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REGINA v POPLAR CORONER, Ex parte THOMAS

[COURT OF APPEAL]

[1993] QB 610

HEARING-DATES: 18, March 13 April 1992, 30, November 15 December 1992

15 December 1992

CATCHWORDS:

Coroner - Inquest - Duty to hold - Deceased having severe asthma attack - Deceased suffering cardiac arrest while waiting for ambulance - Post mortem showing death by natural causes - Possibility of delay in arrival of ambulance contributing to death - Coroner refusing to hold inquest - Whether reason to suspect that death "unnatural" - Coroners Act 1988 (c. 13), s. 8(1)

HEADNOTE:

The deceased, who was aged 17 and an asthmatic, had a severe attack of asthma. A neighbour who made an emergency telephone call for an ambulance shortly after 1 a.m. was connected to a recorded message asking her to wait until someone was available to answer her call. It was decided to take the deceased to hospital by car, but on the way she collapsed and a police officer from a local police station made an emergency call urgently requesting an ambulance. A further telephone call was made from the police station. By the time the ambulance arrived at 1.33 a.m. the deceased had stopped breathing. Subsequent efforts in hospital to revive her failed. There was medical evidence that her life could have been saved had she arrived at hospital earlier. The coroner was informed

and he directed that a post mortem examination be carried out. The pathologist having found that the cause of death had been the asthmatic attack, the coroner refused to hold an inquest under section 8(1) of the Coroners Act 1988 n1 on the ground that the deceased had not died an "unnatural death" within section 8(1)(a). On an application by the deceased's mother for judicial review of the coroner's decision not to hold an inquest, the Divisional Court held that where the medical cause of death was accompanied by concurrent events which themselves might be a cause of death there was a case for considering the death "unnatural" within the meaning of section 8(1)(a); and that it was in the public interest to investigate by means of an inquest whether the deceased's death might have been avoided had an ambulance been available earlier. The court accordingly allowed the application and granted an order of mandamus for an inquest to be held.

On the coroner's appeal: -

Held, allowing the appeal, that an inquest could only be held in a case falling within section 8(1) of the Coroners Act 1988 and there was no general discretion in the Act or elsewhere for a coroner to hold an inquest whenever he considered it to be in the public interest; that (perDillon and Farquharson L.JJ.) the question whether there was reasonable cause to suspect that a deceased had died an unnatural death within section 8(1)(a) of the Act was a practical question of fact to be answered by ordinary common sense; that the coroner had been entitled to conclude that, notwithstanding the late arrival of the ambulance the cause of the deceased's death was the asthmatic attack and that the

death was not an unnatural death; and that, accordingly, there were no grounds for interfering with the coroner's decision not to hold an inquest (post, pp. 626F, H-627B,628B-C, 629A-B, H, 631H-632A).

Reg. v. Southwark Coroner, Ex parte Hicks [1987] 1 W.L.R. 1624, D.C. considered.

Dictum of Lord Salmon in Alphacell Ltd. v. Woodward [1972] A.C. 824, 847 applied.

Per Simon Brown L.J. Although "unnatural" is an ordinary word of the English language, that is not to say that whether or not a particular death is properly to be regarded as unnatural is a pure question of fact. Cases may well arise in which human fault can and properly should be found to turn what would otherwise be a natural death into an unnatural one, and one into which therefore an inquest should be held (post, pp. 630C,631F).

Decision of the Divisional Court of the Queen's Bench Division, post, pp. 614 et seq., reversed.

INTRODUCTION:

APPLICATION for judicial review.

Pursuant to leave granted by Webster J. on 25 October 1990, the applicant, Mrs. Doris Thomas, applied for judicial review by way of an order of mandamus to compel Her Majesty's Coroner for Poplar, Mr. Douglas Robert Chambers, to hold an inquest into the death of her daughter, Mavis Thomas. She sought a declaration that the coroner had a duty to hold an inquest into the death. She also sought an order of certiorari to quash the decision of the Attorney-General of 3 July 1990 refusing to give his authority under section 13 of the Coroners Act 1988 for an application that the High Court make an order that a fresh inquest

be held and a declaration that the Attorney-General had wrongly withheld his authority under section 13 of the Act of 1988.

The applicant sought relief on the grounds that (1) at the time the coroner took his original decision there was considerable evidence before him that the death would not have occurred but for delays experienced by the deceased's family in contacting the ambulance service and later delays by the ambulance service in responding to repeated calls by the police for an ambulance to come to take the deceased to hospital as a matter of urgency; (2) in reaching the conclusion that an inquest was unnecessary the coroner misdirected himself in law for the reasons, inter alia, that (i) section 8(1)(a) of the Coroners Act 1988 required a coroner to hold an inquest where there was "reasonable cause to suspect" that the deceased had died a "violent or an unnatural death;" (ii) there had been clear and uncontradicted evidence before the coroner that avoidable and culpable delays by the ambulance service might have been the reason why the deceased's asthma attack, which could have been treated in hospital, proved fatal, giving rise to a "reasonable cause to suspect" that the cause of the deceased's death was "unnatural;" and (iii) against that background, the coroner erred in law in treating the pathologist's conclusion as conclusive and either misdirected himself as to the meaning of "unnatural death" in section 8 of the Coroners Act 1988 or failed to apply the law properly to the facts of the case.

By consent, the Attorney-General withdrew from the proceedings at the start of the hearing.

The facts are stated in the judgment of Tudor Evans J.

The coroner, by a notice of appeal dated 15 June 1992, appealed on the grounds, inter alia, that (1) since a coroner's jurisdiction to hold an inquest derived from section 8 of the Coroners Act 1988, the first question which the coroner had to ask himself was whether there was reasonable cause to suspect that the deceased had died "an unnatural death" within the meaning of section 8(1)(a); (2) the Divisional Court erred in concluding that he should have asked himself the question whether on the undisputed evidence there might be a case for a verdict of death aggravated by lack of care; (3) "unnatural" was an ordinary word in full current usage and it was a question of fact for the coroner to decide in each case whether there was reasonable cause to suspect that the death with which he was concerned was unnatural, using his

understanding of the ordinary meaning of that word; (4) the Divisional Court failed to determine what was meant by unnatural death; and (5) the coroner was entitled to conclude on the facts that there was no reasonable cause to suspect a violent or unnatural death when it was apparent that the death was from natural causes.

The facts are stated in the judgment of Dillon L.J.

COUNSEL:

Edward Fitzgerald for the applicant. A coroner has no residual discretion not to hold an inquest. Either the preconditions in section 8 of the Coroners Act 1988 are met, in which case an inquest must be held, or they are not and it cannot be held.

