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R v HM Coroner for Inner South London, ex parte Epsom Health Care NHS Trust

QUEEN'S BENCH DIVISION (CROWN OFFICE LIST)

158 JP 973

HEARING-DATES: 14 July 1994

14 July 1994

CATCHWORDS:

Coroners law -- lack of care -- adequacy of coroner's direction to jury -- amendment of verdict.

HEADNOTE:

Tyrone Evans, the deceased, whilst in prison had taken an overdose after barricading himself in the pharmacy. Whilst unconscious he was taken to Epsom district hospital. He recovered and was improving.

He was transferred from that hospital at 1 pm by prison van incorporating a cell three feet by three feet. The van travelled at speed and an accompanying doctor felt ill because of the vibration. He arrived at Bellmarsh prison and at 2.30 pm he walked from the van and climbed to his bed. By 2.30 am the following day he was dead.

The coroner held an inquest lasting eight days and calling 39 witnesses. The cause of death was Adult Respiratory Distress Syndrome and an issue was the possible effects of transfer by the van. When the coroner summed up he left a possible verdict that the "cause of death was aggravated by lack of care" to the jury.

The applicants applied for the verdict to be quashed. Counsel for the relatives (an interested party) at first advocated a new inquest ought to be heard, but later conceded to an amendment to the inquisition.

Held: 1. The coroner's direction upon the law regarding verdict incorporating "lack of care" was defective, notwithstanding the state of the law at that time.

2. The coroner failed altogether to direct the jury with care on the aspect of causation.

3. The coroner failed altogether to direct the jury as to the standard of proof.

4. A new inquest would not be held, but the latter part of the verdict (namely that the cause of death was aggravated by lack of care) would be struck out.

CASES-REF-TO:

R v HM Coroner for North Humberside and Scunthorpe, ex parte Jamieson (1994) 158 JP 1.
R v HM Coroner for Southwark, ex parte Hicks [1987] 1 WLR 1264

COUNSEL:

P Havers (D Mpang on July 14 1994) for the applicants; T Coghlan for the respondent; E Rees for the family.

PANEL: Steyn LJ, Kay J

JUDGMENTBY-1: STEYN LJ

JUDGMENT-1:

STEYN LJ: There is before us an application for judicial review of the verdict and inquisition concerning the death of Tyrone Evans, a 29 year old man, which was returned by the jury at the Southwark coroner's court on May 21, 1993. The jury's verdict as to how Mr Evans came by his death was non-dependent abuse of drugs aggravated by lack of care.

The relief sought by Epsom Health Care NHS trust on this application is an order quashing the latter part of the verdict, namely that the cause of the death was aggravated by lack of care.

It is necessary to set out the background to this matter in a little detail. On February 4, 1993 Mr Evans was a prisoner at Highdown Prison. At about 11 am on February 4 he took a prison officer hostage. He barricaded himself into a pharmacy. While in that pharmacy he took a large quantity of drugs. As a result he fell asleep. He became deeply unconscious. When entry was made into the pharmacy a doctor had to intubate him: that means that his air passage had to be opened by a tube. He was immediately taken to the Epsom general hospital. At 2.20 pm he was given antidotes for the drugs that he had taken. At 5.30 pm there was an emergency situation because he had become cyanosed. That means that he showed blueish symptoms which were indicative of the blood not being properly oxygenated in his lungs. Again his air passage had to be opened by a tube and he was transferred to an intensive care unit.

By midday on February 5, that is the day after his admission, the tube was removed. He was seen by a consultant. The consultant took the view that his respiratory function was normal and that he was breathing normally on room air. On February 6 Dr Jones indicated that he could be transferred to a general ward. The antidotes were stopped at 8 am on February 6. In the hospital the view was taken that his recovery was uneventful and that his clinical condition was improving.

A decision was taken on the morning of February 6 that he should be transferred back to the prison. He was not told of that fact. At approximately 1 pm he was removed from the hospital and taken to Belmarsh prison. He left the hospital at 1 pm. He was taken in a prison van. He was placed in a cell in that van that measured three foot by three foot. The medical expert who travelled with him sat in front in the van and, of course, was not able to have any contact with the prisoner during the journey. The van travelled at speed. There was very considerable vibration to the extent that Dr Jones, who sat in the front of the van, felt ill at the end of the journey. When he arrived at Belmarsh prison at 2.30 pm the prisoner was able to walk to the lift, and he was apparently able to climb on his bed; and the view was taken by Dr Brown that he had no concern for his condition. Thereafter, he was not medically examined but he had died prior to 2.30 am on the morning of February 7, 1993.

