Case No: CO/2866/2016

Neutral Citation Number: [2016] EWHC 3078 (Admin)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 06/12/2016

Before :

LORD JUSTICE BEATSON
And
MR JUSTICE MALES

- -

Between :

	Catherine McDonnell	**Claimant**
	- and -	
	HM Assistant Coroner for West London	**Defendant**

- -
- -

Mr Iain Daniels (instructed by **Saunders Law**) for the **Claimant**
Mr Jonathan Hough QC (instructed by **Westminster Council Legal Services Department**) for the **Defendant**

Hearing date: 23 November 2016

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Judgment

Lord Justice Beatson :

I. Introduction:

1 This is an application brought with the *fiat* of the Attorney-General pursuant to section 13 of the Coroners Act 1988 ("the 1998 Act") seeking an order that an inquest into the death of Leo McDonnell be quashed and there be a new inquest before a different coroner. The claimant is Catherine McDonnell, the widow of the deceased. The defendant is Elizabeth Pygott, HM Assistant Coroner for West London. The Interested Parties are the West London Mental Health Trust which provided the deceased with psychiatric care since mid-2010, and Dr Kate Cabot, who had been the deceased's GP since September 2010. The inquest took place on 30 June and 1 July 2014. The application was made on 13 November 2014 and the Attorney's *fiat* was granted on 10 March 2016.

2 The coroner's decision was that the deceased died due to a fatal cardiac arrhythmia triggered by a vaso-vagal event in the presence of excessive codeine and the drugs citalopram, amitriptyline and quinine. Her conclusion as to the death was "misadventure". It was common ground that in the circumstances of this case the determination of the cause of death was complex and involved the assessment of the evidence of a number of experts as well as the factual evidence by the claimant and others. An important issue at the inquest concerned the trigger for the vaso-vagal event and whether the taking of an excessive quantity of codeine played a material role in providing such a trigger. It was because the coroner concluded that the taking of an excessive quantity of codeine did play a material role that she reached the conclusion of death by "misadventure".

3 The claimant considers that the coroner inquired insufficiently into how the deceased came by his death. It was submitted on her behalf by Mr Daniels that the coroner's conclusion as to the role and relevance of codeine was one she was not entitled to reach. The claimant also questioned the appropriateness of the deceased's prescription, in particular a daily dose of citalopram above that recommended and the use of the citalopram with other medication which was contraindicated. She also questioned the adequacy of his doctors' communication to him of the risks he faced by exceeding the maximum daily dose of citalopram and of their attempts to ensure that he undertook an ECG. The written grounds submitted that the coroner rejected evidence of central relevance, and was not entitled to conclude: (a) that the presence of excessive codeine contributed to the cause of death because that was inconsistent with the cause as stated in Dr Chapman's post mortem; (b) that the deceased had taken an overdose of codeine, and (c) that the deceased had given informed consent to the dosage of citalopram and its prescription with contraindicated medication. The claimant's concerns were thus not confined to the role of codeine, but that was a particular concern because of the impact of the coroner's finding about that on the conclusion that the cause of death was "misadventure".

4 The principal statutory provision governing coroners' investigations into deaths is now contained in the Coroners and Justice Act 2009 ("the 2009 Act") which repealed much of the Coroners Act 1988, but not Section 13 of the 1988 Act. Section 13 provides a

statutory review procedure by those who wish to challenge a refusal to hold an inquest or its adequacy. It provides:

> "(1) This section applies where, on an application by or under the authority of the Attorney-General, the High Court is satisfied as respects a coroner ("the coroner concerned") either—
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> (a) that he refuses or neglects to hold an inquest or an investigation which ought to be held; or
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> (b) where an inquest or an investigation has been held by him, that (whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise) it is necessary or desirable in the interests of justice that an investigation (or as the case may be, another investigation) should be held.
>
> (2) The High Court may—
>
> (a) order an investigation under Part 1 of the Coroners and Justice Act 2009 to be held into the death either—
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> (i) by the coroner concerned; or
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> (ii) by a senior coroner, area coroner or assistant coroner in the same coroner area;
>
> (b) … and
>
> (c) where an inquest has been held, quash any inquisition on, or determination or finding made at that inquest."

