IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT
[2020] EWHC 471 (Admin)

No. CO/2581/2019

Royal Courts of Justice

Wednesday, 12 February 2020

Before:

LORD JUSTICE DAVIS

MR JUSTICE EDIS

HIS HONOUR JUDGE LUCRAFT QC
(Sitting as a Judge of the High Court)

B E T W E E N :

THE QUEEN
ON THE APPLICATION OF
LEWIS — Applicant

- and -

SENIOR CORONER
FOR
NORTH WEST KENT — Respondent

MR J. WATERS (instructed by Thompsons Solicitors) appeared on behalf of the Applicant.

THE RESPONDENT did not appear was not represented.

J U D G M E N T

LORD JUSTICE DAVIS:

Introduction

1 These judicial review proceedings were commenced on 2 July 2019. The relief sought is the quashing of a conclusion of the jury given on 29 April 2019 following an inquest as to the death of Jennifer Lewis. Jennifer Lewis had died on 27 July 2017. In essence, what is said is that the conclusion of the jury at the inquest was vitiated by the failure of the coroner to leave "neglect" as an available finding as part of the jury's narrative conclusion.

2 Permission was granted by Johnson J on 14 October 2019. Before us, the claimant, who is the sister of Jennifer Lewis, was represented by Mr Julian Waters, who had also appeared on behalf of the family of Jennifer Lewis at the inquest. Neither the coroner, that is to say the Senior Coroner for North West Kent, Mr Roger Hatch, nor any of the interested parties was represented before us; they have indicated a position of neutrality with regard to these proceedings.

3 I would say at the outset that the points raised seem to me to involve no controversial issues of law or of principle at all. The question is whether applying the *Galbraith* principles, as they are usually known, to the evidence, the coroner was justified in withholding a finding of neglect from the jury. For this purpose, it is not necessary, or indeed desirable, to summarise the background in any very great detail; but some exposition is necessary.

Background Facts

4 Jennifer Lewis was born on 20 December 1971. In 1990, when she was a university student, she presented with mental disorder. In due course, she was diagnosed as suffering from paranoid schizophrenia. She was provided with medication and, for the most part, in the early years of her illness, she was able to live in the community – albeit her condition did have fluctuations. Latterly, there were increasing problems with her weight; she became seriously obese. Following detailed appraisal, it was assessed that she was suitable for bariatric surgery, to which she gave her consent, although members of her family had expressed strong concerns about such an operation.

5 At all events, gastric bypass surgery was eventually performed on 9 March 2010. Very pronounced weight loss, perhaps predictably, followed this surgery. Unfortunately, it was also accompanied by physical manifestations, such as nausea and vomiting, and by psychiatric manifestations. At all events, it appears that, from around October 2010, it was necessary to section Jennifer Lewis under the provisions of the mental health legislation, and she was admitted to various hospitals for treatment.

6 Latterly, from 17 October 2014, she was admitted to the Bracton Centre, a psychiatric unit operated by the Oxleas NHS Foundation Trust. Her paranoia, if anything, seems to have increased. For example, as it appears, she would refuse to take medication on suspicion that it was contaminated, and she would refuse to give blood samples for fear that they might be used as DNA evidence against her. It was said that she could be dismissive about her physical health needs and sometimes abusive of staff in this regard, and generally could be uncooperative and resistant to requests made of her with regard to her well-being.

7 The records would suggest that, for a number of years after 2010, her weight had remained broadly stable following the significant weight lost in the immediate aftermath of the bariatric surgery in 2010; but by around July 2016 concern was being expressed that she was

again losing a significant amount of weight. It was indicated that she should be monitored. But she suffered continuing weight loss and in addition there were other physical manifestations such as oedema in the feet, diarrhoea, hair loss, and her eyesight being affected.

8 Indeed, there were occasions during 2017 when, at the request of the Bracton Centre, she was admitted to external hospitals: firstly, the Whittington Hospital; and then, secondly, to the gastroenterological unit of the Queen Elizabeth Hospital; and, finally, in July or June 2017, to the Darent Valley Hospital. These admissions were occasioned by the concerns about her physical decline. At one stage in the evidence that was to be given at the inquest, it was said by one of the doctors that she was "just fading away before our eyes". One issue at the inquest that was raised was whether there had been appropriate follow-up aftercare after her admission to the two external hospitals.

9 Points that were to be made by the doctors at the Bracton Centre in due course at the inquest were that she had indeed been uncooperative in many respects with regard to her treatment, and it was also stressed that there were real practical difficulties with regard to feeding her. The essential problem, however, seems to have been not so much in her not taking food but in her not being able to absorb it: "malabsorption", as it was styled.