A death attributed to natural causes becomes an "unnatural death" within the meaning of section 8(1)(a) if it could and should have been prevented by somebody by whom the deceased was owed a duty of care. The verdict of death by natural causes aggravated by lack of care is the appropriate one in such circumstances: see Reg. v. Southwark Coroner, Ex parte Hicks[1987] 1 W.L.R. 1624. The meaning of "unnatural" is a matter of law. The coroner misdirected himself. It is wrong to suggest that the principles stated in Cozens v. Brutus [1973] A.C. 854 apply here.

The possibility of an action for negligence does not affect the duty to hold an inquest. [Reference was made to Reg. v. Price (1884) 12 Q.B.D. 247.] There is no warrant for differentiating death in duty of care cases from other kinds of death. Mandamus should go. If an inquest should have been held and has not been held then there ought to be an inquest.

Terence Coghlan for the coroner. If the post mortem makes the cause of death clear the coroner need not hold an inquest, subject to section 19(1) of the Coroners Act 1988. The coroner should consider the result of the post mortem examination and ask himself whether in the ordinary sense the death is unnatural: see Cozens v. Brutus [1973] A.C. 854. The central question is whether the material before the coroner, including the post mortem report, leads to the reasonable suspicion that the death was

unnatural. The forms of verdicts set out in Schedule 4 to the Coroners Rules 1984 (S.I. 1984 No. 552) have no statutory basis: they are merely helpful suggestions.

The result of Reg. v. Southwark Coroner, Ex parte Hicks [1987] 1 W.L.R. 1624 is that a verdict of "death by natural causes aggravated by lack of care" can be returned. Nothing in section 19 of the Act requires a coroner to hold an inquest when he foresees that such a verdict is possible.

Fitzgerald replied.

Cur. adv. vult.

13 April.

Terence Coghlan for the coroner. The deceased's death was the result of a natural disease process, status asthmaticus; but there was also indisputable evidence that her life would have been spared had the emergency services responded more promptly. Following the procedure in sections 8 and 19 of the Coroners Act 1988 the coroner was obliged to make a decision on causation, in other words, to ask whether the causative potency of the "natural," life-threatening, disease process was eclipsed by subsequent non-attendance of the ambulance. The first question a coroner has to ask himself is whether there is reasonable cause to suspect the deceased died an unnatural death: section 8(1)(a). If there is, it is his duty to hold an inquest.

In certain circumstances, including death by natural causes, it is possible for the inquisition setting out the verdict of the inquest - whether that of the coroner sitting alone or that of the jury - to contain the additional words "and the

cause of death was aggravated by lack of care:" see the notes to Form 22 in Schedule 4 to the Coroners Rules 1984 (S.I. 1984 No. 552).

Here the Divisional Court erred in law by confusing the question, whether the death was aggravated by lack of care (which only arises if the decision is taken to hold an inquest and then only after the evidence has been heard) with the first question the coroner has to ask himself. The court's conclusion was greatly influenced by the notes to Form 22. Inquests are not held to investigate deaths by natural causes. The notes in Form 22 provide for a situation where a coroner has reasonable cause to suspect the death was unnatural, then proceeds to hold an inquest as section 8 requires, but after consideration of the evidence it becomes plain the initial impression was wrong and the cause of death was indeed a natural one. The fact-finding potential of an inquest is remarkably limited; restrictions are placed, for example, by rules 36(2) and 43 of the Rules of 1984. [Reference was made to Reg. v. Her Majesty's Coroner at Hammersmith, Ex parte Peach (Nos. 1 and 2) [1980] Q.B. 211, 219.]

"Unnatural" in section 8, an ordinary word in full current usage, should be given a common sense interpretation: see Cozens v. Brutus [1973] A.C. 854, 861. Where there is a possibility of more than one effective cause of death, it is for the coroner to ask whether the intervening cause or causes are such as to raise the reasonable suspicion that the death became converted into an unnatural death. Where the non-medical cause is merely a failure to act, the position is unclear and difficult; questions of causative potency of various causes are often matters of degree, but it is a matter for the coroner to determine himself at the section 8 stage: see Jervis on Coroners, 10th ed. (1986), p. 112, para. 10.8.

The facts precluded a verdict of death by natural causes aggravated by lack of care. In Reg. v. Southwark Coroner, Ex parte Hicks [1987] 1 W.L.R. 1624 the court was at pains to define "lack of care" closely after a full review of its history. It concluded that it was appropriate only to the physical condition of the deceased as causing the death, and was not to be used to indicate breach of duty by another: see pp. 1632, 1633-1634. The principle was properly applied in Reg. v. Portsmouth Coroner, Ex parte Anderson [1987] 1 W.L.R. 1640, 1646-1648. Thus, the earlier attendance of the ambulance might have ameliorated the condition which in fact led to the death, but the absence of the ambulance did not aggravate the cause of death.

If it is correct that there is a clear public interest that the facts of a case such as the present be investigated by an inquest, coroners would be overwhelmed with work, since, for example, in the very common case of an unexpected death in hospital, distressed relatives may well wish to seek to raise questions of want of care to be determined at an inquest. Rule 42 of the Rules of 1984 clearly precludes the coroner's court from framing a verdict so as to determine any question of civil liability. The position may be different if what is credibly alleged amounts to not merely a breach of duty but to gross negligence or recklessness of a sort which may disclose the offence of manslaughter: Reg. v. West London Coroner, Ex parte Gray [1988] Q.B. 467, 476.

Edward Fitzgerald for the applicant. Wherever a death occurs following breach of another's duty of care to the deceased, the death is unnatural and the coroner has a duty to investigate: see Thurston's Coronership, 3rd ed. (1985), p. 82 and Reg. v. Price (1884) 12 Q.B.D. 247, 248. Where there is clear evidence of culpable human omission, there is reasonable cause to suspect the death was unnatural within section 8(1)(a) of the Act of 1988, in the sense that the death was unusual and unexpected and, alternatively, was preventable but for the negligent response of the emergency services. Interpretation of "unnatural" in section 8(1)(a) is a matter of law, and the question whether the coroner should have held an inquest is one of jurisdictional fact to be determined by the court for itself, just as under section 13(1)(a), on the Attorney-General's application, it determines whether a coroner has refused or neglected to hold an inquest which ought to be held.

The concept of violent or unnatural death has its statutory origin in section 3 of the Coroners Act 1887 (50 & 51 Vict. c. 71), which itself

echoes different words used to define coronatorial jurisdiction in the Statute de Officio Coronatoris 1276 (4 Edw. 1, stat. 2). By 1887 unnatural death included death from disease or illness that could have been prevented but for the

culpable failure of someone owing a duty of care to the deceased, since such a death might involve manslaughter by omission which had a wider ambit at that time than under the present law: see Jervis on Coroners, 5th ed. (1888), pp. 193-194. Moreover, the concept of lack of care clearly existed at that time (see Ex parte Hicks [1987] 1 W.L.R. 1624, 1632, 1634) and has from the start been used particularly to characterise situations where a death from natural causes was preventable by proper care of the deceased. [Reference was also made to Reg. v. Surrey Coroner, Ex parte Campbell [1982] Q.B. 661, 675-676 and Reg. v. Inner South London Coroner, Ex parte Kendall [1988] 1 W.L.R. 1186, 1192-1193.] Thus, the overriding duty must be to ask how the deceased met his death. Rule 42 of the Rules of 1984 did not inhibit that duty and would allow a jury to go as far as necessary to answer the question by their verdict. The inquest is to identify and alert the public to dangers. "Unnatural" should therefore be interpreted so as not to deny jurisdiction. All accidental deaths, even if not violent, should be investigated because they might have been prevented by greater precautions: see, especially, section 8(3)(d) of the Act of 1988.

