CO/5979/2016

Neutral Citation Number: [2017] EWHC (Admin) 1803
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand
London WC2A 2LL

Tuesday, 16 May 2017

B e f o r e:

MRS JUSTICE ANDREWS DBE

Between:

THE QUEEN ON THE APPLICATION OF
(1) HEINONEN
(2) SAWKO

Claimants

v

CORONER FOR INNER SOUTH DISTRICT GREATER LONDON

Defendant

Computer-Aided Transcript of the Stenograph Notes of
WordWave International Limited
Trading as DTI
8th Floor, 165 Fleet Street, London EC4A 2DY
Tel No: 020 7404 1400 Fax No: 020 7404 1424
(Official Shorthand Writers to the Court)

The Claimants appeared in person

Mr Jonathan Dixey (instructed by Southwark LBC) appeared on behalf of the **Defendant**

J U D G M E N T
(Approved)

MRS JUSTICE ANDREWS:

1. This is the oral renewal of an application for permission to bring judicial review of a decision made by the Senior Coroner for Southwark on 2 September 2016 refusing to order a further investigation into the death of a young woman who was identified as being Simona Heinonen, the daughter of the claimants. The claimants are concerned, for reasons that one can entirely understand and sympathise with, that this was a case of mistaken identity.

2. The background to this distressing matter can be summarised as follows. Simona, who was born in April 1988, suffered from a rare type of progressive brain stem tumour for which there was no cure. Towards the end of her life, Simona experienced increasing difficulties in swallowing, and increasing shortness of breath. On 9 March 2016, she was admitted to King's College Hospital. Her family are highly critical of the care that she received there, but this claim for judicial review is not concerned with the rights or wrongs of any complaint that they may have in that regard, which must be directed to the hospital or the relevant NHS Trust.

3. Simona passed away on 20 March 2016. Her family requested a post-mortem examination. Her mother has explained that she was particularly concerned to find out the cause of Simona's death, and whether it was due to the ingestion of stomach fluids. The medical staff at the hospital also wanted a post-mortem examination, but for different reasons; they wanted to know whether the brain tumour should be recorded on the death certificate as a cause of Simona's death or whether it should be recorded as a separate matter from which she suffered, with the main cause of death being, as they said, pneumonia.

4. The coroner therefore became involved, and on 30 March 2016 a consultant neuropathologist at the hospital, Dr I Bodi, carried out a post-mortem examination on a body which was said to have been that of Simona. The macroscopic examination of that body revealed bilateral pneumonia and a large intrinsic brain stem tumour. The microscopy confirmed features that were consistent with aspiration pneumonia and "an extensively infiltrating malignant glial tumour", which had features suggesting malignant transformation from a pre-existing astrocytoma. Simona had had an astrocytoma diagnosed during a brain operation she underwent at University College Hospital in 2014. The conclusion was drawn that the cause of death was brain stem glioma and pneumonia.

5. Dr Bodi's post-mortem report describes the height of the woman he examined as being 1.72 metres. It states that the body was identified by name bands on the wrists and that it was of:

> "a white Caucasian young female with appearances consistent with [Simona's] staged age of 27. She had grey eyes, native teeth and light brown long hair."

It described bruising in various areas consistent with recent medical interventions, and it also stated that "A healed right frontal scar of 1cm in diameter was also seen." The location of the scar was not otherwise identified.

6. Simona's family were understandably extremely concerned by this description, because Simona's height and other physical attributes did not match the description recorded in the post-mortem report. She was 162 centimetres tall, considerably shorter than the person whose height was recorded. That measurement was taken from her general practitioner

records. Her hair was dark brown and it was short, because it was growing out after recent radiotherapy. She had brown eyes rather than grey, and she had a scar from a previous operation at the back of her head which was 10 centimetres long, which was nowhere mentioned in the post-mortem examination. She also had a right frontal scar that was linear, not circular, and 3.5 centimetres long, not 1 centimetre long. Dr Bodi later confirmed to the coroner's office manager that there was a right frontal scar on the head of the person he examined, but that his record was of it being 1 centimetre long. On any view, the coroner's later description is of a linear scar, not a circular one, and it does not explain why a description of 1 centimetre in diameter was on the original record.

