Neutral Citation Number: [2015] EWHC 2561 (Admin)

Case No: CO/6004/2014

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: Tuesday 8th September 2015

Before :

LORD JUSTICE BURNETT

and

MR JUSTICE HOLROYDE

- -

Between :

Ian Clarke Wilson	**Claimant**
- and -	
HM Senior Coroner for Birmingham and Solihull	**Defendant**
(1) Peter Brooks **(2) Alan Tringham** **(3) Alan Lucas** **(4) University Hospitals Birmingham NHS Foundation Trust**	**Interested Parties**

(Transcript of the Handed Down Judgment of
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Official Shorthand Writers to the Court)

Neil Garnham QC (instructed by **Radcliffes Le Brasseur**) for the **Claimant**
The Defendants and Interested Parties were neither present nor represented

Hearing dates: 22 July 2015

Judgment
As Approved by the Court

Lord Justice Burnett :

1. Ian Wilson, the claimant in these proceedings, is a consultant cardiothoracic surgeon formerly employed by University Hospitals NHS Foundation Trust ["the Trust"] based at the Queen Elizabeth Hospital, Birmingham. This claim is concerned with the inquests held into the deaths of three of his patients by Her Majesty's Senior Coroner for Birmingham and Solihull between 23 and 26 September 2014. The claimant complains about a single sentence included by the coroner in her short narrative verdicts in respect of each deceased:

> "An historic failure to accurately record post-operative data for all patients resulted in a missed opportunity to identify potential problems at an earlier stage which may have resulted in [the deceased's] operation being dealt with by a different surgeon."

2. That part of the coroner's conclusion flowed from evidence which had been admitted at the inquest in the teeth of opposition from the claimant. Mr Garnham QC, who appears before the court in these proceedings, but did not appear before the coroner, advanced three grounds in support of the contention that the sentence should be removed by quashing it from each of the narrative conclusions.

   i) It was unfair to rely upon the evidence and reach the conclusion because the claimant was not given a meaningful opportunity to challenge it, in particular by exploring the underlying data which were said to support it;

   ii) The coroner failed properly to explore the evidence relating to the conclusion;

   iii) The conclusion of the coroner in this regard was irrational.

3. The coroner has taken no part in these proceedings but has provided a statement explaining her approach. Similarly, the families of the three deceased, each of whom was represented before the coroner, have taken no part but each has provided written support for the coroner. The Trust, whose medical director Dr David Rosser gave the material evidence, has also taken no part in these proceedings.

Background Facts

4. The claimant was employed as a consultant by the Trust between 1995 and October 2013. The three patients whose inquests were heard together were Peter John Brookes, Alan Charles Tringham and Alan Lucas. Each underwent cardiac surgery at the hands of the claimant. Mr Brookes' operation was on 2 September 2011. He died two weeks later. The coroner recorded a narrative verdict:

> "The deceased underwent extensive open heart surgery on the 2nd September 2011. His surgery was more extensive than was necessary. Given the extent of his underlying heart condition he did not require 6 coronary artery bypass grafts. As a result of this additional element to his operation he had a prolonged operation and bypass time which, on balance of probabilities, resulted in additional damage to his heart. This contributed to further heart irritability, arrhythmias and cardiac arrest which

> occurred immediately after surgery. That episode of cardiac arrest caused a brain injury, which was further exacerbated by a series of cardiac arrests on arrival to the ITU which ultimately led to his death. An historic failure to accurately record post-operative data for all patients resulted in a missed opportunity to identify potential problems at an earlier stage which may have resulted in Mr Brookes operation being dealt with by a different surgeon"

Mr Tringham's operation was on 1 June 2012. He died on 6 June 2012. The narrative verdict was:

> "The deceased underwent extensive open heart surgery on the 1st June 2012. His surgery was more extensive than was necessary. Given the extent of his underlying heart condition, he did not require the atrial fibrillation ablation procedure. As a result of this additional element to his operation he had a prolonged operation and bypass time. This coupled with a long cardioplegia time of 62 minutes on balance of probabilities, resulted in additional damage to his heart. This contributed to further heart failure postoperatively leading to multi organ failure and his death. An historic failure to accurately record post-operative data for all patients resulted in a missed opportunity to identify potential problems at an earlier stage which may have resulted in Mr Tringham's operation being dealt with by a different surgeon."