The existence of a verdict of lack of care shows that an inquest is not solely concerned with fatal omissions so great as to justify a verdict of manslaughter by gross neglect. Thus, a preventable death whose operative cause is a natural cause may nonetheless be regarded as unnatural for the purposes of section 8(1)(a) since it is both an incomplete and an inaccurate description of such a death to characterise it as death from natural causes. The present case is fairly and squarely within the narrow definition of the verdict of natural causes aggravated by lack of care propounded in Ex parte Hicks [1987] 1 W.L.R. 1624, 1634. [Reference was also made to Reg. v. Inner London North District Coroner, Ex parte Linnane [1989] 1 W.L.R. 395, 399; Reg. v. Birmingham Coroner, Ex parte Secretary of State for the Home Department, The Times, 6 August 1990; Reg. v. East Berkshire Coroner, Ex parte Buckley, The Times, 1 December 1992; In re Rapier, decd. [1988] Q.B. 26, 37-38 and Jervis on Coroners, 10th ed., pp. 62-63; 9th ed. (1957), pp. 85-89.]

The purpose and utility of an inquest in the present case are clear: (i) there is a swift and public investigation of the circumstances of the death, far sooner than in any civil proceedings that may follow; (ii) any circumstances the recurrence of which may endanger the public are identified and recorded - a purpose sanctioned by Parliament explicitly in section 8(3)(d) and implicitly in rule 43 of the Rules of 1984 which confers a power on the coroner to make recommendations so as to prevent similar fatalities; (iii) the coroner, or jury, has the duty to answer how the deceased died in a verdict that reflects any culpable omission where it was immediately causative, irrespective of whether that conflicts with rule 42 of the Rules of 1984 since that prevails over the rule: Ex parte Campbell [1982] Q.B. 661, 676; (iv) where the deceased is poor the inquest will often be the only public hearing into the circumstances of death since there will be no financial justification for civil proceedings;

(v) judicial notice may be taken of the fact that great concern has been expressed lately as to the amount of deaths to which avoidable delays in the attendance of the ambulance service has contributed.

Coghlan in reply. The facts in Ex parte Campbell [1982] Q.B. 661 and Ex parte Hicks [1987] 1 W.L.R. 1624, where prisoners were in the care of others, are far different from the present case.

Cur. adv. vult.

15 December. The following judgments were handed down.

PANEL: Watkins L.J. and Tudor Evans J Dillon, Farquharson and Simon BrownL.JJ

JUDGMENTBY-1: TUDOR EVANS J

JUDGMENT-1:

TUDOR EVANS J: read the following judgment. This is an application by Mrs. Doris Thomas with leave of the single judge for an order of mandamus to compel Mr. Douglas Robert Chambers, Her Majesty's Coroner for Poplar, to hold an inquest into the death of her daughter, Miss Mavis Thomas.

The Attorney-General was joined as a respondent to the application because he had declined to grant his fiat under section 13 of the Coroners Act 1988, but at the hearing he was released from the proceedings with the consent of all parties. It was accepted that, notwithstanding the absence of a fiat, this court has a supervisory jurisdiction over the exercise of a coroner's duties pursuant to its powers under section 33(2)(b) of the Act of 1988: see In re Rapier, decd. [1988] Q.B. 26, 28-29.

There is no dispute as to the facts. Miss Thomas was a life-long sufferer from asthma. She had been advised by her doctor to seek admission to hospital in the event of a severe attack. In the early hours of 9 April 1989 she developed such an attack. Between 1.00 and 1.15 a.m. she asked her sister to summon an ambulance. A neighbour who had a telephone dialled "999." She asked for the ambulance service. A recorded message from the service told her: "There is no one here at present. Please hold on and we will answer your call as soon as we can." This answer was repeated several times while the neighbour waited. It was then decided to take Miss Thomas to hospital by car. On the way she collapsed. The car was stopped. Miss Thomas was laid out on a pavement and the police were summoned from a nearby police station. Miss Thomas was alive but unconscious. While attempts were made to revive her, an officer in the street dialled "999," urgently requesting an ambulance. This was probably at about 1.14 or 1.15 a.m. There was a computer system at the police station for recording the times of telephone calls: the time of the call was logged at 1.16 a.m. It would have taken a minute or so to operate the computer. The ambulance did not attend. The computer operator in the station made another call to the ambulance service telling them that the situation was very serious and asking for the estimated time of arrival of the ambulance. This call was logged at 1.17 a.m. The operator was told to expect the ambulance in five to seven minutes. Another call was made at 1.32 a.m. Meanwhile, Miss Thomas was breathing and a pulse was still discernible but, according to a statement from an inspector at the station, she stopped breathing a

minute or so before an ambulance arrived at 1.33 a.m. Miss Thomas was taken to the London Hospital arriving at 1.40 a.m. at which time there was no pulse and no respiratory effort. Immediate attempts were made to resuscitate her; at one stage some electrical activity was restored to the heart but it proved of no avail. There was no cardiac output and resuscitation was abandoned at 1.55 a.m.

According to a report dated 3 July 1989 from Mr. Alistair Wilson who was the accident and emergency consultant in charge at the hospital, there was a note made by the police that cardiac arrest occurred "at 12.21 a.m." This is clearly a mistake for 1.21 a.m. which is itself earlier than the time stated by the inspector. In his report Mr. Wilson states:

"There is no doubt that had Mavis Thomas arrived in the department prior to her cardiac arrest, then it is likely that she would not have died. Had she arrived in the department within some five minutes of her cardiac arrest, it is much more likely that she would have been resuscitated . . . It should be said that the fact that electrical activity was possible indicates that Miss Thomas had experienced the cardiac arrest a relatively short time prior to her arrival in the department and that at least some of the resuscitative effort performed by the police had been effective."

Annexed to the affidavit of the applicant's solicitor dated 17 March 1992 is a report from a consultant physician and cardiologist, Dr. Roy Davies. He expresses the opinion that had Miss Thomas arrived at hospital before 1.32 a.m. she would almost certainly have been saved. But the report from Dr. Davies is not agreed.

