Neutral Citation Number: [2019] EWHC 1232 (Admin)

Case No: CO/3988/2018

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 15/05/2019

**Before**:

**LORD JUSTICE IRWIN**
**MRS JUSTICE FARBEY**
**HIS HONOUR JUDGE LUCRAFT QC**
**(Sitting as a Judge of the High Court)**

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**Between:**

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| **THE QUEEN (on the application of MURIEL MAGUIRE)** | **Claimant** |
| **- and -** | |
| **HER MAJESTY'S SENIOR CORONER FOR BLACKPOOL AND FYLDE** | **Defendant** |
| **-and-** | |
| **(1) UNITED RESPONSE** | |
| **(2) NORTHWEST AMBULANCE SERVICE** | |
| **(3) BLACKPOOL VICTORIA TEACHING HOSPITAL** | |
| **(4) DR SARFARAZ ADAM** | |
| **(5) DR SUSAN FAIRHEAD** | |
| **(6) BLACKPOOL CITY COUNCIL** | |
| **(7) CARE QUALITY COMMISSION** | **Interested Parties** |
| **(8) KENNETH MAGUIRE** | |

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**Ms V Butler-Cole QC and Ms N Kohn** (instructed by **Bindmans LLP**) for the **Claimant**
**Miss S Cartwright** (instructed by **Blackpool City Council**) for the **Defendant**
**Miss C Watson** (instructed by **DAC Beachcroft**) for the **1st Interested Party**
**Miss M Fanneran** (instructed by **North West Ambulance Service**) for the **2nd Interested Party**
**Miss A Samuel** (instructed by **Blackpool Victoria Teaching Hospital**) for the **3rd Interested Party**
**Mr A Perfect** (instructed by **MDDUS**) for the **4th Interested Party**

Hearing dates: 1st and 2nd April 2019

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# Approved Judgment

## Introduction

1. This is the judgment of the court, to which all members have contributed.

2. Jacqueline Maguire (known to all as Jackie) died in hospital of a perforated ulcer at the age of 52 on 22 February 2017. Jackie had Down's syndrome and moderate learning difficulties. She required one-to-one support and had severely compromised cognitive and communication abilities. By the time of her death, she suffered limited mobility, needing a wheelchair to move around outside.

3. Jackie had lived for more than 20 years in a care home in Lytham St Anne's, Blackpool. A post-mortem examination concluded that her death was as a result of a perforated gastric ulcer with peritonitis and pneumonia.

4. HM Senior Coroner for Blackpool and Fylde, Mr Alan Wilson, opened an inquest into Jackie's death on 3 August 2017. The substantive inquest with a jury took place between 20 and 29 June 2018.

5. A few days before the inquest started, a division of this court handed down judgment in *R (Parkinson) v Kent Senior Coroner* [2018] EWHC 1501 (Admin), [2018] 4 WLR 106. That judgment gave guidance on the circumstances in which article 2 of the European Convention on Human Rights may apply in circumstances where a person dies while a patient in a hospital. The Coroner in the present case had at an interim stage considered that article 2 was engaged and had conducted the inquest on the basis that article 2 applied. At the conclusion of the evidence, the Coroner reconsidered the position in light of *Parkinson*. He ruled that the allegations against Jackie's carers and healthcare providers amounted to allegations of individual negligence, which *Parkinson* had clarified as falling outside the state's obligations under article 2.

6. At the same time, the Coroner considered the question of neglect, namely whether there had (under the relevant Chief Coroner's guidance) been a gross failure to provide Jackie with basic medical attention. He ruled that there was insufficient evidence safely to leave the question to the jury. At the end of their deliberations, they concluded that Jackie's death was from natural causes.

7. By these judicial review proceedings, Jackie's mother, Mrs Muriel Maguire, challenges two decisions made by the Coroner. First, she challenges his decision that article 2 was not engaged by the circumstances of Jackie's death. Secondly, she challenges his decision not to leave a determination of neglect to the jury.

8. In addition to the Coroner, a number of the interested persons at the inquest were joined as interested parties in these proceedings. We are grateful to all parties for their helpful submissions.

## The facts

9. We take the factual background from the evidence before the Coroner. We do not understand the significant facts to be in dispute.