II. The factual background:

5 The deceased had a long history of mental health problems, and dependence on alcohol and benzodiazepines. We were told, however, that despite his problems, which dated back to events in his childhood, he had followed a successful career and had been a loving husband and father. He also suffered chronic pain, particularly following an accident in 2012. At the time of his death he was prescribed nine items of medication including citalopram, amitriptyline, quinine and codeine.
He had been prescribed the maximum daily dose of citalopram (20mg three times a day) for many years.

6 On 24 October 2011 the maximum recommended dose of citalopram was reduced due to the risk of what is known as QT prolongation; that is, the time taken for ventricular depolarisation and repolarisation because a long QT may mean that the heart will not start again. The manufacturers also recommended that co-administration with other medicinal products that can prolong the QT interval is contraindicated. Amitriptyline and quinine can prolong the QT interval.

7 In December 2011, Dr Hussain, the specialist registrar at the West London Mental Health Trust who had responsibility for the deceased's psychiatric care until 1 May 2012, reduced the dose of citalopram on a trial basis to the new recommended maximum of 40mg per day. He was not aware that the deceased was also prescribed amitriptyline and quinine. During February 2012 the deceased explained to Dr Hussain that he was having difficulty in reducing his citalopram intake and the prescribed dose was increased to 50mg. It was explained to him by Dr Cabot that the dose had been reduced by the recent guidance, and that higher doses could cause heart rhythm problems. By the end of February, it was clear that the deceased was unable to cope with the reduced dose of citalopram. During this period he was also advised to have an ECG on several occasions but did not take up that advice.

8 On 7 March 2012 the deceased informed Dr Cabot that he could not tolerate the reduced 50mg daily dose, and she agreed to increase the dose to 60mg daily for a seven-day period. After speaking to Dr Hussain it was agreed that a letter should be written to the deceased stating that Dr Hussain had authorised the GP to increase the daily dose of citalopram back to 60mg daily which exceeds the dose that is currently recommended and licensed for prescription. The letter stated:

> "Because the daily dose has been raised, I would like you to sign the section of the letter below confirming that you are aware that I am prescribing a higher dose than is now licensed. You will be agreeing that if you suffer any side effects from the increased dose, that this will be taken as your full responsibility".

The letter then explained that high doses of citalopram have been shown to affect heart rhythm. It advised him to attend Hammersmith Hospital for a walk-in ECG test to check his heart rhythm. The deceased signed the letter on 20 March 2012. Thereafter, the deceased remained on the 60mg daily dose but he did not follow the advice to have an ECG. The claimant says this was because he found travelling difficult as a result of his painful arm. A note in the GP records dated 16 March 2012 states that the claimant had said she would take the deceased to hospital for his ECG.

9 There was further contact between the deceased and Dr Khan, who took over from Dr Hussain as his treating psychiatrist in May 2012, and with Dr Cabot. When the deceased saw Dr Cabot on the day before his death, he told her of an incident between him and his wife and he is recorded as very variable in mood and behaviour and unable to cope with stress or anger. The following day he received a letter from the GP's surgery inviting him to have a discussion in order to decide whether he should remain registered there. According to the claimant this caused him serious concern.

10 The evidence before the inquest was that on the morning of 10 August 2012 the deceased took about 15 codeine tablets in the morning. The paramedic forms state that the crews were told that he had taken "15 codeine approx. midday". Ms Ridout, a

paramedic who attended, stated that she had been told by the family that the deceased had taken 15 codeine tablets at approximately midday. The coroner asked the claimant how many codeine tablets he had taken on the day of his death and she responded he had taken 15 by the time of his collapse.

11 On 10 August, the deceased had a large pile of sandwiches for lunch after which he went to bed. The claimant woke him at about 6pm when he was distressed. She brought him downstairs for a drink and he had about three pints of lemonade and three pints of water over a period of about twenty minutes. In order to ease a feeling of congestion or obstruction, he then tried to make himself sick in the bathroom by sticking his fingers down his throat. After two unsuccessful attempts to make himself sick he suddenly collapsed in his wife's arms. An ambulance was summoned at 7:07pm and he was taken to Hammersmith Hospital where, after prolonged attempts at resuscitation during which there had been no electrical heart activity, he was pronounced dead at 8:31pm.