Mr Lucas's operation was on 26 April 2012. He died nine weeks later on 29 June. The narrative verdict in his case was:

> "The deceased underwent extensive open heart surgery on the 26 April 2012. His surgery was more extensive than was necessary. Given the extent of his underlying heart condition he did not require the tricuspid valve repair atrial fibrillation ablation and only 2 of the 3 coronary artery bypass grafts. As a result of these additional elements to his operation he had a prolonged operation and bypass time. This coupled with a long cardioplegia time of 77 minutes on balance of probabilities, resulted in additional damage to his heart. This contributed to further heart failure postoperatively leading to multi organ failure and his death. An historic failure to accurately record post-operative data for all patients resulted in a missed opportunity to identify potential problems at an earlier stage which may have resulted in Mr Lucas's operation being dealt with by a different surgeon. "

5. The hospital had an internal system which monitored the mortality rates for patients of its surgeons. In August 2012 that system picked up a higher than expected mortality rate amongst Mr Wilson's patients which led to an analysis by Professor Pagano of 15 of his patients who had died over a period of 14 months. An internal clinical review was conducted by a panel of three members established in September

2012. A change was made to the complexity of the procedures which Mr Wilson was permitted to undertake. In January 2013 an interim report was published followed by a final report in April 2013. That report identified significant and consistent inaccuracies in the recording of data by Mr Wilson in connection with the operations under scrutiny, in particular with cardioplegia (introduction of fluid into the heart during the procedure) and cardio-pulmonary by-pass times. Further investigation revealed discrepancies, which extended over a number of years, in the recording of aortic cross-clamp times. This resulted in Mr Wilson's dismissal.

6. The data thus far referred to were collected by staff (known as perfusionists) during the operations but subsequently entered onto a database by Mr Wilson. The investigation compared the manual records of the staff with the data subsequently inputted by Mr Wilson. Some of those data are used not only by a surgeon's employer, but collated centrally by the Society of Cardiothoracic Surgeons ["SCTS"] for its monitoring purposes. The suggestion was that Mr Wilson was not transferring the data accurately onto the database, a proposition he accepted during the course of the inquests. There was a dispute in the evidence about the consequences for the patients of the mis-recording of by-pass, cross-clamp and cardioplegia timings. Mr Wilson considered that the long operation times had no adverse impact on the patients' hearts. Others disagreed. Whilst these issues were explored during the inquests, the final sentence in each of the narrative conclusions refers to something else.

The Inquests

7. Dr Rosser is the Medical Director of the Trust. He produced a statement dated 18 July 2014 for the purposes of the inquests, which was disclosed to the interested persons on 4 September. Much of it dealt with the background to the investigation and the problems with the recording of the data already discussed. A further case review was commissioned by the Trust from Professor Wallwork. It was Dr Rosser who referred the information which had been reviewed to the coroner and also to the General Medical Council ["GMC"]. At paragraphs 33 and 34 of his statement, Dr Rosser dealt with the issue that gave rise to the sentence to which Mr Wilson objects:

> "33. More recently, subsequent to the publication of more detailed data by the SCTS, concerns were raised that Mr Wilson may have provided inaccurate information to the database about certain aspects of the preoperative condition of some of his patients, specifically whether those patients were receiving intravenous nitrates, indicating unstable angina, and/or suffering from pulmonary hypertension.
>
> 34. Investigations into these concerns have demonstrated significant over reporting by Mr Wilson of both of these conditions. This has had the effect of raising the predicted …rate of death, for Mr Wilson's patients over the last 3 years. Please see chart exhibited hereto and referred to as "DR 1". This consequently makes Mr Wilson's actual mortality rate look artificially low as it is compared to the inflated calculated risk. As the Trust does not have access to national data we are unable to calculate whether Mr Wilson's mortality rates would

> have triggered an alert from the SCTS, which would have led to an earlier intervention. We have, however, recalculated the Trust's internal monitoring process, run by Professor Pagano, and it is clear that Mr Wilson's mortality would have triggered an internal alert in 2011 which would have led to an intervention at that stage involving at least a restriction in practice."