In the usual way an inquest was held. It was held before Her Majesty's coroner, Sir Montague Levine sitting with a jury. The inquest lasted from May 12 to 14 and then from May 17 to 21, 1993. The coroner and the jury heard many witnesses, apparently some 39 in all. At the inquest much of the focus was on a condition described as adult respiratory distress syndrome which it was said precipitated his death. By the conclusion of the inquest there was no real issue. It was common ground that that indeed had caused his death, but there was an issue about his discharge from the hospital and the possible effects of the transfer journey in that van. That is how the matter stood.

The coroner was called upon to sum-up. There is before us no complaint about the primary part of the verdict and no complaint about the summing-up in that respect. All the evidence was one way on that. But there are most substantial complaints about the latter part of the verdict, namely, that the cause of death was aggravated by lack of

care. The coroner left that as a possible verdict to the jury, but only with reference to the journey itself in the prison van from the hospital to the prison.

Unfortunately, the summing-up on this aspect is seriously flawed. Since it is accepted on all sides, and accepted by the coroner, that the summing-up is materially defective, I can deal with this aspect quite shortly. First, it was incumbent on the coroner to direct the jury with some care on the meaning of lack of care in this particular context, and as far as that side is concerned, the law is now authoritatively stated in a decision of the Court of Appeal, R v HM Coroner for North Humberside and Scunthorpe, ex parte Jamieson, (1994) 158 JP 1; [1994] 1 WLR at 82. The Master of the Rolls in that decision defined what needs to be proved as follows (at 101A):

"Neglect in this context means a gross failure to provide adequate nourishment or liquid, or provide or procure basic medical attention or shelter or warmth for someone in a dependent position (because of youth, age, illness or incarceration) who cannot provide it for himself."

For present purposes, it is not necessary to go further.

It has to be said in fairness to the coroner, that that decision of the Court of Appeal was given after the summing-up in this case, the law as stated in the case of R v Southwark Coroner, ex parte Hicks [1987] 1 WLR 1264, and I mention in passing that his summing-up did not comply with the law as stated in that decision either.

Secondly, it was necessary for the coroner to direct the jury with care on the aspect of the causation. That requirement was emphasized in the earlier decision of Hicks and restated in the case of Jamieson. The coroner in this case should have directed the jury that there is a need to establish a clear causal connexion between lack of care and the death. It would have been appropriate in this case to say to the jury that without that causal connexion, they were not entitled to bring in a verdict that the cause of death was aggravated by lack of care. In order to bring in a verdict of that nature, the jury had to be satisfied that lack of care was an effective cause of the death. The coroner did not advert to any of these matters. He gave no direction along these lines, nor anything approaching it. It was a material failure to direct the jury properly.

Thirdly, the coroner failed altogether to direct the jury as to the standard of proof in a case of this kind, that is proof on a balance of probabilities.

Initially Mr Rees, who appeared for the deceased's widow, was inclined to argue that notwithstanding a materially defective summing-up, the verdict accords with the evidence. Accordingly, he suggested it is not in the interests of justice for the verdict to be quashed. After some debate he fully accepted that that was an impossible position to maintain in this case. The seriousness of the misdirections makes it inevitable that the latter part of the jury's verdict must be quashed.

But Mr Rees had a more formidable argument. He submitted that if the verdict has to be quashed, it should be quashed completely and a fresh verdict ordered, because on the evidence a properly directed jury could return a similar verdict, ie, a verdict to the effect that the deceased came by his death as a result of non-dependent abuse of drugs aggravated by lack of care. That submission was one on which we were addressed in some considerable detail.

Mr Havers, who appeared on the other side, submitted that that would not be within our powers. He submitted that there was not sufficient material capable of supporting such a verdict, and that in those circumstances it would be beyond our powers to direct it. Mr Havers took us on a thorough review of the evidence and referred us to relevant passages in the expert evidence.