III. The Inquest:

12 The inquest was opened on 16 August 2012. A pre-review hearing was held in October 2013 and the hearing took place on 30 June & 1 July 2014. The claimant, Dr Cabot, the Trust and the Metropolitan Police were all designated Interested Persons in the inquest. They were all represented by experienced lawyers.

13 The claimant gave evidence as to the events of the day, the death, the deceased's medication, and the advice as to him having an ECG and why the deceased had not taken it. There was also evidence from Dr Cabot, Dr Hussain and Dr Khan, his GP and his treating psychiatrists, about his medication and compliance. Dr Love, a forensic scientist, gave evidence concerning the drugs found in the deceased as a result of the post mortem. Dr Chapman, a forensic pathologist, dealt with the post mortem and causes of death. Dr Behr, a cardiologist, dealt with the risks of citalopram and the cause of death. Professor Flanagan, a consultant clinical toxicologist, gave evidence as to the cause of death. There was also written evidence admitted in writing without any objection under rule 23 of the Coroners (Inquests) Rules 2013, SI 2013 No.1616 from Ms Ridout, the paramedic I have mentioned, and Dr Almond.

14 At the hearing, the witnesses dealt with the explanation given by the three treating Doctors of the risks of the deceased continuing to take citalopram at 60mg a day, and the cause and mechanism of his death. As to the first of these, there was a factual dispute between the doctors and the claimant. In summary the doctors stated that they had explained the serious risk to the heart and in Dr Khan's case a risk of death, in straightforward terms. The claimant's evidence was that the doctors had spoken in medical jargon and failed to convey that there was a serious risk.

15 As to the cause and mechanism of the death, the evidence can be summarised as follows. Dr Love's analysis of the drugs found in the deceased's body led him to the conclusion that the combined presence of codeine, amitriptyline and citalopram "may provide a

toxicological explanation for death" but he did not give a firm view as to the likely mechanism of death. Dr Chapman, who had carried out the post mortem examination, concluded that death had been due to mixed drug toxicity. Dr Behr considered that the fatal cardiac arrest had been due to an arrhythmia. The combination of amitriptyline, citalopram and quinine could extend the QT interval which could create a risk of fatal arrhythmia in those with a genetic pre-disposition. He did not consider that the codeine had a directly cardio-toxic effect but stated that high doses of codeine could prevent the stomach from emptying, leading to stomach distension and nausea which could induce a vaso-vagal reflex effect which in turn could trigger a fatal cardiac arrhythmia. Professor Flanagan accepted that the amitriptyline, citalopram and quinine could extend a person's QT interval but considered that it was not possible to say that they had had a dangerous effect on the deceased because that would depend on his susceptibility. In Professor Flanagan's view, some physical trigger was probable and, referring to Dr Behr's evidence, he said that a vaso-vagal reflex was the most likely explanation. He agreed with the coroner who put to him that the cause of death was "fatal cardiac arrhythmia triggered by a vaso-vagal event in the presence of prescribed medication".

16 After the conclusion of the evidence and a short adjournment to enable the coroner to consider it, the coroner heard submissions as to whether, if she accepted a vaso-vagal reflex as the precipitating cause of death, the excess codeine taken could be relevant. In the course of the submissions made about Dr Behr's evidence as to a vaso-vagal event, it was stated by Mr Daniels that Dr Behr had not referred to any quantity of codeine. He had not referred to "excessive" codeine, but that just that codeine may cause a slowing down of the bowel. Mr Daniels submitted that Dr Behr's evidence as to the vaso-vagal effect as a possible trigger event was speculative, and the suggestion as to the way the codeine may have played a part was a further speculation.

17 The coroner stated that she was looking at everything in the round and that she adopted what Professor Flanagan had said as to the cause of death. Professor Flanagan had in effect adopted as the probable cause what Dr Behr had suggested as a possibility. It was suggested to the coroner that, in order to find that codeine played a part, she had to exclude the claimant's evidence that the retching was caused by a deliberate act of the deceased, and it would be appropriate for her to set out the basis on which she disagreed with the claimant's evidence. The coroner stated (3/31/1041) that she was not rejecting the claimant's evidence. Her evidence was that the deceased was relieving a feeling of congestion.