It is to these matters that the coroner was referring in the impugned sentence. The coroner's interest in this issue was to explore whether Mr Wilson would have carried out the operations on the three deceased patients the subject of the inquests had the internal alert been triggered as suggested by Dr Rosser.

8. The chart exhibited to Dr Rosser's statement contains three lines. The first is the actual mortality rate of Mr Wilson's relevant cohort of patients. The second is the predicted rate produced by the data inputted in respect of the two features mentioned in paragraph 33 of Dr Rosser's statement. The third is the predicted rate for the corrected data. It was the disparity between the corrected data result and the actual mortality rates which it was said would have resulted in precautionary action being taken to restrict Mr Wilson's activities pending appropriate inquiry. In his oral evidence Dr Rosser corrected the relevant date from 2011 to 2010.

9. This issue was touched upon but lightly in Dr Rosser's oral evidence. His evidence covers over 70 pages of closely typed transcript. He was called as the Medical Director with overall responsibility for the quality of care within the Trust. He was questioned closely by the coroner and counsel for the various interested parties on a range of topics including, as one would expect, whether the systems in place within the Trust were adequate for monitoring surgical performance and picking up higher than expected mortality rates. He gave evidence relating the erroneous data entered in respect of the three deceased and also explained the procedures and investigations that followed the alert in the summer of 2012. He was asked questions about the procedures carried out on the three deceased, although he accepted that he was not a cardiologist and would defer to Professor Wallwork on all matters expert to do with the surgery itself. His evidence was punctuated by what seem from the transcript to be too many interruptions from the advocates including some sharp exchanges between advocates which called for adverse comment from the coroner. At times the flow of his evidence is lost and its meaning sometimes difficult to follow from the transcript.

10. On the point in issue in these proceedings arising out of his evidence in paragraphs 33 and 34 of his statement, Dr Rosser accepted that Dr Wilson had not seen the underlying data which had been analysed by different "informatics people". Those data related to a large number of patients. He considered the data "very solid". Dr Rosser explained that the data were entered post-operatively but illustrated a measure of pre-operative risk. In his oral evidence given in answer to questions from the coroner he did not identify Mr Wilson as the author of the incorrect data, as he had done in his statement. He said that had the entries been recorded as that analysis suggested they should have been, a flag would have gone up. The coroner asked what effect that would have had. He answered:

> "It's quite a difficult question to answer precisely, because it's very difficult for me to take my mind back to where it would have been back in 2010 with everything I now know. I think it is fair to say that at the very least it would have triggered the same review process that was instigated and I described earlier that led to Mr Wilson's suspension and dismissal. I think this data is more of a flag than actually the flag that we got in 2012. I think it is probably reasonable to say that there's a high likelihood … so on the balance of probability I think we would have taken more serious action at that stage. I think the upshot of it being either we would have ended up with the same outcome i.e. Mr Wilson continued to work at [the hospital] or at the very least we would have seen significant alterations to his practice … We would have stopped … stopped these prolonged periods of cardioplegia at a minimum."

The coroner asked whether had a flag gone up in 2010 Mr Wilson would not have performed these operations. Dr Rosser agreed. He referred to the mis-recording of by-pass and other data going back to 2003 (something discovered in 2012 following the deaths of the 15 patients).

11. It is important to unravel this evidence a little. Paragraphs 33 and 34 of Dr Rosser's statement are concerned with the mis-recording of data other than that which related to cardioplegia, cross-clamp and by-pass times. The point that Dr Rosser was making was that had a difficulty been picked up in 2010 about those other data, an investigation would have followed which would have exposed the wider problems with data recording. He said that

> "the process of mis-recording of bypass and (inaudible) which were of course the key data in the disciplinary process, on the basis of the mis-recording going back to 2003, I don't see any reason why the outcome of those processes and the chain of events that I've described would be any different. So I think that a flag in 2010 would have most likely have ended, as the later flag did, in Mr Wilson's dismissal."