The coroner was informed of the death on 9 April 1989. He had to decide whether or not to hold an inquest. It is convenient at this stage of the narrative to set out what were the coroner's powers and duties. They are contained in sections 8 and 19 of the Coroners Act 1988. Section 8 provides:

"(1) Where a coroner is informed that the body of a person ('the deceased') is lying within his district and there is reasonable cause to suspect that the deceased - (a) has died a violent or an unnatural death; (b) has died a sudden death of which the cause is unknown; or (c) has died in prison or in such a place or in such circumstances as to require an inquest under any other Act, then . . . the coroner shall as soon as practicable hold an inquest into the death of the deceased either with or, subject to subsection (3) below, without a jury."

Section 19 provides:

"(1) Where . . . there is reasonable cause to suspect that the person had died a sudden death of which the cause is unknown, the coroner may, if he is of opinion that a post-mortem examination may prove an inquest to be unnecessary - (a) direct any legally qualified medical practitioner . . . to make a post mortem examination of the body and to report the result of the examination to the coroner in writing."

Section 19(4) preserves the duty in section 8(1) in these terms:

"Nothing in this section shall be construed as authorising the coroner to dispense with an inquest in any case where there is reasonable cause to suspect that the deceased - (a) has died a violent or an unnatural death; or (b) has died in prison or in such a place or in such circumstances as to require an inquest under any other Act."

The coroner decided to exercise his powers under section 19(1). The pathologist who carried out the post mortem reported that death was due to natural causes and that the cause of death was status asthmaticus which is a medical term for a prolonged asthmatic attack. The coroner explains in paragraph 3 of his affidavit:

". . . I was in complete agreement with the pathologist's view . . . that death resulting from status asthmaticus is death due to 'natural causes;' and since there was nothing to suggest, in my opinion (then and now), that the death was 'violent or unnatural,' or that it otherwise fell within the provisions of section 19(4) of the Act [of 1988], I was satisfied, in all the circumstances, that an inquest was unnecessary."

The coroner sent a copy of the pathologist's report to the deceased's family. On 4 August 1989 solicitors acting on behalf of the relatives wrote to the coroner repeating the facts as I have summarised them and requesting that an inquest be held to inquire whether or not the death had been caused or aggravated by failures of the emergency services to respond to the calls and to attend in proper time. On 11 August 1989 the coroner replied, declining to hold an inquest. He wrote:

"I have considered all the facts that you describe relating to the circumstances and they are substantially as in my officer's report to me about the death. In my view they cannot alter the fact that the cause of death was status asthmaticus, a well known complication of asthma and sadly sometimes, as here, fatal. As the pathologist's report describes, it is natural."

It follows from this letter that the facts are not in dispute.

On behalf of the applicant, Mr. Fitzgerald submitted that a death due to "natural causes" in the sense that it was caused by some naturally occurring disease, nevertheless becomes "an unnatural death" within the meaning of section 8(1)(a) when it could and should have been prevented by the performance by some other person or authority of a duty owed by them to the deceased. In such a case a coroner has a mandatory obligation to hold an inquest. The crux of the applicant's argument is contained in a sentence from Thurston, Coronership, 3rd ed. (1985), at p. 82:

"Whenever a death occurs as a result of a breach of another's duty of care to the deceased, the death is unnatural and the coroner is under a duty to investigate."

In support of his submission, Mr. Fitzgerald relied on the known verdict that a death by natural causes was aggravated by lack of care: see, for example, Reg. v. Southwark Coroner, Ex parte Hicks [1987]

1 W.L.R. 1624. Counsel maintained that in any situation where the facts, as here, would give rise to such a verdict, the death should be regarded as "unnatural" within the meaning of section 8.

In paragraph 8(b) of his affidavit the coroner states that a verdict of natural causes aggravated by lack of care is relevant only if an inquest is held and that here he was concerned with the antecedent question whether an inquest

should be held at all. In paragraph 8(c) the coroner explained his reason for deciding that the death was by natural causes. He said:

"Whether or not the death was unnatural can often be a very difficult question to determine; but, in my view, in cases where the cause of death is status asthmaticus it is less difficult than in many other situations. For, in the case of this condition, despite the advance of medical science, fatalities still continue to occur . . . It is a condition, therefore, which has a considerable natural mortality. In my view death resulting from it is a death by natural causes. To illustrate this point further I should like to make the following points. (i) As a result of the progress of medical science certain conditions are now so easily diagnosable and treatable, that, although they once carried a mortality, it can no longer be said that they do, unless that mortality is brought on as a result of some wholly unexpected and exceptional circumstance, for example gross negligence on the part of the doctor treating the patient. Examples of such conditions, in the appropriate circumstances, would be strangulated herniae and ectopic pregnancies. In the event of death occurring in such a case I would accept that it could be an unnatural death."

It follows from these passages from the coroner's affidavit that he did not consider whether it was appropriate to hold an inquest to investigate whether this was a case in which the cause of death was aggravated by lack of care. Once he had obtained a post mortem report identifying the medical cause of death, that was taken to be the sole cause of death: the coroner reached the conclusion that there could be no other cause and so he precluded himself from considering lack of care as a cause. It follows that the approach of the coroner was: whatever other facts there may be, whatever the impact on the cause of death of any extraneous supervening or concurrent event, the death must be regarded as "natural" and an inquest will not be held, unless it qualifies, in the opinion of the coroner, as something equivalent to gross negligence, that is to say in effect, manslaughter either by act or by neglect. Before I consider whether this is a valid approach and whether in this case the coroner applied the correct test when he decided, as he undoubtedly did, that any omission by the ambulance service was not relevant to the cause of death, I must refer to the submissions of Mr. Coghlan, counsel for the coroner.

Mr. Coghlan submitted that in cases of sudden death of which the cause is unknown, there are two stages in a coroner's investigation. If he considers that an inquest may not be necessary, he may act under section 19(1). On the other hand, if he has cause to suspect an unnatural death, he must hold an inquest under section 19(4) and section 8 then comes

into play. Providing a coroner has considered the result of a post mortem examination and he is satisfied that there is no reasonable cause to suspect an unnatural death, then he is entitled to proceed under section 19(1) and to decline to hold an inquest. Counsel submitted that the question here is whether on the material before the coroner, including the post mortem report, there was reasonable suspicion of unnatural death. Mr. Coghlan accepted that a verdict of death by natural causes aggravated by lack of care can be returned in accordance with Reg. v. Southwark Coroner, Ex parte Hicks[1987] 1 W.L.R. 1624, but he submitted that section 19 of the Act of 1988 does not require a coroner to hold an inquest where he foresees that such a verdict is possible. The result of this submission together with the passages from the coroner's affidavit which I have read is, he says, to permit a coroner to ignore other evidence as a possible concurrent cause of death unless, as I have said, such evidence is of an exceptional nature.