10. Jackie had been living in the care home at Lytham St Anne's since 1993. The home was managed by the first interested party United Response. Jackie's placement was paid for and supervised by Blackpool City Council (the sixth interested party). The home provided accommodation for people with learning difficulties who required personal care. It was not a nursing home: staff were not medically or nursing trained. Like other residents, Jackie had been deprived of her liberty under the Mental Capacity Act 2005 to the extent that she was prevented from leaving the home without supervision. The doors of the home were kept locked.

11. The Coroner was provided with the most recent assessment of Jackie's capacity under sections 1-3 of the 2005 Act. The assessment contains reports by a psychiatrist Dr Safdar Ali and by Mr John Davies Fryar (an appropriately qualified social worker) who was employed by Blackpool Social Services.

12. Dr Ali concluded that, as a consequence of her learning disabilities, Jackie lacked capacity to make her own decisions about whether she should be accommodated in the care home for the purpose of receiving care and treatment. He noted that Jackie was "totally dependent" on staff for her day-to-day care. He described her as "a vulnerable adult with no insight". In his opinion, Jackie fell to be considered for deprivation of liberty safeguards in her best interests.

13. Mr Davies Fryar also concluded that it was in Jackie's best interests to be deprived of her liberty for the purpose of being given care and treatment. His report noted that staff in the care home made sure that she had appropriate and timely access to her GP and other NHS services. The home was said to maintain Jackie's safety and welfare which she would not otherwise be able to maintain for herself.

14. On the basis of these two reports, Blackpool City Council had on 7 April 2016 renewed its decision to deprive Jackie of her liberty, imposing deprivation of liberty safeguards (DOLS) on a one-year standard authorisation under section 4 and Schedule A1 of the 2005 Act. It appears that United Response had put in place a care plan (dated April 2016). Like the Coroner, we were supplied only with an incomplete copy.

15. Against this background, we turn to the events that preceded Jackie's death. In the week prior to her death, Jackie had complained of a sore throat and had a limited appetite. For about two days before she died, she had suffered from a raised temperature, diarrhoea and vomiting. On 20 February 2017, Jackie asked to see a GP. Staff at the care home did not act on that request at the time.

16. On 21 February 2017, at 2.55pm, one of Jackie's carers telephoned her GP practice and requested that a GP visit Jackie, as she had suffered a "possible collapsing episode" and had refused food and drink. The receptionist told the carer that the request for a visit would be considered later in the day. At 3.20pm the carer telephoned the GP practice again to report further symptoms.

17. At around 3:30pm a carer telephoned NHS111 for the North West of England, which is an NHS out-of-hours medical advice service and is run by the Northwest Ambulance Service (NWAS) which is the second interested party. The carer was put through to a Health Adviser who asked a series of questions about Jackie's symptoms and advised the carer to telephone Jackie's GP. The carer explained that the GP had

been contacted but had not responded. The Health Adviser said that the GP should be contacted again with a request for a home visit within two hours.

18. At 4.59pm Dr Sarfraz Adam (who was Jackie's GP and is the fourth interested party) telephoned the care home and spoke to a carer about Jackie's symptoms and condition. He concluded that she was suffering from viral gastroenteritis and a urinary tract infection. He did not make a home visit; instead he prescribed anti-sickness tablets and an antibiotic.

19. At 7.10pm a second carer telephoned NHS111. It seems that NHS111 considered Jackie's situation until 7.48pm when the service made an emergency call to NWAS asking for an ambulance to be dispatched urgently. Owing to administrative error, the ambulance crew were not informed that Jackie had a history of Down's Syndrome and learning difficulties.

20. The two-person crew arrived at the care home and reached Jackie just after 8.00pm. The Coroner had a statement and heard oral evidence from one of the crew, paramedic Hannah Ayres. She explained that Jackie had refused to be taken to hospital. Neither the ambulance crew nor staff at the home were able to persuade her. The crew formed the view (with which staff at the care home concurred) that it would have been disproportionate to use physical force, in the light of Jackie's apparently limited symptoms. According to Ms Ayres, Jackie was not displaying any "red flag signs" that her life was at immediate risk. Ms Ayres told the Coroner that she was not qualified to sedate Jackie in order to convey her to the ambulance. In her view, the use of physical restraint would have led to a high likelihood of injury or harm.

