R (on the application of Bilski) v Her Majesty's Coroner for Inner West London

[2021] EWHC 3339 (Admin)

Queen's Bench Division, Administrative Court (London)

Whipple J

10 November 2021

Judgment

DR A. Van DELLEN and MS S. SEN GUPTA (instructed through Direct Access) appeared on behalf of the Claimant.

MS C. VENTHAM (instructed by Coroners for Inner West London) appeared on behalf of the Defendant.

J U D G M E N T

MRS JUSTICE WHIPPLE:

1 This is a renewed application for permission for judicial review. It relates to the Inquest conducted by HM Assistant Coroner for Inner West London, more specifically to a decision made by the Coroner on 15 April 2021 to refuse to adjourn the Inquest for an expert in vascular neurosurgery to be instructed and in relation to the findings in the record of the Inquest as to how the deceased came by her death marked at Box 3.

2 I repeat my sincere condolences to the family of Evalina Bilska, who died on 13 March 2016 aged only 32. That is obviously a tragedy for her family. It is a great sadness to see a life cut short like that.

3 Ms Bilska died of a sub-arachnoid haemorrhage. The cause of death is clearly recorded in boxes 2 and 4 of the Record of Inquisition. Box 3 of the Record of Inquisition states only that on Sunday 13 March 2016 she died at St George's Hospital Blackshaw Road, Tooting, London SW17 0QT. By ground 1, Dr van Dellen, supporting by Ms Sen Gupta, argues that box 3 is fundamentally defective such as to make the Record of Inquisition unlawful because it omits an explanation of "how" she died, answering only the "where" and "when" questions. He seeks permission on the basis that that is an arguable point.

4 When Heather Williams J refused permission for this judicial review she noted that it would have been better if box 3 had cross-referred into box 4, but that there was no lack of clarity as to how this deceased came by her death because it was a death by natural causes (box 4), that being the brain bleed (intracerebral haematoma) noted in box 2.

5 As the point has been argued before me today, the claimant's case progresses a little beyond how it may have been understood on the papers. The essence of it appears to be that although there was a sub-arachnoid haemorrhage that was causative of death in March 2016, Ms Bilska (the deceased) had been diagnosed with a carotid aneurysm about a month earlier, in February 2016, and had been under the care of St George's hospital, but she had been released from St George's with a follow-up outpatient appointment, without any urgency.

6 This course of medical treatment was the subject of much evidence at the Inquest and was summarised by the Coroner in a very helpful determination in a transcript which has latterly been provided to the court and to the parties.

7 The Coroner identified the sequence of events that involved Ms Bilska being seen by Dr Holmes and a Mr Boeris at the hospital. Mr Boeris works to a Mr Johnston at the hospital. That was the treating team.

8 The Coroner had an expert report from a Mr Tsang, who is a consultant neurosurgeon, although not a neurosurgeon with a vascular sub-speciality. She refused to instruct an expert other than Mr Tsang for various reasons, including this:

"We are not talking about complex neuro-surgical sub-specialities here. We are talking about bread and butter work of neurosurgeons which is making a diagnosis of whether it is a sub-arachnoid haemorrhage or an aneurysm."

9 Her conclusion was that Ms Bilska was correctly diagnosed as suffering from an aneurysm when she was seen at St George's on 12 February 2016. Treatment options were discussed in relation to that aneurysm but a legitimate and proper decision was made not to treat her, at least not with any urgency in relation to the aneurysm.

10 As was noted by the Coroner, an incidental aneurysm, as Ms Bilska had, has a risk of haemorrhage of approximately 0.5 per cent in the next year, even taking into account her family history. Interventions to deal with that aneurysm all carried their own risks. The decision about how to treat the aneurysm was a difficult one, but one which was not particularly urgent because left untreated, the aneurysm was not presenting a high risk of rupture in the next year. The fact is that she was not presenting in February with a subarachnoid haemorrhage and thus there was not case for emergency admission or intervention. That was the point on which Dr Tsang advised, and that matter lay well within his area of expert competence.

11 What caused Ms Bilska's death was a massive bleed, and that is what she came to hospital with on 13 March 2016. The bleed was in consequence of a rupture of the aneurysm, as noted as the medical cause of death at paragraph 1b of box 2 on the record of inquisition.

12 The scope of this Inquest was limited to how, when and where this deceased came by her death, and the answer to that was by way of a sub-arachnoid haemorrhage on 13 March 2016 at St George's Hospital. The haemorrhage was described in the record of inquisition as an intracerebral haematoma, with the second entry in box 3 referring to the rupture of the carotid aneurysm.

13 The claimant's argument that somehow there should be captured in box 3 the preceding history that she had attended with an aneurysm in February is not sound. It is not arguable based on the way this inquest proceeded and the way the Coroner summed up at the end. The preceding history did not explain how, where or when the deceased came by her death. Those questions are narrow, and focus on the immediate circumstances surrounding death on 13 March 2016.

14 That then forms an important part of the background to my consideration of whether ground 1 is arguable. I conclude that it is not arguable because having identified the scope of the Inquest to be rather narrower than the claimant now argues or might have desired at the time, all the information which informs how this deceased died is undoubtedly on the Record of Inquisition. There is no addition to box 3 which would make that record any clearer or fuller. That being so, at its height ground 1 relates to a technical defect in the Record of Inquisition; Heather Williams J was right in so describing it. There is no fundamental defect which vitiates this record of Inquisition or causes it to be unlawful. So I refuse permission on ground 1.

15 I come then to ground 2 which relates to the Coroner's refusal to adjourn in order that a vascular neuro-surgeon could be instructed. But a vascular neuro-surgeon would only be relevant and helpful if the aneurysm itself had a bearing on the how, where and when questions answered in the record of inquisition, in other words if the aneurysm was part of the "how" as the Coroner was approaching it. It is clear from the Coroner's conclusions, as I have reviewed them, that the Coroner was satisfied that the aneurysm was part of the background facts only, it did not explain “how” the deceased came by her death for the purposes of this inquest. That being so, there was no reason for her to adjourn to get a further expert report to investigate further. As she said, she had all the experts that she needed to deal with this tragic case of sub-arachnoid haemorrhage, and Mr Tsang, although he may have been less experienced in the vascular sub-speciality than other witnesses who

were called to give evidence, was a perfectly appropriate witness to deal with the matter at hand, which was what was the cause of death in March 2016.

16 I conclude, therefore, that ground 2 is not arguable either, and permission for this judicial review must be refused.