18 I need to refer to two other aspects of the discussion at the time of the submissions after the conclusion of the evidence. The first is that the coroner gave an explanation for the short-form conclusion she entered in section 4 of the Record of Inquest that the death was caused by "misadventure". She stated that Dr Behr had said that the trigger was a vaso-vagal event associated with retching. Dr Behr had said that the codeine was part and parcel of that thesis, a point Professor Flanagan, albeit without explicit reference to codeine, adopted. The coroner stated:

> "[I]f the vaso-vagal event was caused by codeine, the fact is that the deceased took it, he took it in an excessive dose. Whether it was the fact that it was an excessive dose [or] is not clear, but it seems likely it would have been because if he has been taking codeine for a long time, the same argument applies with that in relation to the other drugs …"

19 The second matter concerned the evidence of the risk warnings and the ECG. The coroner stated that "Dr Hussain, Dr Cabot and Dr Khan gave a pretty good idea to Mr McDonnell and his wife of what the possible consequences of taking the enhanced doses of citalopram meant". She stated that "it was quite clear … that they knew the advice was to go and have an ECG. It was not just once that they were told this. It was several times." She did not believe that the deceased and his wife did not know that was recommended. She stated they were well aware that he could have cardiac problems of one sort or another with taking citalopram at an increased dose. She stated that, in that sense, she rejected the claimant's evidence and preferred the evidence of Dr Cabot, Dr Hussain and Dr Khan.

IV. The conclusions recorded in the Record of Inquest:

20 Section 2 of the Record of Inquest (hereafter "Record"), giving the medical cause of death, states:

> "Fatal cardiac arrhythmia triggered by a vaso-vagal event in the presence of excessive codeine, together with citalopram, amitriptyline and quinine at levels consistent with prescribed medication (within the limits when initiated)".

21 In section 3 of the Record, "how, when and where, ….. the deceased came by his… death", it is stated:

> "At about 7pm on 10 August 2012 the deceased collapsed at his home when attempting to make himself sick. He was taken to Hammersmith Hospital where life was pronounced extinct at 8:31pm after prolonged attempted resuscitation during which time there had been no electrical heart activity. In the morning of his death he had taken a considerably higher dose of codeine than prescribed. He had had a large pile of sandwiches and drunk three pints of water and three pints of lemonade after being roused at about 6pm from a long sleep in the afternoon. He had a long history of mental health problems, dependence on alcohol and benzodiazepines and chronic pain for which he was prescribed citalopram, amitriptyline, quinine and codeine among other things. For many years he had been prescribed the maximum recommended dose of citalopram. Following a reduction in the maximum recommended dose he was unable to cope with that and did not follow advice to have a ECG. There is no evidence the deceased intended to harm himself".

22 The coroner's entry in section 4 of the Record, the short-form conclusion, is "misadventure".

23 After the inquest on 3 July 2014, the coroner made a report under paragraph 7 of schedule 5 to the Coroners and Justice Act 2009 and Regulations 28 & 29 of the Coroners (Investigations) Regulations 2013 SI 2013 No.1629, a report on action to prevent other deaths. She set out the circumstances of the death as set out in the record and in section 5 of the "coroner's concerns" she expressed concern that "there was no system in place designed to ensure that both GPs and psychiatrists were aware of all medication patients were taking regardless of who prescribed it and why". She recommended that action be taken to prevent future deaths and stated she believed the Trust and the Commissioning Group had the power to take such action.

V.Discussion:

24 There are two types of inquest. The first is often called a *"Jamieson"* inquest because its scope was considered in the classic judgment of Sir Thomas Bingham MR in *R* v *North Humberside Coroner, ex p Jamieson* [1995] QB 1. This type of inquest is governed by sections 5(1) and (3) of the 2009 Act. By section 5(1), its purpose is to ascertain who the deceased was; "how, when and where the deceased came by his or her death"; and to provide certain information required for the registration of the death. In this case, as in many cases in which there is an inquest, the crucial question was how the deceased came by his death. By section 5(3), a coroner may not express an opinion on any other matter other than those set out in section 5(1) save a report pursuant to paragraph 7 of Schedule 5 to the Act to eliminate or reduce the risk of other deaths.