21. Ms Ayres decided to seek advice from an out-of-hours GP, speaking to Dr Susan Fairhead (the fifth interested party) at around 8.30pm. On the basis of what she was told, Dr Fairhead advised that it would be inappropriate to use physical force. In her evidence to the Coroner, Dr Fairhead accepted that her triage was poor. She said that, had she sought further information about Jackie's condition, she would have asked the visiting doctor to attend. She recommended that Jackie be watched overnight and taken to see her GP in the morning. A final attempt was made to persuade Jackie to go to hospital when Mrs Maguire telephoned the home but to no avail. As a result, Jackie remained at the care home on that night.

22. On the morning of 22 February 2017, staff found Jackie lying soiled on the floor. While they were assisting her to go to the toilet, she collapsed. She was taken to hospital by ambulance where, tragically, in the evening, she died.

**The inquest**

23. At the inquest, in addition to the claimant, United Response, NWAS, Blackpool Victoria Teaching Hospital, Dr Adam and Dr Fairhead were all present and legally represented. A representative of the Care Quality Commission (CQC) attended but the Commission was not legally represented. Mr Kenneth Maguire, Jackie's brother and the eighth interested party in this claim, was not represented. He attended the first day of the jury Inquest hearing.

24. The first Pre-Inquest Review Hearing (PIRH) took place on 8 September 2017. At that hearing the Coroner ruled that he did not believe that article 2 ECHR was engaged.

25. A further PIRH took place on 21 December 2017. Submissions were made about a number of issues before the Coroner. Following the hearing the Coroner, through the Coroners Support Officer, sent an email setting out his determinations as to article 2, scope, interested persons, expert evidence, inquest date and length as well as regulation 28 reports. In relation to article 2 the Coroner stated: "… it is the view of the court that there is an arguable breach and Article 2 ECHR is engaged…"

26. As set out above, the inquest with a jury started on 20 June 2018. On 15 June 2018, judgment had been handed down in *Parkinson*. It is clear from the transcript of the hearing before the Coroner that he, as well as representatives for the interested persons, had just been made aware of the decision when this inquest started. The following interchange between counsel for the Blackpool Victoria Hospital Trust, Ms Samuel and the Coroner took place:

> Ms Samuel: *".. the interested persons reserve their right to come back and argue the applicability of Article 2 before the jury are directed by yourself in order to give us some time to digest that judgment."*
> Coroner: *"It was brought to my attention relatively recently as well. I do not think we can do anything else but if we need to re-visit it as we go along."*
>
> Ms Samuel: *"I think we have to. Certainly the evidence is not going to change. You have already got all of the evidence you would get in any event as to whether it was an Article 2 or, arguably even it was not, so it seems in reality it is going to come down to does that Article 2 decision stay in place when you give directions to the jury? If not, then maybe that is the point to re-visit it, but we would need to have time to digest it and read that case rather than trying to rush and deal with it today."*
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> Coroner: *"I do not think we need to go into it any greater detail. We are almost in one of those situations where coroners always used to say, "We are going to have an Article compliant inquest and then when we have heard all the evidence we will see whether it is Article 2 or not". But let's park that for the moment. I am grateful for the indication."*

The inquest before the jury then got underway. Called to give evidence in the course of the inquest were some 30 witnesses, including Jackie's mother Mrs Muriel Maguire, and relevant nursing, care and medical staff, as well as expert witnesses.

**The claim for judicial review**

27. Following pre-action correspondence with the defendant, the claimant filed an application for judicial review on 26 September 2018. Permission to apply for

judicial review was initially refused, but was subsequently granted by Supperstone J at a hearing on 6 February 2019.

28. As we have indicated, the grounds for judicial review are essentially twofold. First, the claimant contends that the defendant erred in law by determining at the end of the evidence that article 2 no longer applied under *Parkinson*, thereby prejudging a matter that should have been left to the jury. Secondly, the Coroner erred in law by determining that the jury should not be directed to consider whether neglect should form part of their conclusion.

29. By the time of the hearing before us, the Coroner had decided to take a neutral position on these questions as did NWAS and the third interested party Blackpool Victoria Teaching Hospital (which is where Jackie died). Dr Fairhead denied that the Coroner was wrong, both generally and in relation to matters which concerned her. Dr Adam supported the Coroner's decisions. Mr Kenneth Maguire made succinct written submissions which essentially supported the claimant. Neither Blackpool City Council nor the CQC took any part in the proceedings. The principal opposition to the claim, both orally and writing, was provided by United Response who supported the Coroner's decision both in relation to article 2 and in relation to neglect.