12. He later indicated that the total number of patients, going back to 2003, in respect of which there was some mis-reporting was 539.

13. Counsel for Mr Wilson cross-examined Dr Rosser. Mr Garnham referred us to various passages in that cross-examination. He (and indeed the coroner in her statement) cautioned against taking gobbets from the transcripts out of context and emphasised the need to read the entirety of Dr Rosser's evidence.

14. There was an extended exchange between Dr Rosser and counsel about data relating to cardioplegia intervals, and research which had been conducted into a large number of cases (there was confusion about one issue, later cleared up by counsel for the Trust) involving other surgeons by way of comparison with Mr Wilson. The exchange culminated in a discussion about whether the Trust could produce some underlying material relating to that topic. Counsel for Mr Wilson wished to ask questions on that issue based upon an expert's report (Dr Sims) which was not in the possession of

the coroner. It was attached to Dr Rosser's statement made for the purposes of the GMC proceedings. It was provided to the coroner and the other interested persons and Dr Rosser was asked questions about it. This topic covers pages 310 to 323 of the transcript. I have dwelt on it only to emphasise that the various references to raw data in this part of the transcript do not relate to the issues in this case.

15. In a passage which begins at page 328, at counsel's instigation, Dr Rosser returned to the point now in issue and paragraphs 33 and 34 of his statement. The context of counsel's questions was that Dr Rosser had explained that cardioplegia intervals and by-pass times were not monitored by the Trust. The trigger which prompted action in 2012 was the higher than expected mortality rate. The trigger or flag which would have prompted action in 2010 would also have been mortality related but by reference to the accurate recording of the use of heparin (a surrogate for unstable angina) and the incidence of pulmonary hypertension. Dr Rosser recognised, as did the coroner, that neither of these factors was a feature in the cases of the three deceased. At page 332 Dr Rosser summarised the position:

> "Concerns were raised about two of the seventeen data points … One is a surrogate for unstable angina, the other is pulmonary artery hypertension. … They were brought to me after one of the other cardiac surgeons … looked at the new data released by the [SCTS's] website. … [He] noted that Mr Wilson's average incidence of unstable angina and pulmonary hypertension were significantly higher than the national average. The message that relayed through Professor Bigano [said] … they couldn't understand any legitimate explanation for that.
>
> So I asked our informatics team again to look at the unstable angina issue. … We could do that relatively quickly because all the prescribing is electronic. So that was the easiest way of seeing if there was any underlying concern behind this data anomaly. … Two different analysts have to answer this question independently. They discovered 81 patients had been labelled by Mr Wilson on the PATS database receiving one of those two drugs, and therefore having unstable angina, when in fact only four of those patients had any valid prescriptions on the … system that would appropriately have triggered that marker. Just for clarity, it is against Trust policy and would be an issue of gross misconduct for a nurse to give a drug on paper prescriptions. So it is highly unlikely … if they were not prescribed on the only legal system for prescribing and giving drugs in the organisation.
>
> The pulmonary hypertension data is not held electronically. So that was a more complex and slower process. We arranged for a cardiology research fellow who had … no knowledge of the underlying process … or why we needed this information … to go through the notes and identify the patients who did have pulmonary hypertension, didn't have pulmonary hypertension … or those patients [whose] pulmonary blood pressure had

> never been measured post-operatively. … I believe it was sixteen who did actually have a measurement over 60 which is the EuroSCORE definition.
>
> The other thing that comes out from that data is that it is 78 patients. I do have that data here. Of the 78 patients labelled as having pulmonary hypertension, 61 of them … were entered on the database as exactly 65."

16. This represents a more detailed explanation of the content of paragraphs 33 and 34 of Dr Rosser's statement. Stripped to its bare essentials it comes to this. 81 patients were recorded as being prescribed drugs for unstable angina when the prescription records confirmed that to be the position in only four cases. 78 patients were labelled as having hypertension when analysis of their records suggested it to be the case with only sixteen. The overstatement of these conditions amongst Mr Wilson's cohort of patients resulted in an expectation of higher mortality rates than the correct figures would have generated. That long answer having been given, the coroner again indicated that her interest in this topic was to determine whether "the flag" would have gone up. Dr Rosser added that the figures had been validated on a number of occasions and that the information had been provided to the GMC as part of his evidence and that of Professor Bigano and the Trust's Director of Informatics.