25 The second type of inquest is one in which rights under the European Convention of Human Rights, in particular the State's obligation under Article 2 of that Convention to investigate a death, are engaged. It is sometimes called a *"Middleton"* inquest, because its scope and requirements were considered in *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182. The scope of this type of inquest is broader than that of a *"Jamieson"* inquest because section 5(2) of the 2009 Act provides that where rights under the Convention are engaged, "how, when and where the deceased came by his or her death" is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.

26 It is common ground that the inquest in this case was not a *"Middleton"* inquest. Accordingly, the words "how, when and where the deceased came by his or her death" in section 5(1) do not have to be read in the broader way stated in section 5(2).

27 As to the decision and its recording, by section 10(1) of the 2009 Act the coroner is required to make a determination answering the questions mentioned in section 5(1) (read with section 5 (2) where applicable). By section 10(2) that determination "may not be framed in such a way as to appear to determine any question of (a) criminal liability

on the part of a named person, or (b) civil liability". The determination must be recorded on the standard Record of Inquest form: see rule 34 of the Coroners (Inquest) Rules 2013 S.I. 2013 No.1616.

28 It is clear that, as Lord Lane CJ stated in *R v South London Coroner, ex parte Thompson* (1982) 126 SJ 625 and Sir Thomas Bingham stated in *Jamieson's* case at 24 F-G, this type of inquest is a fact finding exercise not a method of apportioning guilt. It is also clear that decisions by a coroner as to the scope of enquiry and as to which witnesses to call are a matter of judgment which may only be challenged on the ground that they are *Wednesbury* unreasonable, i.e. irrational: see *R* v *Inner West London Coroner, ex p. Dallagio* [1994] 4 All ER 139 and *R (Mack)* v *HM Coroner for Birmingham and Solihull* [2011] EWCA Civ. 712 at [9].

29 The broad question before the court in this case is whether it was open to the coroner on the evidence before her to reach the conclusion that she did. As I have stated, the standard of review in a section 13 challenge is the same as in a judicial review claim. The claimant has to establish that the finding or decision was *Wednesbury* unreasonable or irrational in the sense used by Lord Diplock in *Council of Civil Service Unions* v *The Minister for the Civil Service* [1985] AC 374.

30 There were two main candidates for the cause of death. The first was the mixture of medication the deceased was taking, in particular taking a daily dose of citalopram higher than the recommended maximum, and the role of the codeine he had taken on the day of his death. The second was a vaso-vagal event. The coroner found that it was a vaso-vagal event and that the presence of the drugs, including what she described as excessive codeine triggered that vaso-vagal event.

(i) The relevance of codeine:

31 Since it was the role of the codeine that led the coroner to conclude that the cause of death was "misadventure", the starting point in assessing the claimant's critique of her approach and conclusions is the coroner's treatment of that.

32 Mr Daniels submitted that the coroner's conclusion that the presence of excessive codeine contributed to the cause of death was inconsistent with the cause as stated in Dr Chapman's second post mortem, which was "mixed drug toxicity". He argued that the experts who gave evidence on codeine did not suggest it played an instrumental role in the death. Dr Behr's evidence was that the codeine did not play a direct role in the death and what he said about it playing a background role was speculation. Moreover, Professor Flanagan did not attribute a specific role to codeine in the death. Mr Daniels also submitted that the coroner overlooked the claimant's evidence that her husband was purging himself rather than feeling nausea and was wrong to suggest that he had taken excessive codeine. Mr Daniels argued that the effect of the coroner's conclusion as to the

role of "excessive codeine" is to leave the reader of the Report with the view that excessive codeine was a primary cause of death, which on any understanding of the evidence, cannot be so because this was not a codeine overdose case.

33 I do not consider that there is an inconsistency between Dr Chapman's report and the coroner's conclusion. Dr Chapman found that "the combined presence of codeine, amitriptyline, and benzodiazepine drugs at the concentrations detected in the blood taken from [the deceased] may provide a toxicological explanation for his death".