**State duties under Article 2**

30. Article 2 provides that everyone's right to life shall be protected by law. It is now well established that the state's obligations under article 2 have two aspects. First, there is the duty to refrain from taking life unlawfully. In addition, the state has a positive obligation to take appropriate steps to safeguard the lives of those in its jurisdiction: *Osman v United Kingdom* (1998) 50 EHRR 695. In relation to this positive obligation, the primary duty is to put in place effective criminal law provisions together with law enforcement machinery for the prevention and punishment of crime. Article 2 may also imply a positive obligation on the authorities to take preventive operational measures to protect an individual whose life is at risk from criminal acts: *Osman*, para 115. This latter obligation has become known as the operational duty.

31. The ECtHR at paragraph 116 of *Osman* recognised that the operational duty must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities. In order to demonstrate a breach of the duty, it must be established by way of a fact-sensitive enquiry that:

> "the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures… which, judged reasonably, might have been expected to avoid that risk".

32. The subsequent caselaw of the ECtHR has expanded the positive duty beyond the enforcement of the criminal law. The duty to protect prisoners from suicide was established in *Keenan v United Kingdom* (2001) 33 EHRR 913. Subsequent cases (both in the ECtHR and domestically) have held that forms of detention other than imprisonment may engage article 2 including immigration detention (*Slimani v France* (2004) 43 EHRR 1068) and the detention of psychiatric patients in hospital

(*Savage v South East Essex NHS Foundation Trust (MIND and others intervening*) [2008] UKHL 74, [2009] 1 AC 681).

33. Although the duty to protect detainees from suicide has formed a particular focus for the ECtHR, the reach of article 2 has developed to include death from egregious lack of medical treatment. In *Dzieciak v Poland* (Application no. 77766/01), the ECtHR found that article 2 had been breached in circumstances where a prisoner in pre-trial detention had not received adequate and prompt medical care. In *Centre for Legal Resources on behalf of Valentin Campeanu v Romania* (2014) 37 BHRC 423, the failure to provide a psychiatric patient with basic medical treatment and care breached article 2. A similar conclusion was reached in *Jasinskis v Latvia* (Application no. 45744/08) which concerned the authorities' decision to detain an individual in a police station and delay taking him to hospital.

34. In cases where article 2 is engaged in this way, the individual to whom the positive obligation is owed by the state is vulnerable in the sense that he or she is under the control of the state and unable to get away from the dangers posed by detention. The state must be regarded in these circumstances as having assumed responsibility for the individual's safety and for preventing death: *Savage*, para 28.

35. By parity of reasoning, the *Osman* positive duty has been extended to situations where the individual is not detained but where the state exercises a degree of legal or practical control: the suicide of conscripts (see cases cited in *Savage*, paras 34-38); the transfer of elderly residents from one care home to another with risk to life expectancy (*Watts v United Kingdom* (2010) 51 EHRR SE 66); and the suicide of voluntary psychiatric patients *(Rabone v Pennine Care NHS Trust (INQUEST and others intervening)* [2012] UKSC 2, [2012] 2 AC 72) to which we will return below.

36. In *Fernandes de Oliveira v Portugal* (Application no. 78103/14), the ECtHR recognised the emerging trend of imposing the least necessary restrictions in the care of persons with mental disorders through "open door" regimes. Less restrictive regimes cannot exempt the state from its obligations to protect mentally ill patients from the risks they pose to themselves and in particular the risk of suicide (para 73).

37. Healthcare failures have however been treated as a separate class of case and deaths in hospital will not generally engage article 2. The state's positive obligations in relation to healthcare and medical treatment are regulatory: the state must put in place an effective framework that compels hospitals to adopt appropriate measures to protect patients' lives: *Lopes de Sousa Fernandes v Portugal* (2018) 66 EHRR 28, para 186.

38. The Coroner in the present case applied the guidance in *Parkinson* which held, at paragraph 87, that where a state has made provision for securing high professional standards among health professionals and the protection of the lives of patients, matters such as errors of professional judgment or negligent coordination among health professionals in the treatment of a particular patient will not be sufficient to engage article 2. In reaching this conclusion, the court in *Parkinson* reflected the reasoning of earlier cases such as *Powell v United Kingdom* (2000) 30 EHRR CD 362. *Parkinson* is now authority for the proposition that a medical case (in which negligent medical treatment may incur liability in tort) will not generally engage article 2.