7. Simona's family naturally raised questions about all these matters with the coroner, but despite extensive correspondence and the pathologist's statement that he could "confidently say that we performed the post mortem on the right body", they did not receive an answer that satisfied them. The family therefore asked the coroner to open an investigation into the matter. The problem is that the coroner's powers, including his powers of investigation, are circumscribed by statute.

8. By virtue of section 1(1) of the Coroners and Justice Act 2009 the coroner would have to have reason to suspect that the deceased died an unnatural death in order to open an inquest. That would, of course, include a case in which there was reason to suspect culpable failures in care which caused or contributed to an otherwise natural death. However, once the cause of a person’s death is known and it appears to be a natural death, then the coroner has no power to investigate the death any further, and must discontinue such investigation under section 4 of the Act.

9. As a matter of obvious logic, the coroner must be satisfied that the post-mortem examination

was of the body of the deceased, because he must be satisfied as to the cause of death of that person; but he has no power to open an investigation into someone's death on the basis that the post-mortem examination may have been carried out on the wrong body.

10. The coroner in this case, the Senior Coroner at Southwark Coroner's Court, reached the conclusion that Dr Bodi's reports provided a clear conclusion as to the cause of Simona's death and therefore satisfied the requirements of section 4(1)(a) of the 2009 Act.

11. On 15 June 2016, the coroner notified Simona's family that he proposed to accept the findings of the neuropathologist. He stated that he had no reason to suppose that her death was unnatural, and that he did not propose to open an investigation. As a key part of his findings he accepted that the pathologist had carried out the autopsy on Simona, but he recorded in his provisional decision that he had offered her family the opportunity to order a second autopsy. He also ordered that the medical records be made available to Simona's family should they wish to examine these and to provide the coroner's court with new evidence to be considered, or to take legal advice on their position.

12. On 24 August 2016, the solicitors then representing Simona's mother wrote to the coroner expressing the concerns that their client and her family had with regard to the post-mortem. In the letter, the solicitors drew attention to each of the physical differences I have already identified, and said that they had instructions to instruct independent pathologists named Forensic Access to confirm the identity of the person upon whom the post-mortem had been carried out. They stated that they would require samples of the brain from which they could obtain a DNA profile. The coroner responded favourably to that request, and the retained blocks and slides were released to the family for DNA testing. However, that testing does not appear to have been carried out.

13. On 2 September 2016, the coroner made the decision under challenge. He decided to notify the Registrar of Death that he did not consider it necessary to hold an inquest into Simona's death, and to issue Form B certifying that a post-mortem had been carried out under section 14 of the Coroners and Justice Act 2009. It is the latter aspect of the decision that the claimants seek to challenge.

14. The present claim for judicial review was issued on 25 November 2016. In the details of the remedy being sought, the claimants have asked the coroner to "Remove the considerable doubt that the subject of the autopsy is ... Simona ...". They stated that: "a repeat histology of the brain and spinal tissue and DNA test of that same tissue would remove such doubt." In addition, they asked a number of detailed questions about the autopsy itself and certain unanswered questions about its process and conclusions.

15. In refusing permission to bring judicial review on the papers, the single judge pointed out that the coroner's decision, being a matter of discretion, was only open to challenge on the basis that it was Wednesbury unreasonable. His view was that there was what he described as "ample basis" for the conclusion that the coroner had reached on the issue of identity, supported by name tags and the presence of what the pathologist had described as "a very rare brainstem glioma". The judge also referred to the fact that the tissue samples had been made available to Simona's mother so that she may have the DNA in those samples checked.

16. In this renewed application it is contended by the claimants, whose case was very ably argued by Simona's stepfather Mr Sawko, that it is at least arguable with a real prospect of success that the coroner's decision was Wednesbury unreasonable. It is contended, first, that the coroner patently failed to take into account material factors, namely the immutable physical discrepancies in the description in the post-mortem records which had been drawn

to his attention, and that his response to the family's concerns effectively amounted to trusting the pathologist's word that he had carried out the autopsy on the right person.