34 Although Professor Flanagan's view was that "codeine is not the primary cause of death, given its ingestion some 6 hours before collapse", he concluded that Dr Love's toxicology findings were consistent with a significant overdose. He did state that codeine could be excluded as a cause of death because it is not cardio-toxic, but that was a reference to its direct toxic effect on the heart as opposed to any potential role it had as a trigger for a vaso-vagal event. Dr Behr's evidence was that it was a possibility that the codeine caused the abdominal distension and contributed to the nausea which in turn may have triggered the vaso-vagal event. While the coroner's statement in the discussion after the closure of the evidence that Dr Behr's view that the vaso-vagal event was predicated on codeine may have put the matter too high, it is important that the doctor did refer to codeine as a possible cause of such an event. As already stated, Professor Flanagan in effect adopted that evidence, but went further in regarding the vaso-vagal event triggered in the way described by Dr Behr as the probable cause of death.

35 Both Dr Love and Professor Flanagan considered it odd that the codeine had not metabolised to morphine but the criticism of the coroner's conclusion based on this is misplaced. The fact that the codeine had not metabolised did not undermine their conclusion that excessive codeine had been taken. If anything, it could suggest that the codeine may have been taken within a relatively short time of death. I also consider that the coroner was entitled to conclude that the deceased had taken 15 codeine tablets on the day of his death in light of the evidence which I have summarised at [10] above.

36 For these reasons, I have concluded that the coroner was entitled to conclude that codeine contributed to the deceased's death. There was evidence to that effect before her which she was entitled to accept. It follows that her conclusion that the cause of death was "misadventure" is not open to challenge. This is because death by misadventure is a death in which some deliberate but lawful human act has unexpectedly resulted in death, whereas "accident" connotes something over which there is no human control: see *Jervis on Coroners* 13th ed at 13-37. However, it is noted that the distinction between accident and misadventure has been subject to criticism. In *R v Portsmouth Coroner's Court Ex p. Anderson* [1987] 1 W.L.R. 1640 the Divisional Court described the distinction as "without purpose or effect" and favoured the use of "accident". In any event, in the light of the evidence before the coroner as to the taking of codeine by the deceased on the day of death, she was entitled to conclude that this was a deliberate human act which sadly contributed to the deceased's death.

(ii) The appropriateness of the prescribing decisions:

37 Mr Daniels submitted that the coroner's failure to mention in the Record that the citalopram was prescribed beyond the recommended dose without an ECG, and that it was prescribed together with amitriptyline and quinine when this was contraindicated, were reviewable errors. The written submissions appear to suggest that the problem was one of failure by the coroner to investigate, for example the failure of the GP to reduce the dose of citalopram before Dr Hussain recommended it or to consider the effect of the contraindication of the other drugs, and the fact that the other doctors would have reviewed the prescription if they had known the deceased had been prescribed those drugs. At the hearing, however, Mr Daniels' focus was on the coroner's failure to refer to these matters in box 3 rather than any failure by her to investigate them. Mr Daniels also argued that because the deceased was a vulnerable man, the coroner should have stated that Dr Cabot should not have sought to shift responsibility on him by obtaining his written consent to the continuing over-prescription.

38 Mr Daniels was correct not to press the argument that the coroner had failed to investigate the failure of the GP to reduce the dose of citalopram before Dr Hussain recommended it or to consider the effect of the contraindication of the other drugs, and what the treating psychiatrists would have done by way of reviewing the prescription if they had known the deceased had been prescribed the contraindicated drugs. The transcript of the evidence shows that these matters were explored at the inquest.

39 I also reject his criticism of the coroner's failure to refer to these matters in box 3. The coroner considered the failures relied on by the claimant in coming to her conclusion. She does not expressly mention the appropriateness of the deceased's prescription in her conclusion but it is made clear in her Regulation 28 report that she considered this and it was part of her investigation. Since the coroner concluded that the death was caused by a vaso-vagal event, and the deceased had taken this combination of drugs for many years, the conclusion did not in itself explain why the combination of drugs caused death on the day the deceased died. For that reason, the appropriateness of the combination of these drugs and the level of citalopram was of less centrality to the precise question.

