



**COURT OF APPEAL**  
**CIVIL**

[Record No. 2023/39]

**Allen J.**

**Neutral Citation Number [2023] IECA 248**

**Meenan J.**

**Burns J.**

**IN THE MATTER OF THE CORONERS ACTS**  
**IN THE MATTER OF TOMMY SPENCER DECEASED**

**BETWEEN**

**NATASHA CUMMINS AND AIDEN SPENCER**

**APPELLANTS**

**AND**

**THE CORONER FOR CORK CITY**

**RESPONDENT**

**AND**

**UNIVERSITY HOSPITAL WATERFORD**

**NOTICE PARTY**

**JUDGMENT of Mr. Justice Charles Meenan delivered on the 16<sup>th</sup> day of October, 2023**

**Background**

1. On 13 July 2018 the first named appellant attended at University Hospital Waterford, the Notice Party, for the purpose of giving birth. She was accompanied by her partner, the second named appellant. When fully dilated, approximately 34 hours after her admission into

the said hospital, the first named appellant suffered a uterine rupture. An emergency caesarean section was undertaken and her baby, Tommy Spencer, was born alive but in very poor condition. After immediate lifesaving attention and stabilisation, Tommy was moved to Cork University Hospital and placed on life support. Unfortunately, nothing could be done to save Tommy from the brain injuries which he had suffered in the course of his delivery. With deep regret and sadness, the appellants agreed to the life support being removed. Tommy Spencer died on 18 July 2018.

2. The appellants maintain that the uterine rupture, which resulted in a severe drop in the foetal heartbeat with consequent lack of oxygen in the foetal blood flow resulting in brain damage, was caused or contributed to by the use of Oxytocin. The appellants also maintain that the first named appellant's pregnancy was "*high risk*" as her previous child had been born by caesarean section.

3. The office of the respondent was notified of the death of Tommy Spencer and, on the basis of the information supplied, directed that the death warranted further coronial investigation.

### **Coroners' inquest**

4. Following a number of adjournments, the inquest commenced before a jury on 10 September 2020. The appellants were represented by both senior and junior counsel. A number of statements from doctors and midwives involved in the delivery of Tommy were read into the record. Oral testimony was given by the first named appellant, two midwives and four medical doctors who were in attendance during the appellant's labour and/or delivery.

5. At the conclusion of the evidence, senior counsel for the appellants addressed the jury for some twenty minutes. Following this, the respondent charged the jury, stating that there were four possible verdicts open to them:-

- (i) An open verdict.

- (ii) A narrative verdict.
- (iii) Medical misadventure/accident.
- (iv) Natural causes.

The respondent gave an explanation in respect of each of these verdicts.

6. The verdict of the jury was death by “*natural causes*” with a recommendation that “*the hospital take a look at their current policies*”. This was a reference to the use of Oxytocin. The appellants in their grounding affidavit stated that they were “*aggrieved and upset*” by the verdict and maintain that Tommy died, not as a result of natural causes, but because of the use of Oxytocin which caused a uterine rupture when it was “*too late to have an organised caesarean section that would have saved his life.*”

#### **Application for Judicial Review**

7. The appellants were granted leave to seek the following reliefs by way of judicial review:-

- (i) An order of *certiorari* quashing the verdict of the coroner delivered on 10 September 2020 in relation to the circumstances in respect of and the cause of death of Tommy Spencer on 18 July 2018 at Cork University Hospital.
- (ii) A declaration that the coroner failed to charge the jury with regard to its duty under the European Convention of Human Rights and the Coroners Acts (Section 18A), to establish the circumstances in which the death occurred.
- (iii) An order directing the holding of an inquest into the death of Tommy Spencer to establish the cause of death and to make findings in respect of the circumstances in which the death occurred.
- (iv) A declaration that the medical care during the first named appellants labour and the use of Oxytocin are material circumstances relevant to the death of Tommy Spencer and its causes.

8. The matter first came on for hearing in the High Court. The appellants filed their grounding affidavit sworn by the first named appellant. The application was supported by an affidavit sworn by the appellants' solicitor which exhibited, *inter alia*, witness statements and the autopsy findings.