It was further submitted by Mr. Coghlan that it is important in this field that the law should be clear and simple: it is for a coroner to ask himself on any given state of fact whether he would describe the death as unnatural or not. In answering this question, the coroner must use the ordinary and "natural" meaning of the word and act accordingly. Thus it is a question of fact for the coroner to decide whether a death is natural or not natural and it is therefore for him to decide whether an inquest should be held. Mr. Fitzgerald submitted that the meaning of the word "unnatural" is a question of law. In his skeleton argument, although of course we did not hear it developed, the Attorney-General contended that it is a mixed question of law and fact. In support of his argument, Mr. Coghlan relied on Cozens v. Brutus [1973] A.C. 854, a case in which it was held in the House of Lords that the meaning of the word "insulting" used in section 5 of the Public Order Act 1936 was not a matter of law but a matter of fact. Lord Reid said, at p. 861:

"The meaning of an ordinary word of the English language is not a question of law. The proper construction of a statute is a question of law. If the context shows that a word is used in an unusual sense the court will determine in other words what that unusual sense is. But here there is in my opinion no question of the word 'insulting' being used in any unusual sense. It appears to me, for reasons which I shall give later, to be intended to have its ordinary meaning. It is for the tribunal which decides the case to consider, not as law but as fact, whether in the whole circumstances the words of the statute do or do not as a matter of ordinary usage of the English language cover or apply to the facts which have been proved. If it is alleged that the tribunal has reached a wrong decision then there can be a question of law but only of a limited character. The question would normally be whether their decision was unreasonable in the sense that no tribunal acquainted with the ordinary use of language could reasonably reach that decision."

Thus it was submitted that the question whether the death was in this case natural or unnatural was a matter exclusively for the coroner whose

decision can be reviewed only on the basis that no coroner could reasonably have reached the conclusion arrived at here.

In my opinion the approach adopted by the coroner to the question whether an inquest should be held in this case was not correct. He did not ask himself, as in my view he ought, whether on the undisputed evidence this might be a case for a verdict of death aggravated by lack of care. He was, in my opinion, in error to exclude the possibility of holding an inquest by concentrating on the medical cause of death to the exclusion of all other evidence.

It was submitted by Mr. Coghlan that the coroner had no jurisdiction to hold an inquest unless the death could be described as "an unnatural death." It was contended that the decision in Reg. v. Southwark Coroner, Ex parte Hicks [1987] 1 W.L.R. 1624 does not assist. That was a case involving a death in prison and an inquest had to be held by reason of section 3(1) of the Coroners Act 1887 (50 & 51 Vict. c. 71). In other words it is said that a verdict of death aggravated by lack of care may be appropriate once there is an inquest but the availability of such a verdict does not determine the question whether or not there should be an inquest. Whether there should be an inquest turns solely on whether the death was "unnatural."

In my opinion, where the medical cause of death is accompanied by concurrent events which themselves may be a cause of death, then there is a case for considering that the death is "unnatural" and an inquest should be held. The coroner himself conceded that the intervention of a wholly unexpected and exceptional circumstance might make the death "unnatural." He therefore accepts that non-medical causes may turn a "natural" death into an "unnatural" one.

But the forms of inquisition themselves envisage that an inquest might be held where a possible verdict is one of "natural causes aggravated by lack of care." In Reg. v. Southwark Coroner, Ex parte Hicks [1987] 1 W.L.R. 1624, Croom-Johnson L.J. pointed out, at p. 1632:

"In the Schedule to the Act of 1887 there are found, for the first time in a statute, suggested forms of inquisition or verdict. One deals with 'lack of care' in that a failure to fence a pond resulted in a verdict of such negligence as to justify a verdict of manslaughter."

This form is preserved in Schedule 4 to the Coroners Rules 1984 (S.I. 1984 No. 552). In the notes to Form 22 in the Schedule, which deals with inquisitions, it is suggested that in cases, inter alia, of death from natural causes, where appropriate the words "and the cause of death was aggravated by lack of care" may be added. Thus a verdict at an inquest of natural causes aggravated by lack of care has been available for many years. Form 22 itself indicates that it is appropriate to hold an inquest in a case of death by natural causes. The recommendations in Form 22 lack legal force but they are a part of a long-standing history in which such verdicts have been recorded. In Jervis on Coroners, 10th ed. (1986), p. 196 under the title "Self-neglect or lack of care" there are collected in a footnote a number of modern cases in which verdicts "aggravated by lack of care" have been returned. In the Hicks case [1987] 1 W.L.R.

1624 the court held that a verdict of lack of care was permissible. Croom-Johnson L.J. said, at pp. 1633-1634:

"Mr. Fitzgerald . . . submitted that the lack of care which could form the basis of the verdict could be a legitimate method used by the jury of expressing a view that there was a culpable breach by someone of a legal or moral duty to take care of the deceased which would be distinct from the general duty of care on which the modern law of negligence is based. . . . There is no need to presuppose the existence of such a range of duties. What the verdict of 'lack of care' presupposes is that some other persons had at least the opportunity of rendering care (in the narrow sense of that word) which would have prevented the death. There is no need to go beyond that, although in many circumstances such persons would have had a duty, either legal or moral. The opportunity should have been a real opportunity of doing something effective."

Moreover, it is clear that a verdict of death aggravated by the lack of care may be a "free-standing" verdict. In the Hicks case Croom- Johnson L.J. speaking of verdicts of lack of care said, at p. 1634:

"It may be a 'free-standing' verdict, on its own. Self-neglect is, after all, a free-standing verdict: see Reg. v. Surrey Coroner, Ex parte Campbell[1982] Q.B. 661, 676."

For the reasons I have given and subject to one or two further points, I would let mandamus go and order the coroner to hold an inquest. It is a matter for the coroner to decide whether the inquest should be held with a jury: section 19(3)(d) of the Act of 1988 might suggest that a jury is appropriate in this case.

In paragraph 8(d)(i) and (ii) of his affidavit, the coroner expresses an understandable anxiety that inquests should not be used as a medium for testing out evidence for subsequent civil litigation. He states:

"There was every reason for me to suspect that the present was just such a case: the medical cause of the death was perfectly well known to the family - indeed I had sent them a copy of the pathologist's report. Equally they were as well placed as anyone to know about the extent of the delays by the emergency services. They were therefore in possession of all the necessary material facts to enable them to make a complaint a civil claim if they so wished. To insist upon the inquest in these circumstances could only have been for the purpose of procuring a rapping over the knuckles in public of that authority and/or a convenient means of obtaining evidence for a subsequent claim against it. I do not consider those to be proper reasons for the holding of an inquest."

The evidence shows that this may well be a case in which failures by the ambulance service to provide an ambulance more quickly to a person who was in extremis was a cause of the death which might have been avoidable if the ambulance had been available earlier. In my view, in these circumstances, there is a clear public interest that the facts should be investigated by means of an inquest. Moreover, there is a statutory

duty to investigate "how" the death occurred. Section 11(5) of the Act of 1988 provides:

"An inquisition . . . (b) shall set out, so far as such particulars have been proved - (i) who the deceased was; and (ii) how, when and where the deceased came by his death . . ."

