis for same, I am satisfied that it is appropriate to prefer the evidence given by the Coroner to the effect that neither he nor the registrar nor either member of An Garda Síochána who were present at the inquest made any statement to Mr. Lohan or any person that the inquest could not proceed the following day and that in fact arrangements were in place to continue the inquest the following day in the same place had that proved necessary.
48. It is unsatisfactory that the court is asked to quash a verdict of an inquest because of an allegation that the jury were not allowed sufficient time for their determination on the basis of a vague allegation that Mr. Lohan and/or some other unidentified person was told by either the Coroner or the registrar or a member of An Garda Síochána either in open court or elsewhere that the inquest could not continue the following day. The evidence proffered by the applicants does not constitute the type of clear evidence required to ground firstly the serious allegations the applicants make against the Coroner in relation to how he organised the inquest and secondly to grant the relief sought. The serious allegations such as is made against the Coroner in this regard should not be made unless an applicant can adduce clear evidence to sustain it. No such evidence was adduced by the applicant here.

**iii. The Coroner's charge to the jury**

49. The applicants criticise the Coroner for
- (i) not directing the jury on the findings that the applicants' claim was reasonably available to them to make which is set out at para. 31 of the applicants' statement of grounds.
  - (ii) not directing the jury as per s.16(a) of the Act that a verdict of death by negligence, misconduct or malpractice was reasonably available to them.
50. The Coroner in his affidavit describes the evidence that was given to the jury. At para. 23 he confirms the evidence given during the course of the hearing including nine specified matters but he does not say that he summarised it for the jury. He confirmed that his direction to the jury was preceded by oral submissions made by the applicants' senior counsel for some twenty minutes and further oral submissions made by the hospital's solicitors for ten minutes. That was not disputed in the applicants' solicitors' replying affidavit, although he did say at para. 17 in his replying affidavit that there was significant divergence with his recollection and notes and that it would be necessary to cross-examine the Coroner at the hearing of the matter. Ultimately this proposed strategy of cross-examining the Coroner was not proceeded with.

51. The applicants, who were legally represented before the inquest, did not take any issue at that point in time with the Coroner's summary of the evidence, or lack thereof, insofar as they may have considered it to have been lacking.
52. It was open to the Coroner to determine that the jury had been given sufficient information in relation to the evidence and that it was not necessary for him to provide any further summary of the evidence that had been given or to have directed the jury of the findings that were reasonably available to them to make, whether as identified at para. 31 of the statement of grounds or at all.

#### Medical misadventure

53. The Coroner at para. 24 of his affidavit states that he advised the jury that there were four possible verdicts open to them, namely an open verdict, a narrative verdict, medical misadventure/accident or natural causes. He described putting in simple terms to the jury in relation to medical misadventure/accident that if they felt there was a systematic failure or a failure in treatment then this verdict was open to them. This claim was not addressed by Mr. Lohan in his second affidavit replying to the Coroner's affidavit on the applicants' behalf.
54. Mr. Lohan's notes from the hearing gave a brief summary of the submissions made on behalf of the applicants' senior counsel who, according to the Coroner and not disputed by Mr. Lohan, spent twenty minutes making submissions to the jury. Mr. Lohan's notes of those submissions are quite short and there is no reference to counsel suggesting to the jury that a particular verdict, whether medical misadventure or any other verdict, should be given. Mr. Lohan's note of the Coroner's direction to the jury does refer to the Coroner discussing options for a verdict and identifies three verdicts, namely open verdict, narrative verdict and natural causes. There is no reference to medical misadventure/accident or medical malpractice as a verdict but there is a reference to the following after the Coroner advised the jury they could consider natural causes: "A failure to anticipate events - the system did not perform properly". That is similar to the Coroner's averments as to how he explained the verdict of medical misadventure/accident to the jury, as set out above.
55. It is clear that there was no challenge made by the applicants, who were legally represented at the hearing, to what the Coroner said to the jury about the verdicts available to them, at the time that the Coroner directed the jury. If, as appears from the manner in which these proceedings have been drafted, a verdict of medical misadventure was the applicants' preferred verdict for the jury to deliver, it seems strange that what the applicants now say was a shortcoming in the Coroner's direction to the jury on the verdicts open to them was not challenged by the applicants through their representatives at the time.
56. The Coroner gave an adequate direction and summing up on the verdicts available to the jury and any shortcomings therein (and I make no express findings that there were any such shortcomings) do not come close to the high test for rationality that is required for this Court to quash the jury's verdict.