9. The respondent filed a statement of opposition grounded on an affidavit sworn by Mr. Philip Comyn, solicitor, the respondent. This affidavit sets out the details of a number of pre-inquest hearings where directions were given as to what written statements were to be made available together with other documentation for the inquest hearing. The respondent's affidavit gave details as to how the inquest was conducted and the names of the doctors and midwives involved in the care and delivery of Tommy. This affidavit stated that he directed the jury as to the four possible verdicts listed at para. 5 above.

10. On the issue of the jury being under a time constraint to bring in a verdict, the respondent stated that at around 4pm a member of the courthouse staff brought to his attention that the building in which the inquest was taking place was due to close at 5pm. The respondent informed those present of this, but the jury were not told that they had to come back with a verdict at any particular time. The jury had previously been informed to be available the following day to continue with their deliberations if necessary.

11. The respondent also filed affidavits from the consultant, the registrar and midwife involved in the care and delivery of Tommy. There was a further affidavit from the appellants' solicitor which took issue as to whether or not there was time pressure on the jury to bring in a verdict. However, the solicitor did not contradict what the respondent swore in his affidavit in this regard.

### **Judgment of the High Court**

12. Following a hearing in the High Court (Bolger J.) delivered a detailed judgment dismissing the application for judicial review ([2022] IEHC 686). In the course of her judgment

Bolger J. set out the background to the application and identified three headings on which the appellants based their challenge to the inquest verdict:

- (i) Irrationality/inadequacy of evidence;
- (ii) Insufficient time allowed for determination;
- (iii) The coroner's charge to the jury.

**13.** On the heading of “*irrationality/inadequacy of evidence*” Bolger J. cited *Bingham v. Farrell* [2010] IEHC 74, a case in which a coroner's verdict was sought to be quashed on the ground that the evidence given did not support 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*”. The trial judge observed that at the inquest, though entitled to do so, the appellants did not call any medical evidence but chose to rely on CGT traces which they claimed showed inappropriate administration of Oxytocin to the first named appellant. The judgment set out the evidence given to the inquest by relevant doctors and midwives and the propositions that were put to them on cross examination by senior counsel for the appellants stating:-

“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*

*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...”*

**14.** Having considered the submissions made the trial judge concluded:-

*“40... The medical witnesses’ evidence is consistently contrary to the propositions put forward by the applicants, through their counsel, to the inquest about inappropriate Oxytocin on Ms. Cummins having experienced hyperstimulation. It is clear that there was ample evidence before the jury in the form of the medical witnesses’ 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 *The State (Keegan & Lysaght) v. Stardust Victims Compensation Tribunal [1986] IR 642* and *O’Keeffe v. An Bord Pleanála [1993] 1 IR 39”*.*

**15.** On the issue of “*insufficient time*” the trial judge observed that this allegation was neither referred to nor supported in the grounding affidavit of the appellants or their solicitor. It was referred to in a subsequent affidavit but not in specific terms. In her judgment the trial judge stated:-

*“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.”*

**16.** The trial judge then considered the appellants’ challenge to the respondent’s charge to the jury. Having considered the evidence the trial judge stated:-

*“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 Appeal**

**17.** There were some seven grounds of appeal, four of which appear to be material. These grounds are as follows:

(1) The learned judge erred in determining that there was:

(a) Sufficient evidence before the coroner and jury to support a verdict that the deceased died of natural causes.

- (b) No or insufficient evidence before the coroner and jury to support a verdict that the deceased died other than of natural causes and/or in consequence of excessive and unwarranted/unmonitored use of Oxytocin during labour and the absence of an early intervention causing uterine rupture leading to hypoxic bradycardia and then to permanent brain injury.
- (2) The learned judge erred in considering that the coroner's charge to the jury was sufficient in the circumstances.
- (3) The learned judge erred in giving little or no weight to the jury being given a record of verdict form pre-printed with the cause of death, upon which to give their verdict.
- (4) The learned judge erred in determining that sufficient time was provided to the jury to consider their verdict and were not put under time pressure by the coroner informing them at 4pm that the courthouse was closing at 5pm.