The language of rule 36 of the Coroners Rules 1984 is to the same effect. It is, for the reasons I have given, not sufficient in this case to point to the medical cause of death alone when considering the question "how."

It is true that rule 42 of the Rules provides: "No verdict shall be framed in such a way as to appear to determine any question of - . . . (b) civil liability." But any conflict between this rule and the duty to inquire "how" the deceased came by his death must be decided in favour of the stautory duty. In Reg. v. Surrey Coroner, Ex parte Campbell [1982] Q.B. 661, 676, Watkins L.J. said:

"Such conflict as may in any given circumstance appear to arise between rule 33" - of the Coroners Rules 1953 (S.I. 1953 No. 205), the equivalent of the present rule 42 - "and the duty to inquire 'how' must be resolved in favour of the statutory duty to inquire whatever the consequences of this may be."

In Campbell's case, at p. 676, Watkins L.J. quoted with approval a passage in Jervis on Coroners, 9th ed. (1957), p. 179, now to be found in the 10th ed., p. 197, that any conflict between a verdict of lack of care and rule 33 of the Coroners Rules 1953, now rule 42 of the Rules of 1984, can be obviated by making sure that the verdict does not state that the death was aggravated by the lack of care of any particular person or persons but merely states that it was aggravated by lack of care. Watkins L.J. said, at p. 676:

"We agree with this comment. A verdict of 'lack of care by another or others' without more is clearly one which a jury is competent to find if the evidence warrants it without transgressing rule 33."

The final question which arises is whether, in the exercise of our discretion, we should let mandamus go bearing in mind that the events with which we are concerned occurred as long ago as 1989 and then occupied no more than perhaps three quarters of an hour. In paragraph 12 of his affidavit, the coroner doubts whether it is now possible to hold a fair and useful inquest. In my view, despite the passage of time, the evidence is not likely to have run cold. There are police records of the times and frequency of the calls to the ambulance service. There are likely to be ambulance records. The deceased's sister and the neighbour who made the telephone calls were present throughout and they made statements to the police. There are statements from police officers who were involved. In these circumstances I consider that a fair and useful inquest can be held.

For the reasons I have given I would grant the application.

JUDGMENTBY-2: WATKINS L.J

JUDGMENT-2:

WATKINS L.J: I agree.

JUDGMENTBY-3: DILLON L.J

JUDGMENT-3:

DILLON L.J: This is an appeal by Her Majesty's Coroner for Greater London (Inner London North district), Mr. Chambers, against an order of a Divisional Court of the Queen's Bench Division (Watkins L.J. and Tudor Evans J.), ante, pp. 614 et seq., made on 13 April 1992. By that order, made on an application by Mrs. Doris Thomas for relief by way of mandamus, the court ordered that an inquest be held into the death of Mavis Thomas, a daughter of Doris Thomas. The court also directed that that inquest be held by a coroner other than Mr. Chambers, but nothing turns on that.

Miss Thomas died at the age of 17 in the early hours of the morning of 9 April 1989. She had been a life-long sufferer from asthma, and she had a severe attack of asthma at about 1 a.m. that morning. Her sister and a neighbour attempted to summon the ambulance service by dialling "999;" but a recorded message from the ambulance service stated: "There is no one here at present. Please hold on and we will answer your call as soon as we can." This was repeated, and it was decided to take Miss Thomas to hospital by car. On the way Miss Thomas collapsed and the car was stopped. Miss Thomas was laid out on the pavement and the police were summoned from a nearby police station. Miss Thomas was still alive but unconscious, and attempts were made by the police to revive her. At about 1.14 or 1.15 a.m. an officer in the street dialled "999," urgently requesting an ambulance. A similar call was made from the police station and logged at 1.17, and another call was made from the station at 1.32 a.m. An ambulance in fact arrived at where Miss Thomas was at 1.33 a.m., but she had stopped breathing a minute or so before. She was taken by the ambulance to the London Hospital, arriving at 1.40 a.m.; she then had no pulse and was not breathing and attempts to resuscitate her were abandoned at 1.55 a.m.

In exercise of his powers under section 19 of the Coroners Act 1988 the coroner directed a post mortem

examination of Miss Thomas and a report. The report of the pathologist who carried out the post mortem is dated 19 April 1989 and gives as the cause of death status asthmaticus, i.e. a prolonged asthmatic attack.

There is other medical evidence, however, from Mr. Alistair Wilson, the consultant in charge of the accident and emergency department at the hospital, and Dr. Roy Davies, a consultant physician and cardiologist, which shows first, that had Miss Thomas arrived in that department before her cardiac arrest she would not have died, and secondly, that even if she had arrived in the department within some five minutes of

her cardiac arrest there was a good chance that she would not have died. Miss Thomas's family are, naturally, very concerned at the failure of the ambulance to arrive in time to have saved Miss Thomas's life.

The question in these circumstances is whether there should be an inquest on Miss Thomas. A coroner's powers and duties in respect of inquests are now set out in the Coroners Act 1988. Section 8(1) and (3) provide:

"(1) Where a coroner is informed that the body of a person ('the deceased') is lying within his district and there is reasonable cause to suspect that the deceased - (a) has died a violent or an unnatural death; (b) has died a sudden death of which the cause is unknown; or (c) has died in prison or in such a place or in such circumstances as to require an inquest under any other Act, then, whether the cause of death arose within his district or not, the coroner shall as soon as practicable hold an inquest into the death of the deceased either with or, subject to subsection (3) below, without a jury. . . . (3) If it appears to a coroner, either before he proceeds to hold an inquest or in the course of an inquest begun without a jury, that there is reason to suspect - (a) that the death occurred in prison or in such a place or in such circumstances as to require an inquest under any other Act; (b) that the death occurred while the deceased was in police custody, or resulted from an injury caused by a police officer in the purported execution of his duty; (c) that the death was caused by an accident, poisoning or disease notice of which is required to be given under any Act to a government department, to any inspector or other officer of a government department or to an inspector appointed under section 19 of the Health and Safety at Work etc. Act 1974; or (d) that the death occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public or any section of the public, he shall proceed to summon a jury in the manner required by subsection (2) above."

The wording of section 8(1) follows the wording of section 3(1) of the Coroners Act 1887 (50 & 51 Vict. c. 71). There is no general discretion in the Act of 1988 or elsewhere for the coroner to hold an inquest in any circumstances in which he considers it to be in the public interest that an inquest should be held. An inquest can only be held in a case which falls within section 8(1); but in any such case it is mandatory to hold an inquest - the word is "shall" and not "may" - save that under section 19, in a case where there was reasonable cause to suspect that the person had died a sudden death of which the cause was unknown, the coroner can dispense with an inquest if he is satisfied as a result of the pathologist's report after a post mortem that an inquest is unnecessary, i.e. after the pathologist's report the cause of death is known and found to have been natural.

