Case No: CO/3557/2015

Neutral Citation Number: [2016] EWHC 1396 (Admin)
**IN THE HIGH COURT OF JUSTICE**
**QUEEN'S BENCH DIVISION**
**ADMINISTRATIVE COURT**
**Sitting at Manchester Civil Justice Centre**

Judgment handed down at
Royal Courts of Justice
Strand, London WC2A 2LL

Date: 16/06/2016

**Before**:

**THE PRESIDENT OF THE QUEEN'S BENCH DIVISION**
**(SIR BRIAN LEVESON)**
**and**
**MR JUSTICE KERR**

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**Claimant**

**THE QUEEN**
**(on the application of TERESA TAINTON)**

**- and -**

**HM SENIOR CORONER FOR PRESTON AND WEST LANCASHIRE** — **Defendant**

**- and –**

**LANCASHIRE CARE NHS TRUST**

**Interested Party**

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**Emma Favata** (instructed by **Broudie Jackson Canter**) for the **Claimant**

**Bridget Dolan QC** (instructed by **HM Senior Coroner for Preston and West Lancashire**) for the **Defendant**

The **Interested Party** did not appear and was not represented

Hearing date: 25 May 2016

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# Judgment

**Sir Brian Leveson P:**

*Introduction*

1. This is the judgment of the court to which we have both contributed.

2. On 23 October 2013, James O'Neill, who had been a serving prisoner prior to his release on compassionate grounds, died of cancer of the oesophagus. It was and remains common ground that the inquest which followed his death had to meet the obligations of the United Kingdom under Article 2 of the European Convention on Human Rights and Fundamental Freedoms (ECHR) and thus required an investigation into the circumstances of the death. This application which proceeds with permission granted by Judge Stephen Davies raises questions as to the directions which ought properly to be given to an inquest jury by a coroner in such an inquest both generally and specifically directed to the facts of this case.

3. In short, Mr O'Neill's mother, the claimant, challenges the decision of the defendant, Dr James Adeley, HM Senior Coroner for Preston and West Lancashire ("the coroner"), not to leave to the jury the issue whether admitted failings on the part of medical staff responsible for his care while in prison significantly hastened or may have significantly hastened Mr O'Neill's death by delaying the diagnosis of his cancer. The claimant seeks an order quashing the record of inquest and an order that a fresh inquest be held.

4. Thus, propositions advanced in support of this application are, first, that the coroner erred in law by not leaving to the jury the question whether, on the balance of probabilities, the admitted failure of medical care did significantly hasten Mr O'Neill's death. In the alternative, the coroner should have exercised his discretion to leave to the jury the question, even if not proved on the balance of probabilities, whether it was a possibility that his death was thereby significantly hastened.

The Facts

5. Mr O'Neill was born in November 1966 and was aged 46 when he died. In September 2012, he was remanded at HMP Preston. From October 2012 onwards, he complained of symptoms to various medical staff employed by the Lancashire Care NHS Trust ("the Trust"). He complained of a persistent cough. By November 2012, he was noted to be coughing blood. Antibiotics were prescribed. A sputum sample was not taken. He was referred for a chest x-ray.

6. On 3 December 2012, Mr O'Neill was sentenced to eight years and eight months' imprisonment. Three days later, he underwent the chest x-ray, which was clear. He took a blood test on 28 December, the results of which showed a raised erythrocyte sedimentation rate (ESR) of 25 and a raised white blood cell count of 11.4. The review notes indicated that raised ESR is an indicator of infection, inflammation and cancer.

7. Dr Mohammed Rafiq attributed the results to a chest infection. He asked for further blood tests to be done three to four weeks later. There is no evidence that these were

done. On 11 January 2013, Mr O'Neill consulted a blood borne virus nurse, Ms Makoni, telling her that he was passing "whitish" urine. He was given a specimen jar, but there is no record of a urine sample being provided for analysis or of any other follow up.

8. On 25 January, Mr O'Neill saw Ms Makoni again and complained that he was coughing up blood and had a burning sensation when producing phlegm. She could not see traces of blood when he coughed so she gave him a specimen jar and asked him to provide a sputum sample and give it to a member of the health care staff to enable further investigations to be done. There is no evidence that he provided a sputum sample or that this was followed up.

9. On 11 March 2013, Mr O'Neill reported to another doctor that he had lost weight. He saw a different nurse, Ms Dawson, on 4 April 2013. He reported that he still had a productive cough. She advised him to provide a sputum sample and to return if the symptoms got worse.

10. On 1 May 2013, he saw Ms Parry, a different nurse again, at a routine health monitoring clinic. She noted nothing abnormal, but he reported that his urine was darker than usual, that he had been feeling very sick and had lost a lot of weight. The nurse did not check his weight or medical records. She recommended that he be reviewed in six months.

11. On or about 9 May 2013, Mr O'Neill was transferred to HMP Wymott, where he was screened on arrival. He reported to the nurse conducting the screening that he had lost weight, had stomach pains, had not seen a GP for months; he had a burning sensation when he ate and drank and often vomited. She made a routine referral to a GP.