**18.** There were three further grounds in the notice of appeal concerning the fact that the respondent did not exhibit in his affidavit the notes he made in the course of the inquest hearing. It was stated that the trial judge erred in not considering this to be a breach of the duty of candour on the part of the respondent and that she gave too much weight to the fact that the appellants did not apply for discovery of these notes.

**19.** The Notice Party, University Hospital Waterford, did not take part in the appeal.

### **Discussion**

**20.** The nature and limitations of an inquest are provided for in The Coroners Act 1962 (as amended) ("*the Act of 1962*"). The following sections are relevant to this appeal:

#### Section 18A

*"18A. (1) The purpose of an inquest shall be to establish—*

*(a) the identity of the person in relation to whose death the inquest is being held,*

*(b) how, when and where the death occurred, and*



*(c) to the extent that the coroner holding the inquest considers it necessary, the circumstances in which the death occurred, and to make findings in respect of those matters (in this Act referred to as 'findings') and return a verdict."*

### Section 30

*"30.—Questions of civil or criminal liability shall not be considered or investigated at an inquest."*

### Section 31

*"31. - (1) Neither the verdict nor any rider to the verdict at an inquest, nor any findings made at an inquest, shall contain a censure or exoneration of any person.*

*(2) Notwithstanding anything contained in subsection (1) of this section, recommendations of a general character that are designed to prevent further fatalities or are considered necessary or desirable in the interests of public health or safety may be appended to the verdict at any inquest."*

**21.** The effect of these statutory provisions has been considered on several occasions by the Supreme Court. I refer to two decisions, *Farrell v. the Attorney General* [1998] I.R. 203 and *Eastern Health Board v Farrell* [2001] 4 I.R. 627. In the latter decision Keane C.J. stated at p. 636:

*"In my judgment in Farrell v. Attorney General [1998] 1 I.R. 203 at p. 223, I cited with approval the following description by Lane L.C.J. in R. v. South London Coroner, ex parte Thompson (The Times, 9th July, 1982) of the nature of an inquest:-*

*'It should not be forgotten that an inquest is a fact-finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no*

*prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring which ever metaphor one chooses to use.'*

...

*Ultimately, however, the issue for resolution in the High Court and again in this court is as to the proper construction to be given to the wording of s. 30 of the Act of 1962, i.e.:-*

*'Questions of civil or criminal liability shall not be considered or investigated at an inquest and accordingly every inquest shall be confined to ascertaining the identity of the person in relation to whose death the inquest is being held and how, when, and where the death occurred.'*

*While this provision undoubtedly lays stress on the limited nature of the inquiry to be conducted at an inquest, the prohibition on any adjudication as to criminal or civil liability should not be construed in a manner which would unduly inhibit the inquiry. That would not be in accord with the public policy considerations relevant to the holding of an inquest to which I have referred. It is clear that the inquest may properly investigate and consider the surrounding circumstances of the death, whether or not the facts explored may, in another forum, ultimately be relevant to issues of civil or criminal liability. The intention of the Oireachtas that the inquest should not simply take the form of a formal endorsement by the coroner or a jury of the pathologist's report on the post-mortem is also made clear by s. 31 which, although prohibiting the inclusion in the verdict or any rider to it of any censure or exoneration of any person, goes on to provide in subs. 2 that:-*

*‘notwithstanding anything contained in sub-section (1) of this section, recommendations of a general character designed to prevent further fatalities may be appended to the verdict at any inquest.’*”

**22.** It should be noted that in *Eastern Health Board v. Farrell* the court was considering the provisions of s. 30 of the Act of 1962 prior to its amendment but the amendment copperfastened the nature of an inquest, as explained by Keane C.J.. The amended version of s. 30 is set out above.