17. Mr Sawko submitted that the wrist tags are mutable features rather than immutable physical features. Whilst Dr Bodi had pointed to the probabilistic assessment of the identification of the subject of examination, based on it being highly unlikely that there were two female patients of about the same age with the same rare tumour in the examination room at the same time, Mr Sawko argued that this is simply not good enough. This hospital specialises in the treatment of brain tumours, and there is no suggestion that the doctor had checked to see whether in fact there was another patient in the mortuary suffering from the same type of tumour before presenting that argument.

18. As for the fact that the autopsy took place in the presence of the registrar and the mortuary technician, the claimants' answer to that is that any error in recording the physical description which had been made by the neuropathologist should have been identified by the others who were present. The claimants submit that the presence of the other individuals makes it even less likely that the doctor made an error in recording the physical characteristics of the person he was examining, which do not match the description of their daughter. In any event, none of the three persons stated to have been present knew Simona before she entered the hospital.

19. It was also contended that just because the subject of the post-mortem examination could theoretically be identified now, for example, by the carrying out of DNA tests, that does not remedy the original wrong, which is "that the coroner approved the identification of the examinee without proper scrutiny ...".

20. It is extremely important to focus on the nature of the decision that is under challenge. The

essence of the decision was that it was unnecessary to hold any further investigation into the cause of Simona's death. It was not a decision to refuse to carry out further tests on the body or to allow such tests to be carried out; indeed, the family was offered the opportunity of a second autopsy and access to the tissues that would enable DNA testing to be carried out.

21. One can fully understand the views of the family that they should not have to undergo the expense of carrying out such tests to prove that the hospital got it right. That is a point of view with which, on a human level, one can entirely sympathise. However, the fact remains that the claimants do not need a court order in order to obtain those repeat tests. Where there is a viable alternative remedy available to the claimant, the court will not grant judicial review. No doubt that was what the single judge had in mind when he referred to the fact that the tissue samples had been made available to Simona's mother so that she may have the DNA checked, a process which would undoubtedly put to rest any residual doubts over the identity of the person on whom the autopsy was carried out.

22. However, that is not the basis upon which I make my decision, which I make afresh and entirely unaffected by the views of the single judge. The question for this court is whether there is a viable argument that the decision taken by the coroner was an unreasonable decision in the Wednesbury sense, bearing in mind the overriding duty of the coroner to ensure that relevant facts are fully and fearlessly investigated.

23. In order to establish that the decision was Wednesbury unreasonable it would have to be shown that material factors relevant to the decision were omitted from consideration, irrelevant factors were considered, or that no reasonable coroner could have reached that conclusion. The coroner needed to be satisfied that there was no reason to suspect that Simona's death was not due to natural causes, or that death by natural causes had been

brought about by a lack of care.

24. Whatever criticisms may be made of the accuracy of the description of the patient in Dr Bodi's report, it did not support a suggestion that the subject of the autopsy had died from anything other than natural causes, namely a combination of pneumonia and a brain tumour. The coroner was entitled to rely upon the professional opinion of an experienced neuropathologist in these respects.

25. Even if the coroner had not been satisfied that the autopsy had been carried out on the right person, it would not necessarily have justified him in ordering any further investigation. The most he could have done would have been either to request further information, so as to satisfy himself that the subject of the autopsy was indeed Simona. or to direct a fresh autopsy or further tests before determining that he was satisfied of the cause of her death and that there was no need for an inquest. In the light of the information that has now been put before the court, albeit belatedly, there is little doubt that if he *had* asked for further confirmation from, for example, the mortuary staff, that the post-mortem was carried out on Simona, that confirmation would have been forthcoming.

26. It is important to bear in mind that judicial review is a remedy of last resort. Very fairly, the family have stated that no issue is taken with the thoroughness or professionalism of the post-mortem examination from a medical point of view, nor is it contended (although at one point it appeared to be suggested in the papers) that the attributed cause of death was wrongly ascribed, assuming that the body was that of Simona. The complaint is that the coroner was not entitled, on the information which he had, to reach the conclusion that the autopsy was carried out on the right person.