12. On 10 June 2013, he saw another nurse, Ms Kettle, for a routine check for suspected hepatitis C. On 20 June, he collected his medication from another nurse, told her had lost a lot of weight in the previous two months and that he had been vomiting for a week. She noted that his forthcoming GP appointment was fixed for 24 June, four days later.

13. On that day, Mr O'Neill saw a Dr Kantharia, complained that he had been vomiting, that his vomit contained dark red blood and that he had lost four kilograms in the past three months. Dr Kantharia made an urgent referral to a specialist under a procedure which requires an appointment within two weeks where a patient is suspected of having cancer.

14. So it was that on 2 July 2013, he attended the chest clinic at Royal Preston Hospital. An x-ray, computed tomography (CT) scan and blood tests were done. He was diagnosed with cancer of the oesophagus. On 15 July, a further CT scan revealed that the cancer had spread to his liver and right lung. Chemotherapy was considered. On 22 July, he had a "stent" fitted, to help him swallow. On 23 July, he was advised that he had six to twelve months to live and that no active treatment was possible.

15. Mr O'Neill was then referred to Dr Elaine Young, a consultant clinical oncologist, on 23 July. Four days later he returned to HMP Wymott. On 22 August, he was returned to HMP Preston. At the end of September 2013, he spent 10 days in a hospice before returning to HMP Preston. He was admitted to the Royal Preston Hospital for a blood

transfusion on 17 October and released on temporary licence. He died on 23 October 2013.

16. It is not surprising that there was an independent clinical review into the circumstances of Mr O'Neill's treatment and death. It was conducted by Dr Bicknell who, in February 2014, concluded that:

> "the time between presentation with respiratory symptoms to referral was 8 months. This is entirely unacceptable. The majority of this delay was in HMP Preston where abnormal blood tests were not acted upon and serious symptoms such as coughing up blood, weight loss and difficulty swallowing not followed up."

17. Dr Bicknell's view was that the prison health care "fell significantly below an acceptable standard" with regard to the late diagnosis of cancer. That conclusion was effectively adopted in a report by the Prisons and Probation Ombudsman (the PPO report), in June 2014. It made five recommendations including that the heads of health care at HMP Preston and HMP Wymott should:

> "… ensure that nurses refer prisoners to see a GP when they report concerning symptoms, that GPs refer to specialists appropriately and that action identified at consultations are followed up."

18. The Trust accepted the conclusions of these various investigations and, on 4 March 2015, wrote to the coroner in terms:

> "… the Trust accepts, as does Nurse Makoni, that she ought to have referred Mr O'Neill to one of the prison GPs when he presented to her in January 201[3] complaining of haemoptysis.
>
> It is further accepted that had a GP referral been made, the GP would have made a two week referral to hospital for Mr O'Neill to undergo additional investigations – which would probably have involved endoscopy – with a diagnosis of cancer being made around mid-February 201[3].
>
> The Trust is, of course, unable to say how advanced the cancer was in mid-February 201[3]."

19. Against that background, on 29 and 30 April 2015 an inquest was held by the coroner with a jury. The admissions mentioned above were repeated at the start by the Trust's representative, and in evidence by the relevant witnesses. It was not disputed that Mr O'Neill's condition should have been diagnosed in around February 2013, some five months earlier than it was diagnosed, and that it would have been diagnosed in February 2013 if he had been properly attended to by the prison health care staff.

20. We have seen a "transcription of notes" of Dr Young's evidence at the inquest. They are not in the form of a professional transcript but we were told at the hearing that they were typed from a digital recording of the inquest proceedings; by the time of the hearing before us, they were in agreed form. The coroner noted at the end of Dr Young's evidence that it had lasted for about one and a half hours. The main points of her evidence were as follows.

21. When she saw Mr O'Neill on about 23 July 2013, it was too late for chemotherapy; he would not have tolerated it. When she saw him in September 2013, he was worse and, she concluded, nearing the end of his life. The tumour was aggressive and the tests done in July 2013 showed there were already secondary cancers by that stage. As for the progression of the cancer, Dr Young did not think it likely that the earlier coughing of blood was attributable to bleeding in the lung resulting from a secondary cancer that had spread. She did not rule this out, but thought an infection was the most likely cause of this symptom.

22. She explained that if cancer of the oesophagus is "operable" and has not spread, 30 to 40 per cent of patients are still alive after five years. However, between one in six and one in ten patients already have secondary cancers when cancer of the oesophagus is first diagnosed. If the cancer has spread, Dr Young said, the survival period is up to a year with chemotherapy treatment, though it can be for as little as one month. In Mr O'Neill's case, she had told him in July 2013 that she expected he might survive for six to 12 months. She was not able to say when secondary cancers would first have been visible from scans, nor when they first developed.

23. Questioned by Ms Emma Favata, for Mr O'Neill's family, Dr Young explained that blood tests do not indicate whether cancer of the oesophagus is present or not; the diagnostic tools are endoscopy and biopsy. The most common indicator of oesophageal cancer is "dysphagia", or difficulty with swallowing. Dr Young agreed that Mr O'Neill's cancer could have started as early as July 2012. She agreed that if a cancer is inoperable, chemotherapy is discussed with the patient, as are other palliative care measures such as nutrition and pain control.