10 Nevertheless, and notwithstanding the referrals to the external hospitals, following her return to the Bracton Centre her physical decline continued. She was found half-conscious in her room at the Bracton Centre on 14 July 2017. She was transferred to the Darent Valley Hospital. On examination there, she was found to be severely undernourished, unkempt, and dehydrated. She had splits to both sides of her mouth and very poor mouth hygiene. She was also noted as having bed sores. Despite treatment, she died on 27 July 2017. It is perhaps a point of note that the Darent Valley Hospital had been sufficiently concerned as to raise safeguarding concerns about the standard of her care, given her condition.

11 There was a post-mortem examination. The report provided by the pathologist, Doctor Fish, stated the opinion that the cause of death was:

> "1(a) Malabsorption due to (or as a consequence of)
> (b) gastric bypass surgery 2010."

The following comments were added by the pathologist to his report of 5 August 2017:

> "Natural causes. Malabsorption is a recognised complication of gastric bypass surgery. This woman's albumin was less than 15 g/L and had resulted in massive oedema and fluid loss from her circulation. Malabsorption can cause heart and kidney failure and diarrhoea..."

12 On 20 November 2017, a root cause analysis report was prepared on behalf of the Oxleas NHS Foundation Trust. It is right to say that that report seems to be drafted, essentially, from a psychiatric perspective. The report found that the root cause of death was malabsorption syndrome following the gastric bypass surgery. It was, amongst other things, recommended that there be better communication in such cases with outside physical health clinicians. The family of Jennifer Lewis were and are very critical of much of that report, regarding it as, in effect, a whitewash.

13 One complaint that has been much pressed in this regard, although by no means the only complaint, is that neither the Bracton Centre at the time nor the root cause report subsequently had any – or at least any sufficient – regard to the Foundation Trust's own

written policy, issued in February 2010 and updated in October 2015, with regard to the management of nutrition and hydration. It is said that the recommendations and guidance given in that policy simply were not followed at all in the case of Jennifer Lewis.

The Inquest

14 The inquest itself was held before the Senior Coroner for North West Kent and a jury between 25 - 29 April 2019. It was common ground at that inquest that, in view of the fact that Jennifer Lewis had been sectioned and was being kept in the Bracton Centre, the inquest was to be conducted having regard to the considerations arising from Article 2 of the European Convention on Human Rights. Put very shortly, a state obligation clearly arose in the circumstances of this particular case.

15 The medical cause of death was, in the course of the inquest, supplemented by Doctor Fish, the pathologist, so as to read as follows:

> "1a. Malnutrition due to (or as a consequence of)
> b. Gastric Bypass Surgery (2010) and Schizophrenia."

It may be noted, amongst other things, that the word "malnutrition" has been substituted for the word "malabsorption", although, at the inquest, it was indicated that the two may be overlapping matters.

16 There was extensive evidence, both written and oral, from various medical witnesses. The appropriateness of the decision to engage in the gastric bypass surgery in 2010 was, amongst other things, explored. The care and the aftermath of the treatment of the admissions to the Whittington Hospital and the Queen Elizabeth Hospital were also explored. In particular, the treatment of Jennifer Lewis at the Bracton Centre – in particular, in the last year of her life – was closely explored. Emphasis in this regard was, amongst other things, placed on the asserted failure to comply with the Trust's written policy on hydration and nutrition in a significant number of respects, and on the asserted failure to respond adequately to Jennifer Lewis' continuing and pronounced weight loss and physical decline, with evident symptoms of malnutrition.

17 In this regard, much emphasis also was placed on the failure to keep proper and adequate records of her continuing weight loss. It was said that, in effect, one report would simply replicate the previous report which had been given so that the weight and body mass index never were altered. It was said that this was in effect done on a "cut and paste basis". It was complained further that not only was her weight loss and physical decline not being properly monitored, there was also a failure, contrary to all sensible practice and contrary to the policy as it was said, to obtain any appropriate advice from a dietician. Indeed, a dietician only first became involved in March 2017 on one occasion on the recommendation of one of the external hospitals – and there was then one further dietic examination shortly before her death.

18 At the conclusion of all the evidence, the interested persons who were legally represented provided written submissions. It was common ground that this was a proper case for a narrative conclusion. Mr Waters, on behalf of the family, amongst other things, submitted to the coroner that, on the effectively undisputed evidence, one issue that arose was an issue of neglect. Indeed, at that stage he even appeared to suggest that unlawful killing might be an issue for the jury. That an issue of neglect arose was not, it seems, opposed by anyone else appearing at the hearing, although it is right to say that the written submissions submitted on behalf of the Oxleas NHS Foundation Trust were perhaps equivocal in that regard.