27. Mr Sawko makes the point that at no stage in the decision is there any express mention of the discrepancies in the physical description, or any answer as to how they came to be there. He says that that means that essential factors were not taken into account. However, in judging whether essential factors were taken into account, the court has to have regard to the whole of the correspondence, because the factors do not have to be referred to expressly on the face of the impugned decision, provided that they are matters that the coroner has looked at and considered before taking that decision.

28. It is clear on the evidence that after the family raised their concerns in relation to the physical description of the deceased with the coroner, he went back to seek confirmation from Dr Bodi that Dr Bodi was satisfied he had carried out the autopsy on the right person. He received that confirmation. Dr Bodi, it is fair to say, did not specifically address the discrepancies in the physical description, let alone the reasons why they came about, but what he did say was that he was confident that the post-mortem had been performed on the right body. He said that he doubted that there was another young woman with a very rare brain stem glioma in the mortuary at the same time, and he referred to the identification of the body by the name tags.

29. The question for this court is whether or not the coroner, as a reasonable coroner, was entitled to be satisfied with the information that was before him regarding identity. The test is not whether the court would have been satisfied with that information, but whether the decision taken would have been within the reasonable range of responses of a coroner in the circumstances in which this particular coroner found himself.

30. The inaccuracies in the physical description noted down by the pathologist are a genuine cause for concern, and I can understand why Simona's parents were really bothered by them.

Any parent in their position who had gone through the incredibly traumatic events of the weeks over which they observed their daughter's condition deteriorate, and then saw her pass away in the circumstances described in the papers, would be grieving and extremely upset. It can only have added to the weight of their distress to have seen on the face of the post-mortem report a description of somebody which was patently not a description of their daughter. But the alternative scenario is that coincidentally there was another young woman of approximately the same age who died at around the same time, who suffered from an earlier astrocytoma and from the same rare brain tumour as well as pneumonia, and who somehow became mistakenly identified as Simona before the post-mortem. That would mean that the wrong wrist tags were put on somebody else's body, and presumably the wrist tags relating to the other person were on Simona's body.

31. Whilst the wrist tags are not physical evidence in the same way as physical attributes are, they are powerful evidence, because the tags would have been attached to both wrists at or shortly after the time of death, and before the patient was sent to the mortuary. In the course of his professional responsibilities, a coroner would be made aware of the way in which hospitals deal with these matters. He would also have known about the regulation of the procedures by the Human Tissue Authority, which requires certain checks to be carried out at different stages after a person dies. The opportunities for a mistake of this magnitude to have been made would therefore been extremely limited, and the coroner would have known that.

32. The presence of the tags and the fact that a mortuary assistant was amongst those present at the autopsy (i.e. somebody who ought to have spotted if the wrong person had been taken out from the freezer) and the rarity of the brain tumour from which Simona suffered, make it highly improbable that the hospital would have made such a catastrophic error. It is far more

likely that the error lay in the description of the physical attributes in the post-mortem report. In the light of the pathologist's assurances, in my judgment the coroner was entitled to conclude that the hospital had not made the error of performing a post-mortem examination on the wrong body.

33. However, even if there had been any doubt about the matter, it has been resolved by the further information provided to the coroner from the hospital in January this year, describing in detail the process of reception and identification of bodies at the time of receiving Simona's body. It might have been preferable had the coroner requested such information at a much earlier stage of the proceedings, but the fact is that it has been provided now.

34. A lady named Amy Ellis from the mortuary department at King's College Hospital has described the reception of the deceased person into the mortuary and the identification checks which are carried out prior to the post-mortem and also upon release to the funeral directors. Ms Ellis confirms that members of Simona's family were present when she passed away. The nurse then completed a death notice, and checked her wrist bands, which recorded her full name, her date of birth and her hospital number. The whole of that procedure was carried out at a time when the family were still present. The death notice contained information about the patient and recorded everyone who was present at the time of death, including both family members and medical staff. The nurse who had completed the death notice then arranged transportation of Simona's body to the mortuary. She was kept in the fridges during the night, and the following morning the information on the wristbands was checked against the death notice and recorded by two members of the mortuary staff. Her location in the fridge was also recorded.

