CO/4752/2014

Neutral Citation Number: [2015] EWHC 1781 (Admin)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
DIVISIONAL COURT

Royal Courts of Justice
Strand
London WC2A 2LL

Thursday, 14 May 2015

B e f o r e:

LORD JUSTICE BURNETT

HIS HONOUR JUDGE PETER THORNTON QC
(CHIEF CORONER)

Between:
LIAM JOHN THOMPSON

Applicant

v

HER MAJESTY'S ASSISTANT CORONER FOR COUNTY DURHAM AND DARLINGTON

Respondent

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J U D G M E N T
(Approved)

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1. JUDGE THORNTON: This application is made by Liam John Thompson with the authority of the Attorney General dated 4 September 2014. The applicant, Mr Thompson, is the brother of Kristian David Thompson who died on 10 July 2011 aged 19 years, while detained at Walkergate Park Hospital and subsequently at the Tavener Unit of St Andrew's Hospital in Northampton.

2. The applicant applies for an order to quash the inquisition into the death which was held by the defendant assistant coroner for County Durham and Darlington on 14 November 2012 and for an order that a fresh inquest be held. The coroner returned on open verdict at the inquest. The medical cause of death was recorded as "unascertained".

3. The assistant coroner does not oppose the application.

4. Kristian Thompson had suffered severe head injuries from a one punch assault on 9 October 2010, the year before his death. As a result of his injuries his behaviour became so unpredictable and agitated that he had to be detained under section 3 of the Mental Health Act 1983 at the Tavener Unit.

5. On the day of his death, 10 July 2011, Kristian had suffered incontinence of which he had been apparently unaware and went to shower. He was later found in the shower, collapsed on the floor with the shower running. He did not recover.

6. The medical evidence was given at the inquest in person by Dr Mark Egan, the consultant pathologist who conducted the post-mortem examination. Written evidence was admitted from Mr Daniel du Plessis, consultant neuropathologist who later examined the brain, and from Dr Afsaneh Tajer, Kristian's responsible physician.

7. In the absence of a toxicological cause of death Dr Egan and Mr du Plessis both considered two possible causes of Kristian's death but were unable to come to any probable conclusion. Those possible causes were sudden and unexpected death in epilepsy (SUDEP) and sudden adult death syndrome (SADS).

8. In the absence of an ante-mortem diagnosis of epilepsy neither Dr Egan nor Mr du Plessis were able to conclude on a balance of probabilities that the death was caused or contributed to by epilepsy. Neither felt able to come to such a conclusion upon the basis of a single seizure episode, although both would have done so if satisfied that there was earlier evidence of epileptic activity.

9. The applicant submits, using the words of section 13 of the Coroners Act 1998, that there was "insufficiency of inquiry" at the inquest. He makes two points. First, the coroner failed to obtain a comprehensive inspection and review of Kristian's medical history, particularly since the assault, to see whether he had suffered any previous seizure or there were any indications consistent with epilepsy. And secondly, the coroner failed to obtain and scrutinise expert evidence on two features of Kristian's recent history at the Tavener Unit which could have related to epilepsy.

10. These two features were Kristian's recurrent nocturnal enuresis and his medication. The questions the applicant wants answered is whether the enuresis was indicative of

epilepsy and whether the administration of sodium valproate and clonazepam could have masked or prevented obvious seizure activity until the dosage was reduced two months or so before Kristian's death and at a time shortly before incontinence at night commenced.

11. The applicant contends that these questions could not be answered at the inquest, at the very least sufficiently explored, because Dr Egan, as he frankly admitted, was not a clinician and did not have the relevant expertise and because Mr du Plessis, although he had given some consideration to these issues, was not called to give evidence.

12. Dr Egan accepted in evidence that he would alter his opinion on the cause of death if an expert clinician could diagnose epilepsy at any time. But in the absence of any evidence to his knowledge of a history of epilepsy he himself, as a pathologist, could not make that finding.

13. It is our conclusion that there should be a fresh inquest to examine these matters. In the light of that decision we do not propose to go further into the medical detail. We have read the reports of Dr Egan and Mr du Plessis (two each) and the transcript of the evidence given at the inquest in the light of the applicant's submissions. Having done so we agree with the applicant's submissions on this point. We cannot say what the outcome of the fresh inquest will be or whether the medical cause of death will be ascertained. That will be a matter for the senior coroner, with or without the jury. We can, however, say that these matters are sufficiently important that they should be explored afresh with appropriate witnesses.

14. We are therefore satisfied that as a consequence of insufficiency of inquiry it is necessary and desirable in the interests of justice, under section 13(1) of the Coroners Act 1998 (as amended), that another inquest should be held.

15. Accordingly under section 13(2) we quash the inquisition taken on 1 November 2012 and order a fresh investigation including inquest to be held into the death by the senior coroner.

16. For these reasons the application is granted.

17. In view of our decision on "insufficiency of inquiry" we do not need to rule on the applicant's further submissions alleging that the coroner failed to hold an Article 2 compliant inquest and to hold the inquest with a jury. These are matters which can be revisited by the senior coroner who will have conduct of the fresh investigation.

18. We hope that the fresh inquest can be held as soon as is reasonably practicable. In order to assist that process a copy of this judgment (which is not yet in final approved form) will be sent to the senior coroner in Durham.