19 There was no further discussion with the coroner about whether neglect should be left to the jury in the summing-up. As we understand, following the receipt of written submissions, the coroner then proceeded to sum up to the jury. He reviewed the evidence very concisely. In putting matters to the jury, he did not leave neglect as an issue. Towards the end of his short summing up, the coroner posed these potential questions for the jury, saying this:

> "In this case, there a wider circumstances for you to consider and if I can assist you in that respect but I emphasise this is a matter for you and to the factual findings which you consider are firstly, are you satisfied that Jennifer had capacity to agree to the gastric bypass carried out in 2010? In that respect I would refer you to the evidence of Mr Sufi and the enquires that he called before it was carried out and secondly, were appropriate checks carried out in 2010 that she was suitable for the bypass operation? Thirdly, following the operation are you satisfied that should was provided with appropriate diet and vitamin supplements at the Bracton Centre? Fourthly, and most importantly, did she comply with the diet and also take the vitamins that were essential for her following the operation and do you agree that the investigations that were required at the hospital were carried out? Fifthly, was the physical care provided to Jennifer at the Bracton Clinic properly provided following her admission from 2014 and lastly, were timely appointments arranged for Jennifer by the Centre when she was seriously unwell and had to attend local hospitals for treatment and that is when you should recall the evidence that was given at the time?"

20 We were told that these questions, as posed to the jury, were not reduced into writing: which perhaps was rather unfortunate. At all events, as I will come on to say, the jury did not, in their conclusion, precisely answer the questions that were posed.

21 After the coroner had summed up to the jury and the jury had retired, objection was raised by several of the legal representatives who were present to the effect that the coroner had not dealt at all with the question of the standard of proof or with the question of causation. The coroner agreed that he would correct those matters with the jury, and in due course he did so. Mr Waters, however, also objected that the coroner had not left neglect, Mr Waters having assumed that it would be left and being taken by surprise when the coroner did not do so. According to the transcript, the coroner then briefly said, by reference to the case of *Jamieson* to which I will come, that that was deliberate; he clearly had concluded that this was not a case in which neglect should be left as an issue for the jury.

22 In due course, the jury returned. Their conclusions as set out in s.3 and s.4 of the record of inquest were as follows:

> "3. How, when and where, and for investigations... in what circumstances the deceased came by his or her death", the conclusion was: "… Jennifer Lewis died at the Darent Valley Hospital, Darent Wood Road, Darenth on the thirty-first July 2017 as a result of malnutrition…"
>
> 4. Conclusion of the Jury as to the death: Inadequate provision and intake of sufficient nourishment and nutrition, furthered by an inability to appropriate [sic] the necessary medical intervention whilst at the Bracton Centre."

Something may have gone wrong grammatically with that conclusion as expressed; but that is how it was expressed.

23 Following the inquest, the coroner submitted a Regulation 28 report. His concerns that were expressed as follows:

> "During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.
>
> The MATTERS OF CONCERN are as follows: --
> (1) the failure to arrange consultation between the mental health doctors and the doctors responsible for her physical health.
> (2) the failure to provide suitable or adequate care for her needs.
> (3) the failure to provide appropriate care at the Centre."

Then, under s.6, for the action that should be taken: "In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action."

Legal Context

24 I next will refer briefly to the relevant law. Section 10(2)(b) the Coroners and Justice Act 2009 prohibits a jury from framing a determination in such a way as to appear to determine any question of civil liability. It has, however, long been established under the preceding but corresponding legislative scheme that a finding of "neglect" is open to a jury in an appropriate case. In this context "neglect" is a term of art not to be equated with the tort of negligence and, in effect, being the obverse of a finding of self-neglect (see, for example, the case of *R (Middleton) v West Somerset Coroner* [2004] UK HL 10, [2004] 2 AC 182).

25 The position has, in particular, been addressed by a constitution of the Court of Appeal in the case of *R v Her Majesty's Coroner for North Humberside and Scunthorpe, ex parte Jameson* [1995] QB 1. After a lengthy review of the authorities, Bingham LJ, giving the judgment of the Court, said this amongst other things at p.25 of the decision. After stating that the word "neglect" was preferable to the expression "lack of care", he said at subparagraph (9) of his conclusory remarks:

> "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. Failure to provide medical attention for a dependent person whose physical condition is such as to show that he obviously needs it may amount to neglect..."

And then a little later:

> "As in the case of self-neglect, neglect can rarely, if ever, be an appropriate verdict on its own ..."

He further went on to say this:

> "Neither neglect nor self-neglect should ever form any part of any verdict unless a clear and direct causal connection is established between the conduct so described and the cause of death."

26 Whether neglect is to be left to a jury – and, if so, how – is further the subject of Guidance No.17 issued by the Chief Coroner. In setting out the relevant principles, and after reference to the case of *Jamieson*, this amongst other things is said in the guidance at para.74:

> "The following does no more than outline the concept of neglect in coroner law. Neglect is not a conclusion in itself. It is best described as a finding... It has a restricted meaning according to the case law. It should not be considered as a primary cause of death."