40 I turn to the criticism about the failure to mention the need for a review of the prescriptions after the recommendation that the maximum daily dose of citalopram be reduced. Dr Cabot's evidence was that, in circumstances where the deceased was regularly treated and reviewed by a psychiatrist and his case was a complex one, she considered it was appropriate to leave this to the psychiatrist to address the issue of the dose of citalopram. In view of the contraindication of the combination of prescribed drugs, it is noteworthy that the Record does not mention this.

41 Mr Hough QC, on behalf of the coroner, accepted that something on the combination of drugs prescribed in this case could have been properly included provided that could be done without stepping beyond the limits of a *Jamieson* inquest. I have stated that, in such an inquest the determination must be limited to the means of death and comment on other matters, such as underlying causes or missed opportunities to save life, and the

appearance of criminal or civil liability, is prohibited: see *R(Hurst)* v *Inner North London Coroner* [2007] 2 AC 189 at [7] - [8]. During the hearing Males J observed that to have stated anything about the combination of the prescriptions being contraindicated might have been misleading unless it was also stated that the deceased's combination of prescriptions was not unusual. I respectfully agree.

42 Moreover, as I stated at [39] above, in view of the coroner's conclusion that the deceased's death was caused by a vaso-vagal event, the appropriateness of the combination of drugs was of was of less centrality to the relevant question of "how the deceased came by his death, i.e. the means of death". The sixth of the fourteen general propositions about the nature and scope of inquests stated by Sir Thomas Bingham MR in *Jamieson's* case was:

> "There can be no objection to a verdict which incorporates a brief, neutral, factual statement. … But such verdict must be factual, expressing no judgment or opinion, and it is not the jury's function to prepare detailed factual statements."

In short, in such inquests narrative verdicts should be short and focused on the immediate circumstance. See also *R. (Longfield Care Homes Ltd) v HM Coroner for Blackburn* [2004] EWHC (Admin) 2467 at [31] where Mitting J stated that in such cases a narrative verdict should be limited to the means of death and *R(Butler) v HM Coroner for the Black Country District* [2010] EWHC 43 (Admin) at [75].

(iii) The coroner's approach to the need for an ECG

43 In relation to the adequacy of the coroner's approach to the ECG, Mr Daniels' criticism is also about the recording of the determination rather than the scope of the inquiry. I do not consider that what is stated in section 3 of the Record suggests that the failure to have an ECG was entirely the deceased's responsibility. I consider that the coroner's conclusion is factual and accurately summarises the advice that was given but not taken up by the deceased. Nor do I accept that the doctors "merely informed" the deceased that he needed an ECG. He was advised on numerous occasions that he needed one and was provided with a form for a walk-in ECG appointment. There is evidence in the GP's notes that in mid-March 2012 the claimant told the GP practice that she would take her husband for an ECG. That sits very uneasily with and indeed undermines the suggestion that the doctors ought to have realised that the deceased would have difficulties getting to the hospital and should have made arrangements for transport.

44 I also reject the suggestion made by Mr Daniels at one stage during the hearing that the doctors should have refused to prescribe the citalopram absent an ECG. This suggestion does not reflect the reality of the situation which was one in which consistent attempts had been made to reduce the dose of citalopram but the deceased had been resistant to those attempts. He was pressing for the dose not to be reduced or, once it had been, to be increased. Such a request was also made by his wife on one occasion, an understandable request in the light of the difficulties he was experiencing. Given the period the deceased had been on the previous prescription and the difficulties he was suffering

when it was reduced, the coroner was entitled to conclude that the doctors did not have to withdraw the dose of citalopram if he did not have an ECG. In view of his wife's offer to take her husband to hospital for an ECG and the fact that his fracture was healing, albeit slowly, she was also entitled to conclude that the difficulties he faced in travelling to the hospital were not obvious to the doctors.

45 In light of the efforts made by both the GP and the psychiatrists to reduce the dose of citalopram and the advice as to the risks that they gave the deceased, I have concluded that it was open to the coroner to conclude that the doctors properly balanced the risk of maintaining the higher dose on one hand with reducing it and risking the deceased disengaging with medical assistance. Since this was a *Jameson* inquest, the coroner was right not to specifically apportion blame in her conclusions. The statute and the authorities show that in such a case the determination must be non-judgmental and limited to the means of the death.