24. It was common ground that chemotherapy can increase life expectancy by two to three months. Dr Young agreed that this was a case of late diagnosis when there was advanced secondary cancer. She was asked by Ms Favata whether "it is more likely than not that had it been diagnosed earlier he would have had a material or measurable extension in his life"; to which she answered:

> "… if it had been diagnosed at a stage before it had spread then the answer would be yes, possibly, because he would have been staged and if it was operable and if he chose to have an operation which obviously again is the patient's decision … yes, but only if it was before it had spread as soon as it had spread then you may be picking it up a little bit earlier on the curve.

25. Ms Favata then asked whether on the "balance of probabilities" it was "more likely than not [that] if it had been diagnosed before it had spread … that his life would have been extended in a material and measureable way". Dr Young answered: "he would

have been able to be offered treatment which could have extended his life yes". The condition precedent to the question is important.

26. Ms Favata asked whether if at the time of diagnosis there were "the beginnings of secondary cancer and he could have opted to have chemotherapy and radiotherapy", it was "more likely than not that that would have extended his life in a material way". Dr Young answered:

> "Radiotherapy would not have been offered once it had spread that is a local treatment. … Chemotherapy, if he was fit enough for chemotherapy, and that was always a debate with Mr O'Neill, if he was fit enough for chemotherapy, the average increase in life expectancy is 3 months so you might move someone from 9 to 11 or 12 months".

She then answered "yes" to the question: "it's more likely than not that he would have lived for 3 months longer".

27. Mr Sharples, the solicitor for the Trust, then asked questions of Dr Young. The coronial jurisdiction being inquisitorial not adversarial, like Ms Favata, he was permitted to lead the witness. Dr Young agreed she could not say when the cancer started to spread. She agreed with the suggestion that that would be to "speculate" and that she had used that word. Mr Sharples put it to her that it could not be more than a "possibility" that earlier diagnosis would have led to treatment and an improved prognosis. She agreed with that suggestion and with Mr Sharples' proposition that "you cannot quantify that possibility because you simply don't know what the situation was at any given time in terms of the cancer and its progression". The coroner pointed out that if matters involve speculation, "you can't go there that is effectively where you just don't know". Dr Young agreed.

28. Dr Young then proceeded to explain the way in which oesophageal cancer spreads. She did not accept the coroner's suggestion that once a patient has "got difficulty swallowing on the balance of probabilities spread has already occurred"; at that stage, she said that "still leaves you with a possibility of operation", but "it drops the cure rate". Mr Sharples then put his propositions again, eventually eliciting agreement from Dr Young to the suggestion that "unless one knows what advanced stage the tumour has reached it's extremely difficult and I might suggest impossible to say with any degree of confidence at all whether or not chemotherapy would have been beneficial".

29. After discussion of other matters, Mr Sharples returned to this theme with Dr Young. He put to her: "you cannot say when the cancer started or when it spread now chemotherapy whether or not that is going to be beneficial, I understand your evidence to have been that that depends upon one's general health and general condition". She answered affirmatively and Mr Sharples added: "but also the degree to which the cancer has advanced at that time". Dr Young said:

> "whatever the stage of cancer there is a benefit but, if your baseline life expectancy without chemotherapy is 4 months it is

going to go to maybe 6. But if your life expectancy is maybe 9 months because the cancer hasn't spread so much it might go to 11".

30. Mr Sharples then asked whether, in the particular case of Mr O'Neill, "we can realistically say that there is evidence that allows us to conclude that on the balance of probabilities in his case chemotherapy would have been beneficial". Dr Young said "I only know of his clinical condition from when I met him". Mr Sharples put it to the witness that "the answer to my question is no then" and Dr Young agreed.

31. The coroner then took up with Dr Young a discussion of the statistical likelihood of chemotherapy improving life expectancy. She was then asked about the extent to which patients dropped out of chemotherapy on the grounds that they were unable to tolerate it. She said most patients do not complete a course of six sessions, but drop out after three or four. Dr Young could not give an opinion on whether, as at March 2013, Mr O'Neill would have been able to tolerate chemotherapy; that would be speculation. She could only say he was unable to undergo chemotherapy by the time she saw him. She could not, in the coroner's phrase, "extrapolate backwards" from that position.

32. The coroner then explored with Dr Young whether Mr O'Neill had expressed any long term views about chemotherapy, in an attempt to discover whether he would have been likely to accept an offer of chemotherapy if offered it earlier and at a time when his body could still tolerate it. Dr Young was not able to help with this. She explained that many patients do discontinue chemotherapy part way through a course of treatment because of the toxic side effects.

33. An objection was raised by Mr Sharples to Ms Favata's attempt to put to Dr Young a note made by a nurse on 1 May 2013. Dr Young eventually answered that there was "nothing in there [i.e. in the note] which would preclude him from chemotherapy but it wouldn't be an indicator that he was fit enough".