17. It had been the consistent position of those representing Dr Wilson that this evidence was irrelevant, but if it was relevant he should have been provided with all the underlying data to check whether the analysis in respect of both aspects was accurate. By that they meant the medical records of all the patients concerned. Dr Rosser did not have them with him. His reference to having the data with him was to the results of the analyses of both aspects. The coroner had (more than once) indicated her view that this evidence was relevant and also that it was inappropriate in these inquests to embark upon an investigation into the medical records of the 81 patients in the angina cohort and 78 in the pulmonary hypertension cohort. It is unclear to what extent the two overlapped, although it is likely to have been substantially. The coroner restated her position at this stage in Dr Rosser's evidence:

> "He's explained fully why he says the flag would have gone up. … You're perfectly entitled to suggest why it might not have gone up, but what we're not going to be doing in this inquest is analysing all of those cases and all of that data, because that would not be an appropriate way forward, in my view. So you can challenge him generally on those figures."

18. Counsel then explored the "long answer" and confirmed that two analysts examined the angina drug issue and that a cardiac research fellow had examined the pulmonary hypertension issue. There followed this exchange with the coroner at page 335:

> "Coroner: … Mr Wilson has been completely open throughout all his evidence about the inaccuracies of recordings. Does he have a view in relation to this? Does he accept that they are right or wrong, or not in a position to say so?
>
> Counsel: He cannot do so because he's not been shown it.

> Coroner: Okay. I'm just asking. You might want to turn round. He's got his hand up. Do you want to speak to him? Thank you.
>
> Counsel: It's self-evident he's not in a position to deal with it.
>
> Coroner: Okay.
>
> Counsel: He has a view, but it's self-evident he's not in a position to deal with the substance of it. Of course, had it been the intention to lead this evidence then, or my learned friend, the expectation this evidence was going to be led, then I would have expected at least the broad proposition to be put to Mr Wilson by somebody. Anyway, I'll move on.
>
> Coroner: Well, it was in the statement."

19. The position was that Mr Wilson had given discrete evidence three times in respect of each death separately. Dr Rosser's evidence came later. The subject matter of paragraphs 33 and 34 had not been raised during any of those three evidence sessions.

20. Counsel continued his cross-examination of Dr Rosser and explored the precise circumstances in which the mortality rates, judged against the data suggested to be correct, would have caused a flag to go up. Dr Rosser readily accepted that his conclusions rested upon the integrity of the data analysis but added that "it's been done to an extremely high level of integrity by a nationally and internationally valued team of informaticians." Beyond observing that they were "employed by you" there was no challenge by counsel during the cross examination of Dr Rosser to the overall conclusions of that team. That observation was not a question but an insinuation which prompted a mild rebuke from the coroner. This led to a renewed request from counsel for all the underlying medical records. He added:

> "There are two ways you can deal with this. One, you do what I may have to ask you to do, which is to give me an adequate period of time to address it. Alternatively, you take the view that this is an issue that is best addressed by the General Medical Council, and you know that Dr Rosser has referred this issue to the General Medical Council. I'm not suggesting you dismiss it, but whatever you do with it, you have to deal with it fairly for the family and fairly for Mr Wilson. That's all I'm suggesting."

Counsel for all the other interested parties supported the coroner's stated approach.

21. There are two further aspects of what occurred at the inquests which I must note. First, at their outset, counsel for Mr Wilson developed submissions on paragraphs 33 and 34 of Dr Rosser's statement both as to relevance and the "more important ground", fairness. The fairness argument was in support of the complaint about the absence of raw data. He added:

> "We have some limited information from a separate source, but via Dr Rosser. From that, it appears that the Trust looked at 78 cases. Mr Wilson has not seen the notes for any of those cases."