39. Nor will the positive duty under article 2 always be engaged by the death of a detainee or of a person in the care of the state. In particular, death by natural causes will not engage article 2 in the absence of any reason to believe that the state failed to protect the life of the individual in question. The sort of failure of protection for which the state would be responsible would be a failure to provide timely and appropriate medical care to a prisoner obviously in need of it: *R (Tyrrell) v HM Senior Coroner County Durham and Darlington and Ministry of Justice* [2016] EWHC 1892 (Admin), para 33.

40. In our view the following principles emerge from the cases. First, in the absence of systemic or regulatory dysfunction, article 2 may be engaged by an individual's death if the state had assumed responsibility for the individual's welfare or safety. As expressed by Lord Rodger in *Mitchell v Glasgow City Council* [2009] AC 874, para 66 (cited in *Rabone*, para 22):

> "In particular, where a state assumes responsibility for an individual, whether by taking him into custody, by imprisoning him, detaining him under mental health legislation, conscripting him into the armed forces, the state assumes responsibility for that individual safety. So in these circumstances police authorities, prison authorities, health authorities and the armed forces are all subject to positive obligations to protect the lives of those in their care".

41. Secondly, in deciding whether the state has assumed responsibility for an individual's safety, the court will consider how close was the state's control over the individual. Lord Dyson observed in paragraph 22 of *Rabone* that the "paradigm example" of assumption of responsibility is where the state has detained an individual, whether in prison, in a psychiatric hospital, in an immigration detention centre or otherwise. In such circumstances, the degree of control is inevitably high.

**The parties' submissions on article 2**

42. Ms Butler-Cole QC (together with Ms Kohn) on behalf of the claimant submitted that the Coroner had misdirected himself in law by treating Jackie's case as a purely medical case under *Parkinson*. The law since *Osman* (she contended) has developed so that the court should now recognise the state's positive obligations under article 2 towards those who may be described as "particularly vulnerable persons under the care of the state" (*Parkinson*, para 63). Alternatively, the Coroner ought to have concluded that there was sufficient evidence of systemic problems in events leading to Jackie's death that article 2 ought to have been left to the jury. There had been no effective communication system between those authorities charged with protecting Jackie (GP services, NHS111, the ambulance service and the hospital) and no individual with oversight of Jackie's healthcare who could convey an accurate account of her symptoms in circumstances where she was unable to do so. These were regulatory and structural failures. Together with the failure to sedate Jackie on the evening of 21 February, they were capable of amounting to systemic dysfunction.

43. On behalf of United Response, Ms Watson submitted that although Jackie was living in a residential care home under a standard authorisation there could be no dispute that she had died of natural causes. The substantive obligation to have in place a

system to protect the lives of patients or service-users like Jackie had been met. The claimant's criticisms related to the steps taken to facilitate Jackie's access to medical care and treatment. Any deficiencies were individual failings attributable to errors or bad judgment in relation to the procedures which were in place to protect people such as Jackie. The Coroner had correctly applied *Parkinson* and correctly concluded that this was a medical case in which article 2 was not engaged.

**Analysis and conclusions on article 2**

44. That the case law has extended the positive duty beyond the criminal justice context in *Osman* is not in doubt. The reach of the duty, beyond what Lord Dyson called the "paradigm example" of detention, is less easy to define. We have reached the conclusion, however, that the touchstone for state responsibility has remained constant: it is whether the circumstances of the case are such as to call a state to account: *Rabone*, para 19, citing *Powell*. In the absence of either systemic dysfunction arising from a regulatory failure or a relevant assumption of responsibility in a particular case, the state will not be held accountable under article 2.

45. Applying these principles to the present case, we have carefully considered the chain of events in the days before Jackie's death: Dr Adam's failure to make a home visit; Dr Fairhead's failure to triage properly or to elicit a full history from carers; the paucity of advice from NHS111; the difficulties experienced by Ms Ayres and her colleague who had not been notified that Jackie had Down's syndrome and who found themselves unable to take Jackie to hospital. It may fall to others to decide whether any failures give rise to individual civil liability or professional disciplinary proceedings. They are not, however, capable of demonstrating systemic failure or dysfunction. Such failings as there may have been were attributable to individual actions and do not require the state to be called to account.

46. We should add that the academic and general evidence relating to premature deaths of people with learning disabilities, produced in these proceedings but not supplied to the Coroner, cannot advance Ms Butler-Cole's submissions on systemic failure. On conventional principles of judicial review, the Coroner's ruling cannot be impugned by reference to evidence that was not before him.