34. Mr Sharples then suggested to Dr Young that "chemotherapy with all its repercussions and side effects would be quite a high price to pay for a maximum benefit of 2 months prolongation of life". Dr Young responded that it was "very much the opposite with some patients … we know from asking patients or asking the general public the patients will take a lot of treatment for a small benefit".

35. At the end of the inquest, Ms Favata submitted that there was evidence that should be left to the jury that the delay in diagnosing Mr O'Neill's cancer was material, in that his life would on the balance of probabilities have been measurably extended if he had been given the opportunity for chemotherapy treatment several months earlier. The coroner rejected that. From his verbal ruling, it is possible to extract the following main points which, having regard to its significance, we set out extensively.

(1) It was not known when the cancer had started to spread from the oesophagus to the lungs and liver, or locally.

(2) A referral on 25 January 2013, which should have occurred, would have been to the lung rapid referral unit.

(3) If that had occurred, it is only possible to speculate whether secondary cancers would have been detected.

(4) The lung symptoms, i.e. coughing of blood, were either not connected to oesophageal cancer or, if they were, the cancer must have already spread to the lung tissue.

(5) On Dr Young's evidence, 90 per cent of tumours have already generated secondary cancers at the time of diagnosis (more accurately, she said it was up to 90 per cent).

(6) Surgery for Mr O'Neill as at 9 May 2013 was a possibility but, statistically, it was likely his cancer had by then already spread, before diagnosis.

(7) It was not possible to extrapolate backwards in time from July 2013 to discern the point at which he became unable to tolerate chemotherapy.

(8) However, by 9 May 2013, Mr O'Neill had already lost three kilograms in weight and was not eating properly; at the time that was attributed to depression.

(9) While many patients will accept the adverse effects of chemotherapy for a short extension of life, it was unknown whether Mr O'Neill would have tolerated it and when he became unable to tolerate it.

(10) There were too many "unknowns" to enable the jury to "make any meaningful decisions about what is a possibility …"; "any firm conclusions" would be "inherently unsafe".

(11) This was not a case where there were two "schools of thought" as to whether he could have chemotherapy or not; "the variety of information that is missing from this is extremely large".

(12) This was not a case where the jury's views were needed for a "regulation 28 report" (on prevention of future deaths), because the failings identified and admitted by the Trust had been addressed by it;

(13) He was not convinced that he had any "general discretion" to leave the issue of causation to the jury.

(14) If he was wrong about that and he did have such a discretion, he declined to exercise it because he did not think it would be "fair .. to ask them to make conclusions when so much of the evidence is missing".

(15) In the circumstances, he would therefore leave to the jury only the short form conclusion that Mr O'Neill had died from natural causes; he was prohibited by both the "Galbraith" and "Galbraith plus" tests from doing otherwise.

36. The coroner then summed up the case to the jury, leaving the two possible verdicts of either death by natural causes or an open verdict. The jury returned its verdict in short

form, stating that Mr O'Neill had died from metastatic adenocarcinoma of the oesophagus; that he contracted cancer of the oesophagus which metastised, spreading to other organs, ultimately leading to his death by the disease running its full course; and that he died from natural causes.

*The Issues*

37. We will begin with what is agreed between the parties. First, it is common ground that the procedural obligation on the United Kingdom under article 2 of the ECHR applied to this inquest. Indeed the coroner proceeded, correctly, on the footing that article 2 was engaged. The scope of that obligation as applied to this case is not agreed; but it is agreed that, broadly, the obligation is to conduct an effective and independent investigation into the death, including the circumstances in which Mr O'Neill met his death and not just by what means, when and where he met his death.

38. Secondly, it is agreed that it is the proper function of the coroner, acting as a "judicial filter" (in Ms Favata's phrase), to exclude from the jury's consideration conclusions which it cannot properly reach on the evidence. It is also not in dispute between the parties that in exercising this function, the coroner must leave a particular issue to the jury by applying the "Galbraith plus" test: see the useful account of the law given by Haddon-Cave J in *R (Secretary of State for Justice) v. HM Deputy Coroner for the Eastern District of West Yorkshire* [2012] Inquest LR 76, [2012] EWHC 1634 (Admin), at [17]-[23], reviewing earlier authorities, in which Haddon-Cave J explained (at [23]), that the "extra layer of protection" afforded by the second question "makes sense in the context of a coronial inquiry where the process is inquisitorial rather than adversarial, the rights of interested parties to engage in the proceedings are necessarily curtailed and coronial verdicts are at large".

39. According to that test, when deciding whether or not to leave a particular conclusion or issue to a jury, coroners should answer "yes" to both of the questions (a) whether there is evidence on which a jury properly directed could properly reach that conclusion; and (b) whether it would it be safe for the jury to reach that conclusion on the evidence before it? The latter question is the "plus" part of the test, added to the classic formulation in the criminal law derived from the judgment of Lord Lane CJ in *R. v. Galbraith* (1971) Cr App R 124, CA.