Mr Garnham has explained that that was a reference to an exhibit to a statement from Dr Rosser in the GMC proceedings which contained the results of the analysis of the data, albeit not the underlying medical notes. We have not seen it but it seems to be the "data" Dr Rosser himself suggested he had with him at the inquests. There was no authority from the GMC to disclose that exhibit into the inquest proceedings. It was, however, a document which came from Dr Rosser (as had Dr Sims' report which was produced into the proceedings) emanating from the Trust's investigation. The GMC were not asked by Mr Wilson's team to authorise the use in the inquest of any material which had come to him through them. Since it was the Trust's document and Dr Rosser indicated he had it with him, the Trust might have agreed to its being introduced in evidence. Dr Rosser's reference to it would suggest he was not concerned. If it was felt by Mr Wilson's team that its use in that way would place him in difficulty with the GMC, as to which I express no view, the coroner could have been invited to use her powers to compel its production: see section 32 and schedule 5 of the Coroners and Justice Act 2009. Be that as it may, Mr Wilson, as was accepted by his counsel at the inquest, had sufficient insight into the exercise that had been undertaken to produce the analyses in question for it to be suggested that he might give evidence on the topic.

22. Secondly, towards the end of the inquest, counsel for Mr Wilson produced written submissions dealing with this issue and also returned to the topic in oral argument. Mr Garnham submits that there was confusion at the inquest over whether the historical mis-reporting related to angina and pulmonary hypertension or the issues concerning the deceased, namely cardioplegia, cross-clamp and by-pass times. I accept that it was a concern of counsel for Mr Wilson but time and again the coroner made clear that her interest was in the flag that it would have raised. For example, at 404:

> "But we went over this so much yesterday and my understanding, which I think everyone else understands, is it doesn't apply to these three patients. The point is that accurate recording of the data would have flagged a trigger on other patients and mortality which would have put a chain of dominoes that would have fallen. That was Dr Rosser's evidence."

23. In his oral submissions counsel repeated an argument that had been rejected by the coroner on multiple occasions, namely that Dr Rosser's evidence on this aspect was irrelevant. At page 411 counsel again pressed the point that the evidence did not relate to by-pass or cross-clamp times and yet again the coroner explained what its relevance was. Counsel's written submissions had been circulated in advance of the round of oral submissions. The first part of those written submissions repeated the relevance argument. The second part was entitled "Fairness". It included this paragraph:

> "It should be understood that Mr Wilson does not accept the validity of the review. It is fundamentally unsound. The reasons for this can be set out in submissions or explored in evidence with Dr Rosser. Whilst Mr Wilson could be recalled to confirm that he does not accept the validity of the review it is suggested that this is probably not necessary."

Counsel submitted that it was unfair to expect Mr Wilson to deal with this in the absence of disclosure of all the underlying data; and that even were it to be disclosed it would not be possible to deal with it in the inquest. He submitted that the GMC was better suited to deal with the issue.

24. The explanation of why the review (I infer both as to angina and pulmonary hypertension) was fundamentally unsound was not given by counsel in his oral submissions. Nor was it suggested that Dr Rosser should be recalled so that the reasons could be explored with him. Furthermore, it was not suggested that Mr Wilson should be recalled to deal with it. As we have seen, Counsel had raised the latter possibility in his written submissions. Counsel for one of the interested persons indicated that he would be more than happy for Mr Wilson to be recalled, but the point was not pressed.

Submissions

25. Mr Garnham submits that the essential unfairness to Mr Wilson was that he was not given a proper opportunity to deal with the evidence of Dr Rosser which has resulted in a serious adverse finding against him. That finding has two components namely (a) a conclusion that data were mis-recorded; and (b) that had they been accurately recorded the consequence may have been that Mr Wilson would not have performed the operations on the three deceased. Mr Garnham submits that although not named in the sentence, the reference to a different surgeon is a clear contrast with him. He also submits that the use of the passive "an historic failure to record data" carries the implication that it was Mr Wilson himself who entered inaccurate data, rather than others. He relies upon dicta in *Vogon International Limited v the Serious Fraud Office* [2004] EWCA Civ 104 and *MRH Solicitors Ltd. v The County Court Sitting at Manchester* [2015] EWHC 1795 (Admin) concerning findings of dishonesty made by judges against a party (Vogon) and solicitors for a party (MRH) when it had not been suggested, pleaded or put. Mr Garnham also submits that in the absence of a proper exploration at the inquest of the underlying data supporting the conclusions advanced by Dr Rosser in his evidence the coroner failed in her duty of investigation and, furthermore, could not rationally conclude as she did.