And then, at para.79, after referring to *Jamieson*:

> "This definition has been expanded more by illustration than by changes in the law, testing the words 'gross failure' and 'basic' against particular facts. In broad terms there must be 'a sufficient level of fault' to justify a finding of neglect. That does not mean that, for example in a medical context, there has to have been no action at all, simply that the action (or lack of it) on an objective basis must be more than a failure to provide medical attention. It must be a gross failure. The difference will be highly fact-specific... In a medical context it is not the role of an inquest to criticise every twist and turn of a patient's treatment. Neglect is not concerned with the correctness of complex and sophisticated medical procedures but rather the consequences of, for example, failing to make simple ('basic') checks."

Disposal

27 Against that factual and legal background, I turn to the outcome for these proceedings. I will express myself shortly. It is, if I may say so with respect, most unfortunate that, submissions having been made to the coroner prior to summing up that "neglect" should be left to the jury, the coroner gave no reasons at all at that time for declining to do so. It seems to us that much the better practice would have been, given that the point had been raised, for the coroner at the time to indicate, if he was minded not to leave neglect to the jury, what his reasons were for taking that course. But that did not happen.

28 The first time that Mr Waters realised that neglect was not going to be left was when the summing-up was delivered. Thereafter, when he queried the position with the coroner, the coroner shortly said that he made a deliberate decision on that, having regard to the cases of *Galbraith* and *Jamieson*. He gave no further reasons to explain the course that he adopted. Moreover, I would note that subsequently, on receipt of a very lengthy pre-action protocol letter, the coroner expressed himself no less briefly in saying why he had not left neglect as an issue for the jury to determine. That has been particularly unfortunate, not only given that it has generated, in part, these proceedings, but also that at the time the family had no real reasons from the coroner as to his announced conclusion.

29 It has to be said, as it seems to me, the background here is somewhat disconcerting. On any view, Jennifer Lewis had suffered pronounced weight loss in the months before she died. There were accompanying manifestations of physical decline and malnutrition, including, as I have said, hair loss, oedema in the feet, sores, and diarrhoea. The medical records were

never properly maintained or updated and, on the face of it, the written policy on hydration and nutrition simply was not adhered to.

30 As Mr Waters understandably stressed, the context is a striking one, indeed, on one view, a very uncomfortable one. Here we have an individual detained under the authority of the state, pursuant to the mental health legislation, in a state-controlled institution, who has died of malnutrition. Given all the circumstances revealed by the evidence which was adduced at the inquest – and we have all the transcripts – I am, for myself, unable to see how a finding of neglect applying *Galbraith* principles was not properly available to the jury or, indeed, how it could not be safe for the jury to make such a finding, if so minded.

31 Mr Waters, before us today, tentatively suggested that this Court should make its own finding and conclusion of neglect. That, it seems to me, is entirely inappropriate. All I would say is that the evidence gave rise to an issue of neglect, which was properly to be left for the jury to determine. Whether a jury would or should make such a finding would be a matter for the jury. As I see it, this Court cannot second-guess that particular point. But the point which does remain, as I see it, that this was a conclusion, that is to say a finding of neglect, which was properly open to the jury on the evidence. It seems to me, with all respect, that the withdrawal of such an issue of neglect from the jury was not one which was reasonably open to the coroner; and it has, in consequence, resulted in a flawed inquest. Indeed, it is perhaps a point of a comment that the coroner's own statement in his Regulation 28 report indicated his own concerns as to what had happened here.

32 In all the circumstances, I see no alternative but to quash the conclusion of the jury, and I see no alternative but to order a new inquest. Given the circumstances, I think that it would be better if such inquest were conducted before a different coroner.

33 I should add that, at one stage in his argument before us, Mr Waters seemed to press that there should have been left to the jury the option of making a finding of "gross" neglect. It is to be borne in mind that, under the *Jamieson* approach, for neglect to arise at all there must be a gross failure to provide adequate nourishment or basic medical attention. I have to say, I formed the impression that Mr Waters was, in many ways, seeking to equate the concept of "neglect" with the quite different concept of negligence, and that is impermissible. At all events, I need say nothing further about that particular point: because all can be left to the fresh inquest and the appraisal of the evidence adduced at that inquest.

34 I would, however, wish to repeat that I think it was unfortunate, and not good practice, that the decision not to leave neglect as an issue was not the subject of a proper reasoned ruling at the time; had it been, it may be that matters would not have taken the course that subsequently they have taken. That said, for my part nevertheless, I would grant the relief sought by these proceedings.

MR JUSTICE EDIS: I agree.

JUDGE LUCRAFT QC: I agree.

CERTIFICATE

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Official Court Reporters and Audio Transcribers
5 New Street Square, London, EC4A 3BF
Tel: 020 7831 5627 Fax: 020 7831 7737
CACD.ACO@opus2.digital

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