35. Immediately before the post-mortem examination commenced, the name and date of birth

recorded on both wristbands were checked by two staff members against the coroner's request for a post-mortem examination, as was the hospital number and also Simona's date of death, and all four pieces of information matched. After the post-mortem, Simona's body was returned to the same fridge bay as before. The wristbands remained present throughout, and they were still there when the funeral directors came to collect her body from the mortuary.

36. Ms Ellis has also confirmed that there were no other patients in the mortuary with the same or similar names to Simona at any material time, thus allaying the possibility of any confusion on that account.

37. The court does not grant judicial review in circumstances where the issue has become academic, nor will it grant relief as a matter of discretion if there has been an error which is susceptible to review, but if the matter were sent back for reconsideration by the decision-maker, and all material factors were taken into consideration, he would make exactly the same decision. I am not satisfied that the coroner did make an error which was susceptible of judicial review, or that there is a sufficient argument that he did, but even if there were, I would not grant permission because it is obvious on the totality of the information that has come to light before the court, that if all that information were placed before the coroner he would reach exactly the same decision for exactly the same reasons. That fresh decision would not be open to challenge on public law or any other grounds. That means that these proceedings would achieve nothing.

38. For those reasons, whilst I understand and sympathise with Simona's family's natural concerns about the fact that the examination notes contain a wholly inaccurate physical description of her, the coroner's decision is unimpeachable. As I say, not without sympathy for the family and their understandable wish to get to the bottom of why someone made such

errors in describing Simona in the records of the post-mortem, I am unable to accede to their renewed application for permission to bring a claim for judicial review. I will just add this. It seems to me, at the very least, that Simona's family deserve a full apology from the hospital and some explanation as to why it was that there was this erroneous description which can only have added to their distress. I hope that such an apology and some explanation as to how it came about will be forthcoming, but I have no power so to order. I can merely express a hope that that will happen in due course. So, with the greatest sympathy, I am afraid that this application is dismissed.

39. Thank you all very much for coming. Thank you for your very clear and helpful submissions.

40. MS HEINONEN: So I should pay for DNA as well on top?

41. MRS JUSTICE ANDREWS: You do not have to pay the other side's costs. Mr Dixey, was an order made for costs by the single judge?

42. MR DIXEY: No, my Lady.

43. MRS JUSTICE ANDREWS: You are not asking for costs?

44. MR DIXEY: No.

45. MS HEINONEN: I was talking about the DNA, for we should pay DNA costs?

46. MRS JUSTICE ANDREWS: It is a matter for you whether you want to carry out the tests or not. If you do, obviously you will have to do it at your own expense, because the court

cannot order the coroner to have those tests carried out.

47. MS HEINONEN: And if DNA shows that it wasn't Simona, then what?

48. MRS JUSTICE ANDREWS: Well, that is for another day. That is fresh evidence and you might be able to reopen the application for an inquest.

49. MS HEINONEN: And we never asked for inquest. You mentioned that several times. Never, ever, we asked for inquest.

50. MRS JUSTICE ANDREWS: Right, I shall correct that then if I made a --

51. MS HEINONEN: Because an inquest is a serious thing and we didn't want it.

52. MRS JUSTICE ANDREWS: You wanted an investigation, is that right?

53. MS HEINONEN: Yes.

54. MRS JUSTICE ANDREWS: I shall correct that, and I apologise to you for getting that wrong.

55. MS HEINONEN: So, do you think that it's any point to applying to the Court of Appeal?

56. MRS JUSTICE ANDREWS: I cannot advise you as to what is the right thing to do.

57. MS HEINONEN: All right. But do we have to ask you now for permission?

58. MRS JUSTICE ANDREWS: I do not think I have power, Mr Dixey, do I?

59. MR DIXEY: I do not think (Inaudible) permission, no.

60. MRS JUSTICE ANDREWS: I think they have to go to the Court of Appeal if they want

permission?

61. MR DIXEY: Yes.

62. MRS JUSTICE ANDREWS: You do not need to ask me, I do not think I have power to grant you permission to appeal to the Court of Appeal. You would have to make that application to them.

63. Thank you all very much indeed.

64. MS HEINONEN: Can I ask, so we will never find out what happened? Why this description is wrong?

65. MRS JUSTICE ANDREWS: I suggest you might have a word with Mr Dixey outside.