Discussion and Conclusions

26. An inquest is the culmination of an investigation which must determine how, when and where the deceased came by his death: section 5 of the 2009 Act. As Sir Thomas Bingham noted in *R v North Humberside Coroner, ex parte Jamieson* [1995] QB 1, it is for the coroner fully, fairly and fearlessly to investigate deaths and it is for the coroner to set the bounds of the inquiry: see general conclusion 14. An inquest is an inquisitorial process and not comparable to a criminal trial or civil proceedings. Lord Lane CJ memorably stated in *R v South London Coroner, ex parte Thompson* (1982) 126 SJ 625, DC:

> "Once again 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 not 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 trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use."

27. Fairness in an inquest must be fashioned in an environment where there are no pleadings and in which those given leave to appear as interested persons do not have a case to put. The evidence at inquests often takes an unexpected turn and calls for a degree of flexibility in the procedure to be followed as a consequence. The rules of evidence applied in criminal and civil proceedings do not apply. Questions of fairness to those involved in inquest proceedings must be judged against all these essential features and also in the context that the statutory scheme prohibits a finding of criminal liability on the part of a named person, or of civil liability.

28. *Vogon* is authority for the proposition that in civil proceedings a judge should not find that a claimant had pursued a dishonest claim when such a suggestion had not be made in the course of those proceedings or put to any witness. At paragraph 29 May LJ said:

> "It is elementary common fairness that neither parties to litigation, their counsel, nor judges, should make serious imputations or findings in any litigation when the persons against whom such imputations or findings are made have not been given a proper opportunity of dealing with the imputations and defending themselves."

29. *MRH* concerned allegations of dishonesty made against the claimant's solicitors and others involved following a road traffic accident which the judge concluded was "staged". The defendant, whilst pleading that the accident was staged and the claims were fraudulent, had pleaded expressly that it was not his case that the solicitors, or claims management or hire companies, were participants in the fraud. The judge encouraged the defendant's counsel in the course of the hearing to allege dishonesty against the solicitors and others. That invitation was declined. Dishonesty was thus never suggested in the course of evidence or argument. The judge nonetheless made findings of dishonesty against the solicitors and companies, which this court decided were impermissible.

30. Both these cases are far removed from the circumstances surrounding the evidence foreshadowed in paragraphs 33 and 34 of Dr Rosser's statement. I shall endeavour to explain why.

31. The starting point is that Mr Wilson was aware of the suggestion by the Trust that his data relating to angina and pulmonary hypertension had been inaccurately recorded, although we are told that he received evidential material relating to it only very

shortly before the inquests began. The evidence relating to it had been provided to the GMC by Dr Rosser and served upon Mr Wilson, with detail of the underlying analysis albeit without the medical records of the 80 or more patients whose records had been examined. Overshadowing all of the consideration of the issue at the inquest was the fact that the GMC was seized of a complaint relating to that very issue. Indeed, it is clear that the aim of Mr Wilson and his advisers, as the written submissions from which I have quoted make plain, was to keep this issue out of the inquest and reserve it to the GMC. Mr Wilson was not entirely taken by surprise when the matter emerged in Dr Rosser's statement for the inquest.