40. Applied to this case, the coroner accepts, through Ms Dolan QC, that if there was sufficient evidence upon which the jury might safely find that the admitted delay in diagnosis probably hastened Mr O'Neill's death, then that issue should have been left to the jury to determine. The parties disagree, however, on whether that test was met by the evidence of Dr Young on the subject of causation of Mr O'Neill's death; in particular, whether earlier referral and diagnosis would or could have led to treatment that would have significantly prolonged his life.

41. Third, it is common ground that the threshold for causation of death is not the same thing as the standard of proof required to prove causation of death. In cases such as this, the latter is proof on the balance of probabilities. It is agreed that the threshold that must be reached for causation of death to be established, is that the event or conduct said to have caused the death must have "more than minimally, negligibly or trivially contributed to the death" (see e.g. *R. (Dawson) v. HM Coroner for East Riding and Kingston upon Hull Coroners District* [2001] Inquest LR 233, [2001]

EWHC Admin 352, per Jackson J at paragraphs 65-67). Putting these two concepts together, the question is whether, on the balance of probabilities, the conduct in question more than minimally, negligibly or trivially contributed to death.

42. Fourth and finally, it is common ground that a coroner has a discretion, though not a duty, to leave to the jury causes of death that are merely possible and not probable. The existence of the power was established in *R. (Lewis) v. HM Coroner for the Mid and North Division of the County of Shropshire* [2010] 1 WLR 1836, CA, per Sedley LJ at [28]. The position is correctly expressed in the Chief Coroner's guidance document (No. 17), at paragraph 50 (in the revised version dated 14 January 2016):

> "The coroner has a power in an Article 2 inquest, but not a duty, to leave to the jury, for the purposes of a narrative conclusion, circumstances which are possible (ie more than speculative) but not probable causes of death: *Lewis*; *LePage* …. A narrative conclusion may also (but does not have to) include factual findings on matters which are possible but not probable causes of death where those findings will assist a coroner in a Report to Prevent Future Deaths: *Lewis*."

43. We come next to the issues that divide the parties in this case. The claimant, through Ms Favata, made wide-ranging submissions in a lengthy skeleton argument and orally at the hearing. We will concentrate on the main points. First, she submitted that the state's procedural obligation under article 2 of the ECHR had to be discharged by an inquest in this case; and that this required an expression of the jury's conclusion on the "disputed factual issues at the heart of the case": *R (Middleton) v. West Somerset Coroner* [2004] 2 AC 182, per Lord Bingham (opinion of the Appellate Committee) at paragraph 20. This was not a case, she said, where the state's obligation could be discharged by means of other proceedings such as a criminal trial or public inquiry.

44. Ms Favata reminded us of the oft-cited passage from the judgment of the Grand Chamber of the European Court of Human Rights in *Öneryildiz v. Turkey* (2005) 41 EHRR 20, at paragraph 94, stating that the procedural obligation under article 2 requires the contracting states to:

> "initiate investigations capable of, first, ascertaining the circumstances in which the incident took place and any shortcomings in the operation of the regulatory system and, secondly, identifying the State officials or authorities involved in whatever capacity in the chain of events in issue."

45. She submitted that to achieve compliance with article 2, the coroner should have directed the jury to determine whether Mr O'Neill's death was hastened as a result of the admitted delays in his treatment; whether the medical attention he received was inadequate or amounted to neglect; whether there were systemic failings within the Trust's health care provision at HMP Preston; and how the hastening of deaths, in similar circumstances, could be prevented in the future. In particular, she said it was "perverse and unreasonable" for the inquest to hear evidence from the nurses who admitted their failings in Mr O'Neill's medical care, yet to exclude those omissions and failings from featuring in a narrative conclusion.

46. Indeed, Ms Favata went further and submitted that the failings were such as to justify a verdict of neglect, in the form of "a gross failure to …. procure basic medical attention … for someone in a dependant position (because of youth, age, illness or incarceration) who cannot provide it for himself (*R v. HM Coroner for North Humberside and Scunthorpe ex p. Jamieson* [1995] QB 1, 24 (being the ninth proposition elucidated by Sir Thomas Bingham MR). She submitted that neglect ought to have been left to the jury, not as a verdict on its own but as a contributor to death by natural causes.

47. On the issue of sufficiency of evidence, it was Ms Favata's contention that the coroner reached the wrong conclusion on the evidence: Dr Young's evidence, she submitted, was sufficient to support a conclusion that the delays in referral and diagnosis of Mr O'Neill's cancer caused his life, on the balance of probabilities, to be shortened measurably as it was more likely than not, on Dr Young's evidence, that he would have lived two or three months longer had those negligent delays not occurred.

48. Ms Favata pointed out that on the evidence, chemotherapy is not necessarily untenable for a patient whose cancer has spread and caused secondary tumours. Much depends on the extent to which spreading of the cancer has weakened the patient and diminished his ability to withstand chemotherapy. Ms Favata pointed out that in February 2013, Mr O'Neill was still able to swallow and was more robust than he later became; and he had yet to suffer major weight loss.