**23.** These are judicial review proceedings and not an appeal of the verdict brought in by the jury at the inquest. The trial judge referred to the passage from the judgment in *Bingham v. Farrell* as set out at para. 13 above and also referred to the test set out in *State (Keegan and Lysaght) v. Stardust Compensation Tribunal* [1986] IR 642. This test was stated in the oft cited passage from the judgment of Finlay C.J. *O’Keeffe v. An Bord Pleanála* [1993] 1 I.R. 39 as follows:

*“(a) ‘Irrational decision’*

*The question arising on this issue falls to be decided in accordance with the principles laid down by this Court in The State (Keegan) v. Stardust Compensation Tribunal 1986 IR.642 which are set out in the judgment of Henchy J. in that case, with which in respect of the legal principles applicable, all the other members of the Court specifically agreed.*

*In dealing with the circumstances under which the Court could intervene to quash the decision of an administrative officer or tribunal on a grounds of unreasonableness or irrationality, Henchy J. in that judgment set out a number of such circumstances in different terms.*

*They are:*

*‘1. It is fundamentally at variance with reason and common sense.*

2. *It is indefensible for being in the teeth of plain reason and common sense.*
3. *Because the Court is satisfied that the decision-maker has breached his obligation whereby he 'must not flagrantly reject or disregard fundamental reason or common sense in reaching his decision'.*

In the course of the appeal the appellant did not challenge the appropriateness of the test applied by the trial judge.

24. The first submission made by the appellants on the oral hearing of the appeal concerned the use of a pre-printed form which sets out “*cause of death*” that only provides for the proximate cause of death. It was submitted that the use of such a form does not permit the circumstances of the death to be set out. Under s. 18A, set out above, an inquest can establish the circumstances of a death where the coroner considers it necessary.

25. The issues concerning the use of the printed form were not referred to in the statement of grounds and so were not addressed in the judgment of the court below. Though this, of itself, is sufficient to reject this ground of appeal this court will consider the issue. The form used at the inquest is provided for in the Coroners Act 1962 (Forms) Regulations, 1962 (S.I. No. 94 of 1962) which provides by art. 5 that:-

*“The record of verdict at an inquest shall be in the form set out in the Fourth Schedule to these Regulations.”*

26. The “*record of verdict*” of the death of Tommy Spencer stated:

***“The cause of death was:***

***(disease or condition directly leading to death)***

*1 (a) Acute Hypoxic Ischaemic Encephalopathy*

***due to (or as a consequence of) Antecedent causes)***

*1 (b) Intra-uterine hypoxia*

*due to (or as a consequence of) Morbid conditions, if any, giving rise to the above cause)*

*1 (c) Placental Malperfusion (an association of encephalopathy)*

**Verdict:**

*Natural causes”.*

These findings were derived from a pathology report prepared for the inquest. This report had a concluding comment “*Baby Tommy died following an agreed decision to withdraw life support.*”

**27.** It is clear that the cause of death, set out in the form, was not just a statement of the proximate cause of death but referred to events that took place whilst Tommy was in utero. Such were the circumstances that led to his death. As to the cause of these events, that may be a matter for another forum which could involve issues of civil liability which are clearly outside the jurisdiction of an inquest.

**28.** The substantive part of the appeal concerned the submission that the evidence for the inquest did not support the verdict of natural causes and the trial judge erred in concluding that there was relevant evidence on which the verdict was based. In the course of her judgment Bolger J. set out the evidence of Dr. Asaait, consultant obstetrician. This evidence was to the effect that there was no hyperstimulation and that the midwife in charge noted “*that proper contractions were present, that they were good, and that there was a good resting tone*”. The trial judge also referred to the evidence of Dr. Botros, registrar, who stated that some six minutes prior to his suspecting that the first named appellant had a ruptured uterus, his examination showed a soft abdomen with no scar tenderness.

**29.** In addition, the trial judge had before her an affidavit from a midwife who gave evidence before the inquest which stated that there was continuous monitoring of the use of

Oxytocin and that there was no evidence of hyperstimulation such that the use of Oxytocin could have been discontinued any earlier than it was.

**30.** The appellants took a different view as to what caused or contributed to the uterine rupture and the subsequent death of Tommy. Various propositions were put by counsel for the appellants to medical and midwifery witnesses on cross examination. However, no medical or midwifery evidence was called by the appellants to support these propositions. As the trial judge observed, *“there is an obvious and fundamental difference between evidence given and propositions made.”* While an affidavit sworn by the appellants’ solicitor had presaged an application to cross examine the respondent and the solicitor who had acted for the hospital at the inquest, no such application was ever made. Applying the principles from the authorities cited, the trial judge was correct in concluding that there was evidence before the jury upon which it could lawfully bring in a verdict of death as a result of *“natural causes”*.