47. As to the responsibility which the state assumed here, Jackie was a vulnerable person for whom the state cared. In her written submissions, Ms Butler-Cole relied on the placement at the care home and the deprivation of liberty in respect of that placement. She emphasised the evidence about Jackie's reliance on her carers and other professionals in relation to medical treatment and healthcare. However, in oral submissions, supplemented by a written Reply, she accepted that mental incapacity sufficient to justify deprivation of liberty under the Mental Capacity Act is insufficient on its own to trigger the engagement of article 2. This was an important and proper concession.

48. We agree that a person who lacks capacity to make certain decisions about his or her best interests - and who is therefore subject to DOLS under the 2005 Act - does not automatically fall to be treated in the same way as Lord Dyson's paradigm example. In our judgment, each case will turn on its facts.

49. Where the state has assumed some degree of responsibility for the welfare of an individual who is subject to DOLS but not imprisoned or placed in detention, the line between state responsibility (for which it should be called to account) and individual actions will sometimes be a fine one. However, it was the function of the Coroner to draw it. This court will not interfere save on grounds of irrationality or other error of law. The Coroner's approach reveals no such error. On the evidence before the Coroner, it was open to him to conclude that this was a medical case and that a jury could not safely find that Jackie died as a result of any actions or omissions for which the state would be responsible. The Coroner considered the relevant issues and reached a conclusion that was open to him. This ground of challenge fails.

**Neglect**

50. We turn to the second ground of challenge which relates to the Coroner's decision not to leave a finding of neglect to the jury. In his ruling, the Coroner set out parts of the Chief Coroner's Guidance on Conclusions, and paragraphs 74 to 85 in particular, which deal with neglect. The Coroner referred to the definition of neglect in the decision in *R v HM Coroner for North Humberside and Scunthorpe, ex parte Jamieson* [1995] QB 1 as set out in paragraphs 76, 77 and 78 of the Guidance. The Coroner then stated:

> "Whether neglect ought to be left to the jury, however, needs consideration of the following, first, whether there is evidence of a gross failure and, secondly, whether the arguably neglectful conduct can be said to have a clear and direct causal connection with the death. …. So far as the clear and direct causal connection is concerned, we have heard evidence from Dr Shaktawat, the pathologist, giving evidence that, in his views, the direct cause of death related to the perforation of a gastric ulcer, albeit with evidence of pneumonia, which is why it is put as part 2 of the medical cause of death. In relation to arguably gross failings, the court is of the view that there are no individual failings that could be safely put before the jury as arguably gross".

51. The Coroner went on to consider the question of whether neglect ought to be aggregated or left to the jury on a cumulative basis. He concluded that it would not be *Galbraith* safe to leave neglect to the jury in the circumstances of Jackie's death. This was a reference to the decision of this court in *R (Secretary of State for Justice) v. HM Deputy Coroner for the Eastern District of West Yorkshire* [2012] EWHC 1634 (Admin) where Haddon-Cave J (as he then was) said that the *Galbraith* test alone was not enough. More was needed: ".. would it be safe to for the jury to convict on the evidence before it?". He also concluded that it would not be appropriate to accumulate failings.

52. No issue is taken over the legal framework adopted by the Coroner. Ms Butler-Cole submits that the Coroner was wrong to proceed on the basis that only the presence of one or more individual failings that could each be described as "gross" could justify neglect being left to the jury. She submits that acts or omissions by different individuals and/or different failures in the system can combine to form a "total picture that amounts to neglect". In support she relies on the decision of this court in *R*

*(Lewis) and others v. HM Coroner for Shropshire and others* [2009] EWHC 661 (Admin).

53. It is also submitted that the Coroner was in error to exclude actions prior to an assessment made by paramedics on 21 February 2017 from being potentially accumulating factors. He wrongly failed to consider whether various individual failings, taken as a whole, were capable of being viewed by the jury as amounting to a gross failure to provide basic medical care to a vulnerable person.

54. Ms Watson submitted that, on a full analysis of the evidence, there was insufficient evidence upon which the jury could have found that Jackie's death would have been prevented had the medical professionals who dealt with her acted differently. She also submitted that there were a number of gaps or grey areas in the causation evidence so that the jury would have been required to engage in speculation when considering whether, absent the alleged gross failures, Jackie's death could have been prevented. She submitted that the Coroner was right to make the assessment he did on the issue of neglect.