49. Ms Favata went on to submit in the alternative that if the coroner was right not to leave to the jury the hastening of death issue applying the Galbraith plus test, it was nevertheless unreasonable for him not to exercise the discretion to leave that issue to the jury on the basis that the failings may possibly have hastened Mr O'Neill's death significantly, even if a jury could not safely find that was more probable than not. The possibility was more than speculative, she submitted.

50. For the coroner, Ms Dolan QC submitted that the inquest was compliant with the procedural obligation of the state under article 2 of the ECHR. She submitted that obligation was one of "means not result". She contended that it would be otiose for the jury to be asked to determine that the admitted short-comings in Mr O'Neill's medical care occurred, since that had been established by Dr Bicknell's review, the PPO report and the public admission of those shortcomings by the Trust at the inquest itself.

51. She noted that in *Middleton* Lord Bingham, when formulating guidance by reference to the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976, had pointedly omitted to include in the guidance the part of section 6(1) of that Act which states that a determination should include "the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided"; a point noted in *Lewis* by both Sedley LJ (at [22]) and Etherton LJ (at [41]).

52. Ms Dolan further submitted that article 2 of the ECHR does not require non-causative shortcomings on the part of agents of the state to be recorded in a narrative verdict. There was no duty to leave to the jury the issue of whether those shortcomings hastened Mr O'Neill's death. Neither the "pure Galbraith" nor the "Galbraith plus" test was met because a reasonable jury could not, safely or at all, reasonably

"convict", i.e. find causation of death on the balance of probabilities, on the basis of Dr Young's evidence.

53. That evidence, according to Ms Dolan, supported at best a mere speculative possibility that, had the cancer been diagnosed in February 2013 rather than July 2013, this might have led to chemotherapy in time to prolong Mr O'Neill's life significantly. That was sufficient to give rise to a discretion in the coroner to leave the issue to the jury, but not a duty to do so.

54. In her skeleton argument, Ms Dolan reproached the claimant's submissions for confusing the standard of proof and the test of causation. Possible causation of death was not enough, as pointed out by Tomlinson J in *R. v. HM Coroner for Coventry ex p. Chief Constable of Staffordshire Police* [2000] Inquest LR 35, at [41] (in the context of whether a "neglect rider" should be added to a verdict). Nor, she pointed out, is the loss of a "substantial chance" of life a relevant test of causation, as it would be in a case where alleged breach of the substantive right to life under article 2 of the ECHR was in issue (as it was in *Savage v. S. Essex Partnership NHS Foundation Trust* [2010] EWHC 865 (QB); see per Mackay J at [82]). At the oral hearing before us, it became clear that these points were accepted by the claimant. There was no disagreement between the parties about the nature of the test of causation here, nor the standard of proof.

55. As for the coroner's discretion to leave to the jury the issue of possible causes that fell short of meeting the Galbraith test or the Galbraith plus test, Ms Dolan submitted that the coroner properly exercised his discretion, for the reasons he gave in his ruling. There were too many unknowns, as he pointed out. He was justified in that view. He was also justified in his view that no report to prevent future deaths (as provided for in regulation 28 of the Coroners (Investigations) Regulations 2013) was necessary in the public interest, since the Trust had already addressed the admitted shortcomings identified in Dr Bicknell's clinical review and subsequently in the PPO report.

*Analysis*

56. We can deal quite briefly with the rival contentions of the parties. The state's procedural obligation under article 2 ECHR arises when there is an investigation into a death in circumstances "where it appears that one or other of the … substantive obligations [under article 2] has been, or may have been, violated and it appears that agents of the state are, or may be, in some way implicated" (per Lord Bingham, on behalf of the Judicial Committee, in *Middleton* at paragraph 3).

57. Where, as in this case, the instrument by which the state discharges its investigative obligation under article 2 is an inquest, the verdict (now conclusion) must establish not only by what means the deceased met his death, but in what circumstances he met his death (*ibid.*, per Lord Bingham at [35]); see now the Coroners and Justice Act 2009 (the 2009 Act) and, in particular, s. 5(1)(b), read with s. 5(2).

58. As Lord Bingham added at [36], it is a matter for the coroner, in the exercise of his discretion, to decide how best in a particular case to elicit the jury's conclusion on the central issue or issues. In some cases, a traditional short form verdict (now conclusion) will suffice; in other cases, the jury's factual conclusions need briefly to

be summarised. All this is now settled law and uncontroversial. We turn next to consider how those principles and propositions apply to this case.

59. There was never any doubt that Mr O'Neill died from cancer of the oesophagus and that this was a death by natural causes. If that had been all there was to the case, no question could have arisen as to whether anything further than a short form "natural causes" conclusion was required. Indeed, if there had no shortcomings in the standard of medical care he received, the article 2 procedural obligation may not have arisen at all and, if it did, would have been readily satisfied by a short form verdict.

60. The reason why that obligation arose, and it is common ground that it did arise, was not just because Mr O'Neill died while in custody but also, of more importance, because the circumstances in which he met his death included, in the last year of his life, starting in October 2012 when he began to complain to prison medical staff of symptoms and ending with his death about a year later, instances of substandard medical care. These are documented in Dr Bicknell's review and in the PPO report, and are admitted in email of 4 March 2015 from the Trust. The admissions were repeated orally on behalf of the Trust at the inquest and in evidence by those responsible for the errors.