32. I readily accept that material provided to Mr Wilson in the GMC proceedings could not be used for a different purpose without authority. The status of Dr Sims' report, which the transcript suggests had also come to Mr Wilson through the GMC, did not prevent its use in the inquests. As I have already indicated, there were mechanisms that would have enabled the additional material attached to Dr Rosser's statement to the GMC to be deployed by Mr Wilson had he wished to do so. He did not wish to do that for reasons which are entirely understandable, but he cannot complain about any consequential disadvantage that flowed in the inquest proceedings. In the exchange quoted at paragraph 18 above, the coroner sought to understand whether Mr Wilson disputed the evidence relating to angina and pulmonary hypertension. Beyond being told Mr Wilson had a view about it, which was not explained, the opportunity to engage with the evidence was not taken up. The observation made by counsel that someone should have put Dr Rosser's paragraphs 33 and 34 to Mr Wilson whilst he gave evidence about the individual patients suggests an approach akin to civil or criminal proceedings which was not in keeping with the inquisitorial nature of the inquests and the status of interested persons (not parties). I read the coroner's intervention at this point as amounting to an invitation to Mr Wilson to explain his position regarding this evidence.

33. The written submissions suggested that counsel might explain Mr Wilson's reservations about the analysis which underpinned paragraphs 33 and 34 of Dr Rosser's statement, but that did not happen. The same written submissions canvassed the possibility of questioning Dr Rosser further on the topic but that too was not pursued. That Mr Wilson might give evidence on the topic, being recalled for the purpose, was mentioned but effectively discounted on his behalf.

34. The expanded answer given by Dr Rosser on the substance of the analyses suggested that only one in twenty patients noted as receiving drugs for unstable angina was confirmed by the prescription records. 78 patients were labelled as having pulmonary hypertension when the records suggested the true number was 16. Furthermore, there was the improbable fact that a large number of those so labelled had the same score, namely 65. In respect of both measures, the inaccurate data were far removed from the average expected. There is every reason to suppose that Mr Wilson could have explained, if it be the case, that the figure of only one in twenty confirmed by the computerised prescription records was wrong. So too the apparent substantial over-reporting of pulmonary hypertension and the coincidence of so many recordings at 65. For the purpose of dealing with these stark inconsistencies, the medical details of the patients were unnecessary. It was explicitly stated in the written submissions that Mr Wilson had serious reservations about the figures. The submissions indicated that an explanation would be provided but that did not happen.

35. In these circumstances I am unable to accept the submission made on behalf of Mr Wilson that he did not have adequate notice of the point or have an opportunity to deal with it before the coroner came to her narrative verdict. In reaching that conclusion I also reject the submission that the only way which the matter could be dealt with fairly, alternatively adequately (which I use as shorthand for the second way in which Mr Garnham advances the point), was to explore the individual medical records of the 81 or more patients and the prescription records. The coroner took the view that the purpose of exploring this aspect of the evidence was to determine whether an alert would have been triggered and that it was unnecessary to delve into the detail of the individual records (even had they been available). As *Jamieson* confirmed, it is for the coroner to determine the scope of the inquest. This decision was taken by the coroner in a context, it should not be forgotten, where Mr Wilson was aware of the issue and could have engaged with it. In my judgment there was no public law error in her approach.

36. Furthermore, whilst I accept that the impugned sentence clearly pointed to Mr Wilson as the surgeon who may not have operated on the three deceased patients had the "flag gone up", the coroner was careful not to identify him as the person who recorded the inaccurate data. That was consistent with the original oral evidence of Dr Rosser, who also did not identify Mr Wilson as the source of the inaccurate data, albeit that his expanded explanation did so.

37. On the evidence before her, the coroner was entitled to come to the conclusion she did. It cannot be described as irrational.

38. Informing each of the three grounds advanced on behalf of Mr Wilson are two complaints about Dr Rosser. First, it is said that he was not independent because he reported the concerns about inaccurate data to the GMC and was involved in the process that led to Mr Wilson's dismissal. Secondly, he was not expert in the matters which were the subject of analyses in question. Both propositions are correct but do not lead to the suggested conclusion that his evidence of this issue should have been discounted by the coroner. The first might go to the question whether to accept the evidence, were their any suggestion that it was unreliable because of some animus, conscious or unconscious against Mr Wilson. The transcript does not support such a suggestion. The second raises the point that this part of Dr Rosser's evidence was hearsay. That might lead to some caution in accepting it but, as I have already indicated, no basis for questioning the underlying analyses of the raw data was ever given by or on behalf of Mr Wilson.

39. I would dismiss this claim for judicial review.

Mr Justice Holroyde

40. I agree.