In the present case no one disputes the pathologist's assessment of the cause of death in the post mortem report if only the medical aspect is considered. It follows that, as none of the other alternatives in section 8(1) is remotely relevant, the only basis on which an inquest could be

held would be if it can be said that, because of the late arrival of the ambulance, there is reasonable cause to suspect that Miss Thomas died an unnatural death. That is therefore the question we have to consider.

Mr. Coghlan submitted on behalf of the coroner that the word "unnatural" is an ordinary word of the English language which should be given its ordinary meaning. He referred to Cozens v. Brutus [1973] A.C. 854 which was concerned with the meaning of the word "insulting" in the phrase "insulting words or behaviour." In my judgment, that approach is in general correct as there is no context in section 8(1) to suggest that the word "unnatural" is being used there in any unusual sense.

In the context of death "unnatural" is obviously the antithesis of "natural." But since the most obvious instances of

unnatural deaths, in the ordinary sense of that word, are violent deaths which are, no doubt for that reason, expressly covered by section 8(1)(a), it is helpful to consider what non-violent deaths are none the less to be regarded as unnatural.

One obvious class is people who have died of industrial illness, as opposed to industrial accident. We were told that in such cases an inquest is always held. That can only be upon the basis that such deaths were unnatural; though the illness took its course leading to death, the inception of the illness was from unnatural causes. A parallel would be the deaths of persons in a typhoid epidemic, such as occasionally used to happen, occasioned by contamination of the public water supply in a particular area. We were also told that inquests are invariably held on persons who die of Legionnaire's disease. That is presumably because the disease is thankfully very rare in this country, and it is regarded, on a broad view, as unnatural that a person should die of an extremely rare disease. But asthma is not very rare and there is nothing unnatural per se in a person dying of asthma.

Another instance of deaths which are unnatural but not violent is where persons die from "lack of care" in the narrow and somewhat technical sense in which that term was interpreted by the Divisional Court in Reg. v. Southwark Coroner, Ex parte Hicks [1987] 1 W.L.R. 1624. That phrase "lack of care" bulks somewhat large in the judgment of Tudor Evans J. in the Divisional Court in the present case, with which Watkins L.J. agreed. But as the concept was interpreted in Ex parte Hicks it has no relevance, in my judgment, to the circumstances of the present case. Thus in Ex parte Hicks Croom-Johnson L.J. said, at p. 1633:

"The history of the verdict 'lack of care' indicates that it is appropriate only to the physical condition of the deceased as causing the death and should not be used to indicate a breach of duty by some other person. Questions of criminal negligence amounting to manslaughter were always a different problem and now that they are out of the way the verdict of 'lack of care' can be given its original and proper meaning. It should generally be regarded as the other side of the coin to self-neglect, and consequently was an inappropriate verdict in the case to which I have referred of the child who drowned in the Serpentine."

Similarly Peter Pain J., at p. 1637, reiterating what Croom-Johnson L.J. had said, said specifically that in this context lack of care "bears no relation to the question whether there was a duty of care in the Donoghue v. Stevenson [1932] A.C. 562 sense and whether that duty of care has been breached." In the present case it could not be said that Miss Thomas was in the "care" of the ambulance service in the sense in which that word was used in Ex parte Hicks.

Whether Miss Thomas's death was natural or unnatural must therefore depend on what was the cause of death. At this point, I remind myself of the observation of Lord Salmon in Alphacell Ltd. v. Woodward [1972] A.C. 824, 847, where he said:

"I consider . . . that what or who has caused a certain event to occur is essentially a practical question of fact which can best be answered by ordinary common sense rather than by abstract metaphysical theory."

Lord Salmon repeated what he had there said in his speech in McGhee v. National Coal Board [1973] 1 W.L.R 1, 11, and it seems to have been an important part of the material which in Wilsher v. Essex Area Health Authority [1988] A.C. 1074 led the House of Lords to classify McGhee'scase as a robust application of ordinary principles of causation to the undisputed primary facts of the case. In Alphacell Ltd. v. Woodward[1972] A.C. 824 Lord Wilberforce also said that "causing" must be given a common sense meaning, and he deprecated the introduction of refinements such as causa causans, effective cause or novus actus.

In the present case the complaint is that the chance of saving Miss Thomas's life was lost because such a long time, 33 minutes, elapsed between the first abortive "999" call and the actual arrival of the ambulance at the place where Miss Thomas was lying. But it is easy to think of a variety of different scenarios as a result of which an ambulance could have arrived too late to save a patient who had suffered a severe attack of asthma like Miss Thomas's, e.g. (i) the distance from the ambulance centre to the patient's home was too great for there to have ever been any chance of the

ambulance arriving in time to save the patient; (ii) there was much more traffic than normal in the locality and so the ambulance was delayed and arrived just too late; (iii) the ambulance was diverted on its journey and had to take a much longer route because of flooding caused by a burst water main, which may have been due to lack of proper maintenance by the water company; (iv) a newly installed computer installed by the ambulance service to handle emergency calls more efficiently malfunctioned, as newly installed computers are prone to; or (v) the ambulance came late because the ambulance crew were inefficient and the management was slack.

I do not suggest that any of these scenarios actually fits the facts of Miss Thomas's case. I do not know what the cause of delay was. But in each of these scenarios common sense indicates that what caused the patient's death was, on Lord Salmon's test in Alphacell Ltd. v. Woodward [1972] A.C. 824, 847, the asthmatic attack, not the congestion of the traffic, the bursting of the water main, the malfunction of the computer or the inefficiency of the ambulance service. But the asthmatic attack is

a natural cause of death, and the death is not, in my judgment, turned into an unnatural death by any of the facts suggested in any of the alternative scenarios.

The Divisional Court criticised the coroner for concentrating on the medical cause of death to the exclusion of all other evidence. I do not think the criticism is justified. The coroner was not excluding the other evidence; he was saying that, even when all the other evidence is taken into account, the cause of death was still the asthmatic attack and the death was not an unnatural death. That is also my view for the reasons I have endeavoured to give.

The Divisional Court also criticised the coroner for not asking himself whether this might be a case for a verdict of death aggravated by lack of care. But on the analysis in the Hicks case [1987] 1 W.L.R. 1624 the concept of lack of care as understood in this field of law is not appropriate to this case. Other verdicts could easily be devised, if it were appropriate to hold an inquest, since forms of inquisition set out in form 22 in Schedule 4 to the Coroners Rules 1984 (S.I. 1984 No. 552) are merely suggestions and not mandatory. But the key question is not what the form of inquisition or verdict ought to be; it is whether an inquest should be held at all.