61. In the analysis up to this point, there is no real difference between the parties. As regards causation of death, the submissions of the parties were marked by differences of emphasis rather than of principle. We received confirmation at the hearing that there was no disagreement between the parties about the principles on the basis of which the cause of Mr O'Neill's death fell to be addressed by the coroner. They are as follows.

62. First, an event or conduct said to have caused the death, must have contributed more than minimally, negligibly or trivially to the death. The conduct or event must make an actual and material contribution to the death of the deceased. As Ms Dolan pointed out, it is not enough, in the present context, to show that a particular event, or particular conduct, deprived the deceased of an increased chance of life or, to put the point the other way round, made his death more probable than it would otherwise have been.

63. Second, causation of death (in the above sense) must, in the context of an inquest of this type, be proved to the civil standard, i.e. on the balance of probabilities. In this case, if the issue of whether the shortcomings in Mr O'Neill's medical care hastened his death were to be left for the jury to decide, the jury would be required to decide that issue on the balance of probabilities, i.e. whether it was more likely than not that those shortcomings caused (again, in the sense explained above) Mr O'Neill's death.

64. Thirdly, the coroner was bound to leave that issue to the jury if, but only if, his answer was "yes" to both the questions (a) whether there was evidence on which a jury properly directed could properly conclude that the shortcomings in Mr O'Neill's medical care measurably hastened his death; and (b) whether it would be safe for the jury to reach that conclusion on the evidence before it (the latter being the "plus" part of the test).

65. In the present case, if the issue were approached by reference to the first of those two questions only, but not the second, a reasonable coroner might conceivably have

reached the conclusion that the answer to the question was yes. There was *some* evidence pointing to that conclusion: Dr Young, at one point, appeared to accept the proposition that it was "more likely than not [that] if it [the cancer] had been diagnosed before it had spread … that his life would have been extended in a material and measureable way". As noted above, she answered: "he would have been able to be offered treatment which could have extended his life yes".

66. That was the high water mark of the evidence supporting that proposition, but it was founded on the triple assumptions (i) that the cancer had not already spread too far as at February 2013, when the cancer should have been diagnosed; (ii) that Mr O'Neill would have accepted an offer of chemotherapy at that stage (there being no evidence of his personal disposition on that issue one way or the other); and (iii) that he would have withstood the toxic side effects of the treatment sufficiently to benefit from it and extend his life measurably.

67. It is not surprising that Dr Young adopted a more cautious approach later in her evidence when those assumptions were drawn to her attention. She agreed with the proposition that in the light of those unknowns, it would be speculative to say that diagnosis of the cancer in February rather than July 2013 would have led to a measurably longer life for Mr O'Neill. The coroner's decision to withdraw the issue of causation from the jury was essentially founded on a negative answer to the second question: it would not be *safe* for the jury to reach the conclusion for which Mr O'Neill's family contended.

68. We are firmly of the view that the coroner was right to reach that conclusion, and that he was not bound to leave the issue of causation of death to the jury. We agree with his analysis: there were too many unknowns in the factual history; it would not be safe for a jury to accept the family's contention that Mr O'Neill's death was measurably hastened as a result of the admitted shortcomings in his medical care.

69. The coroner went on to consider the submission of Ms Favata that he had a discretion to leave the issue to the jury nonetheless. Ms Dolan accepts in this application that he had such a discretion: it was open to him in the exercise of that discretion to leave to the jury a cause of death that was a mere possibility, short of meeting the civil standard of proof on the balance of probabilities.

70. The coroner professed himself unconvinced that he had such a discretion. In this, he was not correct. But he went on to say straight away that if he were wrong and he did have the discretion to leave the issue of a possible hastening of death to the jury, he exercised his discretion against doing so. He would not be willing to leave that issue and would not leave open a narrative verdict "when so much of the evidence is missing".

71. In our judgment, the coroner was entitled to exercise his discretion in that way, and properly did so. We would not interfere with the coroner's decision on that issue; he was justified in not leaving a "neglect finding" as a potential finding for the jury to reach.

72. Thus far, the progress and conduct of the inquest was fair and lawful. However, there is one aspect of the case where we do consider that the coroner erred in a manner that was material. It arises from the admissions that were made by the Trust's

representative at the inquest that there were serious shortcomings in Mr O'Neill's medical care. The evidence called by the coroner included admissions of those failings by the witnesses guilty of them.

73. Although these facts were not disputed, we consider that the coroner should have directed the jury to include in the Record of Inquest a brief narrative of the admitted shortcomings of the health care staff responsible for the late diagnosis of Mr O'Neill's cancer. In the light of the fact that the coroner withdrew the issue of causation from the jury, such a statement would have to have been supplemented by an explanation that it could not be concluded that these shortcomings significantly shortened Mr O'Neill's life. In this case, such a statement would have completed the incomplete account of the circumstances in which Mr O'Neill met his death, which the Record of Inquest contains (Form 2, Schedule to the Coroners (Inquests) Rules 2013), and would have been a fair reflection of the issues that the inquest had focussed upon even if the issue was left to the jury only on the basis of a choice between a conclusion of death by natural causes and an open conclusion.