### The Coroner's note

57. For completeness I set out below my views on the applicants' criticism of the Coroner's failure to exhibit his notes.
58. The applicants maintain that this put them at a disadvantage and was a failure on the part of the Coroner in terms of his duty of candour. The Coroner has, very candidly, confirmed that he retained his notes of the hearing but states that he is not aware of any precedent whereby it is appropriate for a Coroner's notes to be disclosed. The applicants sought to rely on the decision of Barrett J. in *Murtagh v. Kilrane & Ors.* [2017] IEHC 384 in which Barrett J. confirmed that a respondent in judicial review proceedings should disclose to the court all materials in its possession which are relevant to the decision sought to be impugned. Barrett J. also noted that such a duty did not require the respondents to disclose material in respect of which they would be entitled to claim privilege in a discovery on the basis of the clear dicta of Keane CJ in *O'Neill v. Governor of Castlerea Prison* [2004] 1 IR 298.
59. I do not think it follows from the Murtagh decision that a Coroner is automatically obliged to furnish their notes of inquest particularly in the light of the decision of Edwards J. in *D. O'Q v. Judge Buttimer* [2009] IEHC 25 which was an application for discovery in judicial review proceedings. The applicant was seeking discovery of the notes made by a Circuit Court judge during family law proceedings in which he sought to have a maintenance order made by the judge quashed. Edwards J. very clearly determined that it was not appropriate to allow discovery of the judge's notes and in doing so, expressed the court's concern that it represents an impingement upon the judge's constitutionally guaranteed independence. He concluded that if discovery of the judge's notes were theoretically possible it could only happen in the most exceptional circumstances and where the necessity for it was clearly demonstrable.
60. The Coroner in this case seeks the same sort of protection for his notes. However, it is significant that the decision of Edwards J. was in circumstances where the applicant had sought discovery of the judge's notes which is a different situation than what arose in *Murtagh* where the court was critical of the respondent not disclosing materials relevant to the decision sought to be impugned. Barrett J. specifically noted in *Murtagh* that that duty of candour does not require the respondents to disclose material in respect of which in a discovery process they would be entitled to claim privilege.
61. If the applicants are entitled to criticise the Coroner's decision not to furnish his notes, I do not think it appropriate to do that in the way they have done i.e., a claim that it was part of his duty of candour to exhibit those notes in his affidavit. The applicants had options available to them if they wished to argue that the Coroner was compelled to provide his notes, the most obvious of which was to seek an order for discovery. Indeed, before seeking an order for discovery the applicants could have asked the Coroner to furnish his notes and whilst they did ask him for a digital recording (which it appears simply did not exist) they never expressly sought a copy of notes by way of correspondence. It would appear from what the Coroner had said on affidavit that had he

been asked for the notes or had the applicants sought the notes by way of voluntary discovery, he would have refused both requests. Had he refused a request for voluntary discovery it of course would have been open to the applicants to have sought an order from the court compelling him to make discovery of those notes, which in turn would have enabled the court to properly determine whether it is appropriate to compel a Coroner, whether generally or within the specific circumstances of this case, to provide their notes. It is possible that such a decision would have followed Edwards J. in *D. O'Q* and from an analogy between the notes of a Circuit Court judge and the notes of a Coroner, or perhaps a different view might have been taken of a Coroner's notes, or indeed might have determined that this was one of the exceptional circumstances in which Edwards J recognised in *D. O'Q* that it might be necessary even for a judge to provide their notes by way of discovery.

62. I do not consider it appropriate for this Court to condemn the Coroner's decision not to exhibit a copy of his notes, at this stage of the proceedings. The time to challenge that decision was before the matter was set down and the proper method for doing so was by way of an application for discovery. I therefore draw no conclusion, adverse or otherwise, from the Coroner's refusal to furnish his notes and I do not consider any basis for relying on that refusal to garner support for the applicants' challenge to the jury's verdict of death by natural causes.

#### **Conclusions**

63. I am satisfied that the Coroner conducted the inquest appropriately, allowed the jury sufficient time for their determination and gave the jury adequate directions on the evidence, insofar as that was necessary in light of the evidence given and the submissions already made, and the verdicts that were open to them. I draw no conclusions from the Coroner's decision not to exhibit his notes in circumstances where the applicants chose not to seek the notes by way of discovery.

64. I therefore refuse the application.

#### **Indicative view of costs**

65. This case arises from very sad circumstances for the applicants. However the respondent has succeeded in defending their claim for reliefs and in those circumstances, in accordance with s.169 of the Legal Services Regulatory Act 2015, my indicative view on costs is that costs should follow the cause. I will list the matter before me at 10:30am on 14 December to allow the applicants to make whatever case they wish as to whether there are particular reasons why the usual costs order should not be made.