In the course of argument a certain amount of attention was directed to section 8(3) which sets out the circumstances in which a coroner's inquest should be held with a jury. Attention was particularly directed to paragraph (d) in subsection (3), viz., "that the death occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public or any section of the public." Paragraph (d) was helpfully interpreted by Taylor L.J. in Reg. v. Inner London North District Coroner, Ex parte Linnane [1989] 1 W.L.R. 395, and it has been suggested that recurrence of delay on the part of the ambulance service in answering emergency calls is a matter of justified public concern which falls within paragraph (d) and would warrant having a jury if an inquest is held.

That may be so but it does not answer the particular question which is before us. One can easily think of cases which are obviously within subsection (1) and would require a jury for the inquest under subsection (3)(d). But it does not follow from that that every case in which the death occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of a section of the public is necessarily an unnatural death within the meaning of subsection (1).

It is also as well to remember, as a check on any tendency to over purposive construction of section 8, that rule 42 of the Coroners Rules 1984 expressly provides that "No verdict shall be framed in such a way as to appear to determine any question of - (a) criminal liability on the part of a named person, or (b) civil liability;" it is not the function of a coroner's inquest to provide a forum for attempts to gather evidence for pending or future criminal or civil proceedings.

For these reasons I would allow this appeal and I would set aside the order of the Divisional Court save in so far as it dealt with costs.

JUDGMENTBY-4: FARQUHARSON L.J

JUDGMENT-4:

FARQUHARSON L.J: I agree for the reasons given by Dillon L.J. that this appeal should be allowed.

JUDGMENTBY-5: SIMON BROWN L.J

JUDGMENT-5:

SIMON BROWN L.J: I have had the advantage of reading Dillon L.J.'s judgment in draft. I agree with the result which he proposes but since I reach that conclusion with more hesitation than Dillon and Farquharson L.JJ. and by a rather different route it is, I think, desirable to set out something of my own reasoning.

The central question raised in these proceedings is: did Miss Thomas die an unnatural death? The question was, of course, in the first instance one for the coroner in the context that, if he had reasonable cause to suspect that the answer was "Yes," i.e. if he thought that might be the true view, he was bound to hold an inquest. It is only a question for this court, and even then only with a view to remitting the matter for further decision by the coroner, if the coroner misdirected himself in law upon the proper approach to it.

I agree that "unnatural" is an ordinary word of the English language and that there is nothing to suggest that in section 8(1) it is being used in any unusual sense. That, however, is not to say that whether or not a particular death is properly to be regarded as unnatural is a pure question of fact. On the contrary, it seems to me that some guidance at least can and should be given as a matter of law by the courts to coroners so that they may focus their attention upon the real considerations material to the decision and, one hopes, thereby achieve an essential measure of consistency in their approach to the section. Cozens v. Brutus [1973] A.C. 854, in short, seems to me of limited value in this case: even ordinary words can have more than one usual sense and be capable of differing applications depending upon the particular context in which they are found.

I agree further that the question whether or not a death is natural or unnatural depends ultimately upon the view one takes as to the cause of death. But I do not find the question of causation in this context susceptible of quite the same sort of robust approach that the House of Lords advocated in a very different context in cases such as McGhee v. National Coal Board [1973] 1 W.L.R. 1. The question arising there was: can the court properly infer, in the absence of a provable direct link, that one particular state of affairs caused or contributed to another. In those cases the possibility of there being more than one cause was immaterial. Indeed courts often find there to have been several different causes of a given eventuality. Take this very case: can it really be doubted that if an action was brought in respect of Miss Thomas's death, whatever the court found regarding negligence it would certainly find the death to have been caused at least in part by the late arrival of the ambulance? The question posed in the present context is surely therefore different: given that all the important facts are known to the coroner, what view should he take of causes that may well be secondary but are not self-evidently irrelevant? As in litigation why should he not sometimes find a death to be the result of two causes, either one of which could serve to make it unnatural.

I do not suggest that the coroner was bound to take that view here. But there will be occasions when in my judgment that will be the only proper approach. Take a medical condition between the extremes postulated by the coroner in this case - neither a condition like strangulated hernia or

ectopic pregnancy which clearly ought never to result in death and which if it does will require an inquest, but nor a condition as serious as this deceased's asthma with its considerable natural mortality rate; assume then that consequent upon some clear failure of the emergency services the condition, unusually, proved fatal. Would not common sense dictate that that was an unnatural death? Indeed, I for my part would so regard this very case if the late arrival of the ambulance had constituted a more extreme failure of the service than I believe it did. If death from Legionnaire's disease is accepted to be unnatural only because it is extremely rare, why not these sorts of cases too?

One hopes and believes that grave failures of the emergency services are an extreme rarity too. I should perhaps

add that by failure I mean culpable human failure on the part of those responsible for providing a reasonably efficient emergency service. Congested traffic or other transportation or communication difficulties causing delayed arrivals are not, I fear, rare and certainly could not as a matter of common sense be thought directly causative of the death such as to make it in this context unnatural.

I recognise, of course, that rule 42 of the Coroners Rules 1984 prohibits a verdict being framed so as to appear to determine any question of civil liability. It is indeed true to say more generally that the scope of what a coroner's inquisition may achieve by way of a formal result has gradually been whittled down over the years. All indeed that remains, bar the verdict, is the coroner's limited power under rule 43:

"A coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held may announce at the inquest that he is reporting the matter in writing to the person or authority who may have power to take such action and he may report the matter accordingly."

Merely, however, because the coroner's inquest may nowadays be thought lacking any very clear or cogent role is no sufficient reason for adopting too narrow an approach to section 8. I repeat, it seems to me necessary to recognise that cases may well arise in which human fault can and properly should be found to turn what would otherwise be a natural death into an unnatural one, and one into which therefore an inquest should be held. What the appropriate verdict should then be is no doubt open to question although to my mind the answer is of limited importance. As I endeavoured to point out in Reg. v. Inner South London Coroner, Ex parte Kendall[1988] 1 W.L.R. 1186 it is unclear what if any use is in fact made by the responsible authorities of the actual inquisitions and annexed coroner's certificates; and the forms themselves merely provide "suggested" ways in which the coroner may fulfil his statutory duty under section 11(5)(b) to set out who the deceased was and how, when and where he came by his death. But that is really by the way. Whether or not the Home Office choose to rationalise and clarify the role intended to be played by inquisitions in present day society, coroners and reviewing courts must necessarily grapple with the legislation as presently it stands.

The coroner in the present case was, I believe, entitled to reach the conclusion he did that this particular deceased's death was properly to be

regarded as natural. He cannot be criticised for regarding the late arrival of the ambulance as insufficiently causative of death to alter its essential character. I, too, therefore would allow this appeal and set aside the order of the Divisional Court.

[Reported by JOHN SPENCER ESQ., Barrister]

[Reported by ROBERT RAJARATNAM ESQ., Barrister]

DISPOSITION:

Application granted.

Appeal allowed.

Legal aid taxation of applicant's costs.

Leave to appeal refused.

SOLICITORS:

Solicitors: Deighton Guedalla; Hempsons.

Solicitors: Hempsons; Deighton Guedalla.