74. Putting the point another way, in an inquest such as this, where the possibility of a violation of the deceased's right to life cannot be wholly excluded, section 5(1)(b) and 5(2) of the 2009 Act should require the inclusion in the Record of Inquest of any admitted failings forming part of the circumstances in which the deceased came by his death, which are given in evidence before the coroner, even if, on the balance of probabilities, the jury cannot properly find them causative of the death.

75. This was a matter of fairness to the family of the deceased, and was required in this case in order to discharge in full the obligation on the state imposed by article 2 of the ECHR and on the coroner by section 5(1) and (2) of the 2009 Act. Our conclusion is not altered by the fact that the coroner was not bound to decide to make a report with a view to the prevention of future deaths under regulation 28 of the Coroners (Investigations) Regulations 2013. The coroner properly decided that he did not need to make such a report, because the Trust had addressed the criticisms of its health care staff, which had emerged from Dr Bicknell's review and from the PPO report.

76. Ms Dolan submitted that, because the criticisms had been publicly aired in those documents, and had been publicly admitted by the Trust and its witnesses at the inquest, inclusion of the narrative of those failings in the Record of the Inquest, as part of the conclusion, would be superfluous. She relied on the state's ability, recognised in *Middleton* and other authorities, to discharge its article 2 procedural obligation by means other than an inquest, such as a criminal trial or a public inquiry.

77. She submitted that in this case, the PPO and the public admissions at the inquest, combined with the natural causes conclusion, sufficed to perform the state's obligation. She pointed out that Lord Bingham in *Middleton* (at paragraph 20) had confined the requirement for a narrative verdict to cases where it was necessary to set out "the jury's conclusion on the disputed factual issues at the heart of the case". She reminded us that he did not say that a statement of undisputed facts had to form part of a narrative verdict.

78. We do not accept those submissions. In the present case, without the admitted failings forming part of the narrative in box 3 of the Record of Inquest, the conclusion was materially incomplete and verged on misleading by omission. Lord Bingham in

the passage in *Middleton* to which our attention was drawn, was not dealing with a situation such as arose in this case. As Ms Favata pointed out, at paragraph 18 of his speech, Lord Bingham noted that:

> "… a verdict of an inquest jury which does not express the jury's conclusion on a major issue canvassed in the evidence at the inquest cannot satisfy or meet the expectations of the deceased's family or next-of-kin. Yet they, like the deceased, may be victims. They have been held to have legitimate interests in the conduct of the investigation (*Jordan* 37 EHRR 52, para 109), which is why they must be accorded an appropriate level of participation: see also *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653. An uninformative jury verdict will be unlikely to meet what the House in *Amin*, para 31, held to be one of the purposes of an article 2 investigation: "that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others."

79. There are no doubt cases in which public acknowledgment of failures on the part of agents of the state in a forum other than an inquest can indeed form part of the means by which the state discharges its investigative obligation. We are not suggesting that any admitted failings have to be included in every case. The manner in which the state discharges that obligation will, as Ms Dolan correctly submitted, vary from case to case. The position may be entirely different if, for example, a public inquiry or a criminal prosecution has taken place.

80. But this is not such a case. Here, there is real force in Ms Favata's submission that it was not reasonable or lawful for the admitted shortcomings in Mr O'Neill's medical care to be excluded from the Record of the Inquest, so that the conclusion as to the death was merely described as natural causes. The material facts leading up to the deceased's death included substandard care by agents of the state which, if they were to pass unmentioned, would render the bland short form "natural causes" verdict inadequate to describe properly the circumstances in which the deceased met his death.

81. In our judgment, the admitted failings of the Trust's medical staff were not otiose because they were admitted, as Ms Dolan submitted. On the contrary, they should have formed part of the inquest findings precisely because they were admitted, and formed part of the evidence heard by the jury.

82. We do wish to emphasise, however, that this does not mean the scope of investigations in inquests needs to be expanded. We are very far from saying that inquests should become more complex than they already are. That would be contrary to the public interest. It is not necessary to look into every possible issue. The narrative that ought to have been included in this case could have been expressed in a couple of brief sentences. This would have produced a more complete, publicly available, Record of Inquest.

83. To that extent only, the application is well founded and the inquest was deficient. However, a fresh inquest is unnecessary and would serve no useful purpose (as was decided, despite a misdirection, in *R (P) v. HM Coroner for the District of Avon* [2009] EWCA Civ 1367, [2009] Inquest LR 287; see paragraph 33 of Maurice Kay LJ's judgment). The present application before the court, and the court's judgment, suffice to make good the deficiency, without any further order or relief being granted. The Record of Inquest should therefore not be quashed, and subject to hearing counsel, we do not consider that any further relief is required beyond a declaration that the application is well-founded to the extent identified in this judgment.