**31.** The appellants challenged the coroner’s direction to the jury as to the verdicts that were available. The trial judge, correctly, placed emphasis on the fact that at the inquest hearing counsel for the appellants did not seek to challenge the direction given by the respondent. Indeed, the trial judge could reasonably have added that counsel for the appellants addressed the jury for some twenty minutes prior to the charge given by the respondent.

**32.** In the course of her judgment the trial judge considered what verdict the appellants hoped to get from the jury. She said:-

“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.”

**33.** The appellants case set out at para. 31 of the statement of grounds was that the coroner should have directed the jury that the findings about the circumstances in which Tommy had died, which were reasonably available to them to make, included, *inter alia*:-

*“c. Oxytocin was administered during Ms. Cummins’ labour without adequate consultation with, or informed consent from, Ms. Cummins and/or by assuming informed consent was given.*

*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, as per reference period exceeded the required limits, and/or, was not investigated further, and not acted upon by ceasing the use of Oxytocin.”*

Para. 19 above set out the provisions of ss. 30 and 31 of the Act of 1962 which expressly exclude questions of civil liability being considered or investigated. Thus, the verdict sought by the appellants at para. 31 of the statement of grounds would not have been permissible as it clearly questions the care given and use of Oxytocin by the medical and midwifery staff in attendance.

**34.** The appellants sought to rely on the provisions of s. 16A of the Act of 1962. However, s. 16A has nothing to do with what verdicts may be brought in by a jury at an inquest as it deals with *“reportable deaths”*. Section 16A does not abridge or limit the effects of ss. 30 and 31.

**35.** As for the submission that the jury were under a time constraint to bring in a verdict, the trial judge pointed to the lack of evidence on the part of the appellants to support this contention, referring specifically to the grounding affidavits for the application. Indeed, it could be further pointed out that when the respondent informed the inquest hearing that the

courthouse was due to close at 5:00 p.m., no clarification or objection was sought or made by counsel for the appellants.

**36.** In the course of her judgment the trial judge referred to the decision of Barrett J. in *Murtagh v. Kilrane & Ors* [2017] IEHC 384 where he confirmed that a respondent in judicial review proceedings should disclose to the court all materials in his possession which are relevant to the decision sought to be impugned. However, referring to the decision of Edwards J. in *D O'Q v. Judge Buttimer* [2019] IEHC 25, which concerned an application for discovery in judicial review proceedings of the notes made by a Circuit Court judge during family law proceedings, Edwards J. determined that it was not appropriate to allow discovery of the judges' notes as it would represent an impingement on the judge's constitutionally guaranteed independence. Edwards J. concluded that if discovery of a judge's notes was theoretically possible, it could only happen in the most exceptional circumstances where the necessity for it was clearly demonstrable. The trial judge stated:

“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 in 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 applicant's challenge to the jury's verdict of death by natural causes.”

**37.** If the appellants believed the respondents notes to be either relevant or necessary, it was open to them to bring an application for discovery prior to the hearing in the High Court. This they did not do. As stated earlier, the appellants were represented in court by senior counsel and a solicitor who was in a position to take notes of the hearing. Although the appellants have referred to a number of propositions that were put to the medical and midwifery witnesses, they



have not identified any evidence which would have rendered the verdict brought in by the jury to be irrational. Thus, the appellants failed to establish any basis on which the respondents' notes might be either relevant or necessary to these proceedings.

### **Conclusion**

**38.** By reason of the foregoing, the appeal will be dismissed. As for costs, the provisional view of the court is that as the appellants have been entirely unsuccessful in their appeal, costs should follow the event and an order for costs is to be made against the appellants. I will direct that the appellants submit written submissions on the matter of costs, not exceeding 1,000 words, within fourteen days of the date of this judgment and the respondent has fourteen days thereafter to respond.

**39.** As this judgment is being delivered electronically, Allen and Burns J.J. have authorised me to record their agreement with it.