For my part, I would not assent to any proposition that a jury was not entitled, in all the circumstances of the case, to take a view that there was lack of care in the sense as defined in Jamieson, but Mr Havers was on stronger ground when he said that there was a substantial dearth of evidence as to a causal connexion between any lack of care and the death. As far as that aspect is concerned, I do not propose to review the whole battlefield, because largely the points

that Mr Havers was able to make to us and make to us very fairly, are of a negative nature. There is, indeed, a great dearth of evidence, but on reflection there are two items of evidence which seem to me to overcome this hurdle, and that is two passages in the evidence of Dr Hill, a Home Office pathologist, who was called by the coroner. He said:

"In this man's case probably the journey to Belmarsh could have been a factor which tipped the balance. He was taken by a van in a cell and it has been known that if you transfer patients from A to B not suitably prepared with drips etc it can contribute to ARDS,"

that being an abbreviation for the term I previously described.

"Dr Jones said he felt sick as did Mr Evans after the journey. It is related to the vibrations which occur in the travel."

Now pausing there for a moment, it will be noted that Dr Hill spoke about probability, but at the same time he said that that could have been the cause, leaving unclear whether he was referring simply to a mere possibility or a probability, but he reverted to this matter and said:

"I believe ARDS caused by a mixture of drugs he took, and the journey. He would not have got ARDS if he had not taken the drugs."

If one takes those two passages together, it seems to me that the jury who heard the evidence were entitled to take the view that he was testifying to a probability, and that, in my view would be just sufficient to establish that there is some material establishing a causal link to go before the jury.

But Mr Havers had another more specific submission to which I must turn, and that is the submission that in any event there was no evidence at all that the provision of what little medical attention as was identified by Dr Hill, namely drips etc caused or contributed to the death of the deceased, ie, would have made any material difference to the outcome. That is certainly a logical point and one to which I have given consideration, but it does not dissuade me from the view that there was just enough material to be left to the jury.

My conclusion is, therefore, that it would be within our power to direct that the verdict be quashed and that there be an entirely new inquest. But then I turn to the next matter, and that is, whether in the exercise of our discretion, we ought so to order. It must be remembered that here was an inquest over eight days. Thirty-nine witnesses were heard. Issues were explored in very great detail. It yielded a minimum of evidence on any causal link between lack of care and the death. It is realistic to assume that if we direct another inquest, that similarly the evidence will be of a very limited nature.

Then I also pose to myself the question: what would be the purpose of another inquest? It is axiomatic that we are not entitled to direct an inquest as a stepping-stone to a civil claim. That is a forbidden purpose and not a matter that we can take into account in regard to the question whether there should be an inquest or not.

In many cases a factor that the court will carefully consider is whether an inquest is necessary to remove a stigma that might have attached to a deceased's name and cause the family anguish. That in itself, the question of a stigma attaching to the deceased is not a factor that operates in this case.

There is, however, another matter to be considered, namely the public interest in what happened. Having heard evidence over eight days, having heard 39 witnesses, the jury returned a verdict which included the finding that the cause of death was aggravated by lack of care. While I certainly bear in mind at all times that the jury arrived at that verdict after a summing-up which was materially flawed, nevertheless, it seems to me that that verdict of the jury was some testimony to the jury's view that it is astonishing that it was thought proper towards the end of the 20th century that a man, on any view, in a somewhat vulnerable position, should be exposed to the rigours of an hour and a half's journey in a cell three by three in a police van travelling at speed. To that extent the verdict of the jury served its

purpose in highlighting something which the jury apparently regarded as outrageous, and if that is the correct interpretation which one may put on the verdict, then I for my part would only add that that reaction of the jury would, in my view, be understandable.

In these circumstances and giving anxious consideration to the family's interests, there seemed no sense in directing a new inquest. We posed that position squarely to Mr Rees, who asked for an adjournment in order to discuss the matter to take instructions. He did so. Mr Rees then told us that the family accepted that there would in all these circumstances be no point in a further inquest. I agree. I would in any event have so ruled.

In these circumstances, I would simply direct, if my Lord agrees, that there be an order quashing the latter part of the verdict, namely, that the cause of death was aggravated by lack of care, and that is the only order I would be minded to make.

JUDGMENTBY-2: KAY J

JUDGMENT-2:

KAY J: I agree with the conclusions reached by Lord Justice Steyn and his reasons for reaching those conclusions. Since it is clearly a matter of importance to the family of the deceased, I specifically make clear that in so far as the jury's verdict was intended as an expression of disapproval at the manner in which the deceased was transported from hospital to prison, I, like Lord Justice Steyn, understand the reaction of the jury and sympathize with it.

SOLICITORS:

J Tickle & Co; Hempsons; Thomas Watts & Co