55. In submissions before us the Ms Cartwright on behalf of the Coroner takes a neutral stance. Counsel for the remaining interested persons adopted the submission made by Ms Watson.

56. Guidance No 17 issued by the Chief Coroner on 30th January 2015 and revised on 14th January 2016 sets out guidance "... to assist coroners in the use of short-form and narrative conclusions and with a view to achieving greater consistency across England and Wales." Paragraphs 19 to 21 set out as follows:

> "19. There are two alternatives for conclusions which are sanctioned by the Coroners and Justice Act 2009, the Coroners (Inquests) Rules 2013 and the common law as expounded in case law: (1) a short-form conclusion and (2) a narrative conclusion. It is also permissible to combine the two types of conclusion.
>
> 20. The conclusion, short-form or narrative, must be entered in Box 4 of the Record of Inquest.
>
> 21. There must always be sufficient evidence on a Galbraith plus basis for a conclusion."

57. On page 13 of the Guidance the focus is on neglect. The Coroner referred to paragraphs 74 to 85 and to paragraphs 74, 76 and 77 in particular. Those paragraphs and 78 to 80 state:

> "74. The following does no more than outline the concept of neglect in coroner law. Neglect is not a conclusion in itself. It is best described as a finding. It must be recorded as part of the conclusion (in Box 4). It has a restricted meaning according to the case law. It should not be considered as a primary cause of death.

> 75. A finding of neglect (formerly lack of care) was specifically approved in Jamieson. It may form part of the conclusion in Box 4, either as words added to a short-form conclusion (see paragraph 32 above) or as part of a narrative conclusion.
>
> 76. Neglect is narrower in meaning than the duty of care in the law of negligence. It is not to be equated with negligence or gross negligence. It is limited in a medical context to cases where there has been a gross failure to provide basic medical attention.
>
> 77. The deceased must have been in a dependent position (because of youth, age, illness or incarceration): see next paragraph.
>
> 78. Neglect was defined in Jamieson (a hanging in prison) in this way:
>
> > '(9) Neglect in this context means a gross failure to provide adequate nourishment or liquid, or provide or procure basic medical attention or shelter or warmth for someone in a dependent position (because of youth, age, illness or incarceration) who cannot provide it for himself. Failure to provide medical attention for a dependent person whose position is such as to show that he obviously needs it may amount to neglect ...'
>
> 79. This definition has been expanded more by illustration than by changes in the law, testing the words 'gross failure' and 'basic' against particular facts. In broad terms there must be 'a sufficient level of fault' to justify a finding of neglect. That does not mean that, for example in a medical context, there has to have been no action at all, simply that the action (or lack of it) on an objective basis must be more than a failure to provide medical attention. It must be a gross failure. The difference will be highly fact-specific.
>
> 80. In a medical context it is not the role of an inquest to criticise every twist and turn of a patient's treatment. Neglect is not concerned with the correctness of complex and sophisticated medical procedures but rather the consequences of, for example, failing to make simple ('basic') checks."

58. In our judgment the approach taken by the Coroner to the evidence in the inquest cannot be faulted. He considered all the relevant evidence that may point to neglect as individual acts as well as considering the potential for the cumulative effect of each of the individual acts. He properly directed himself as to the appropriate test to apply to the issue of neglect and having done so declined to leave the issue to the jury. As part of his ruling on this issue (and article 2) he summarised the competing submissions before him on the evidence from those at the care home, Dr Fairhead, Dr Adam and the paramedics and ambulance crew. Having done so, he concluded that

there was no individual failing that could safely be said to be gross. We agree with that assessment of the evidence. The evidence here does not lead to a finding of neglect.

## Conclusion

59. We fully understand the anxiety and concern of the family in this case, and indeed in all such cases, where a vulnerable person has died and the family are worried that the death was or may have been avoidable. Part of the function of an inquest is to explore the facts fully, so that at least the family (and the public) learn in detail what happened. Nothing we have said affects that. The questions here are different: firstly, is this a case where a state obligation arises and secondly, was it an error of law to withhold a verdict of gross neglect from the jury. That we have reached the answers set out above in no way diminishes the need for and validity of a full investigation of the facts. The knowledge gained may of course, in suitable cases, give rise to a legal remedy of another kind.

60. For those reasons this application is dismissed.