(iv) The interests of justice

46 It remains to consider the broad discretion in the court to order a new inquest where the requirements of section 13(1(b)) of the 1988 Act are met. The necessity or desirability of another inquest in the interests of justice may arise by reason of "fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise".

47 In *R (Sutovic)* v *HM Coroner for Northern District of Greater London* [2016] EWHC 1095 (Admin) at [53] and [54] it was stated that:

> "Notwithstanding the width of the statutory words [the] exercise by courts [of the power contained in section 13(1(b))] shows that the factors of central importance are an assessment of a possibility (as opposed to the probability) of a different verdict, the shortcomings in the original inquest, and the need to investigate matters raised by new evidence which had not been investigated at the inquest".

48 In this case, Mr Daniels did not suggest that there are new facts or new evidence. He focussed on "irregularity of proceedings" and "or otherwise". He did not pursue the suggestion in the written grounds that evidence had been wrongly rejected. Notwithstanding the statement in the written grounds that the insufficiency of inquiry meant there was the possibility of a different narrative conclusion, as I have stated, at the hearing the principal criticism of the coroner's approach relates to the content of the Record rather than the sufficiency of her enquiry.

49 For the following reasons, I do not consider that this is a case in which a new inquest should be ordered in the interests of justice. First, in view of my conclusion as to the codeine I do not consider that there is any valid criticism of the coroner's verdict. In a case such as this where the cause of death was complex and there was a range of medical opinion given in evidence, the possibility of a different verdict in a further inquest cannot

be excluded: a different coroner might take a different view of the evidence. But that possibility does not mean that it is in the interests of justice to hold a new inquest. If it did, that would potentially be so whenever there was complex and disputed medical evidence and finality could hardly ever be achieved. Secondly, for the reasons I have given, the only possible criticism of the way the Record is expressed concerns the failure to refer to the combination of medication prescribed because some were contraindicated with citalopram. I have stated that it might have been possible and advisable to refer to the combination of drugs prescribed because some were contraindicated with citalopram, although I have also referred to the difficulty of doing so in a neutral and brief way so as to be within the proper scope of a *Jamieson* inquest. I do not, however, consider that this means it is either necessary or desirable in the interests of justice to hold a further inquest. Apart from the difficulty of referring to this factor in a neutral way in any future Record of Inquest, I also take into account what is stated in the coroner's Regulation 28 report, to which I turn.

50 The absence of a system to make sure clinicians at GP practices and Trusts are aware of the full range of the medication a patient is prescribed was the subject of the coroner's Regulation 28 report. There is no challenge to its ambit. Moreover, the issues that are said to justify a further inquest and which might lead to a further Regulation 28 report are not ones that can be described as "systemic" as required in a Regulation 28 report. They concern failings alleged on the part of the individual doctors involved in the care of the deceased. Mr Daniels submitted that the continued over-prescription of citalopram alongside other drugs which may have a cardio-toxic effect in the absence of an EGC is a systemic problem which could properly be the subject of a Regulation 28 report. Even if this is so, I do not consider that, in all the circumstances of this case including the fact that this decision will highlight the point about the fact that contraindicated medication was prescribed with the citalopram, the interests of justice require a new inquest because a new coroner may make a further and different Regulation 28 report.

51 In *Re Kelly* (1997) 161 JP 417 the Court considered it "surprising" that the wearing of body armour was not addressed at the inquest into the death of a soldier in Kenya. However, at [6] it was stated that:

> "The emergence of fresh evidence, and the Coroner's wish to conduct further investigation, do not relieve the court of its responsibility to keep in mind the public interest involved and the purpose served by an inquest as a fact finding exercise and not a method of apportioning guilt".

Rather than ordering a new inquest in that case, the Court referred to the importance of the new evidence in its judgment and did not find it desirable to have a re-run of all the issues which had now been made public. In the present case there is a weaker case for a new inquest because Mr Daniels' criticisms are founded on evidence which was investigated and dealt with at the inquest. Therefore, while it may have been appropriate for the coroner to refer to the contraindicated medication in her conclusion, it would not be in the interests of justice to order a new inquest on that basis.

Mr Justice Males

52 I agree.