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Your Ref: LIT 477/08/B5/CR

Our Ref: BMcL-0096-13

Date: 15th May 2013

Dear Ms Rodgers,

Re: Raychel Ferguson (Lucy Crawford Aftermath)

Further to my letter of 10 May (BMcL-0089-13) I attach copies of the Clegg decision and the CMO communication to doctors about information to coroners, to which Bridget Dolan referred in her report.

I look forward to hearing from you as soon as possible in relation to the matter raised in my letter of 10 May.

Yours sincerely,

Brian McLoughlin
Assistant Solicitor to the Inquiry

Justice of the Peace Law Reports/1996/Re Clegg (deceased) - (1996) 161 JP 521

(1996) 161 JP 521

Re Clegg (deceased)

QUEEN'S BENCH DIVISION (CROWN OFFICE LIST)

PHILLIPS LJ, HOOPER J

2 DECEMBER 1996

2 DECEMBER 1996

A Weereratne for the Applicant

Salisbury, Wiltshire

PHILLIPS LJ

This is an application made by Mr James Clegg for an Order quashing the Inquisition on the inquest on his daughter Catherine Lucy Clegg and directing that another inquest be held. It is made pursuant to s 13 of the Coroners Act 1988 and with the authority of the Attorney-General, which was granted on 29 March 1996.

The inquest was conducted by William Bache Esq, Her Majesty's Deputy Coroner for the County of Wiltshire, on 11 June and 16 July 1992. The Respondent to this application, David Masters Esq, was appointed Her Majesty's Coroner for Wiltshire on 1 January 1993. He has sworn a helpful affidavit, which confirms that the relevant facts are common ground. In this he explains why he is opposed to this application. He does not, however, appear in person or through counsel. In a letter he has explained that this is because his appointing authority, Wiltshire County Council, has taken the view that it has no authority to indemnify him in respect of the costs to any judicial review. He emphasises that he intends no discourtesy to this court.

In the circumstances, I do not consider that his absence is discourteous, although it is both surprising and unfortunate if, on an application such as this, the appointing authority has no power to indemnify a Coroner for legal expenses reasonably incurred in respect of involvement attributable to his office.

The Facts

The Inquisition records the following findings made by the Deputy Coroner in respect of Lucy's death:

"1. ...

2. Injury or disease causing death: (1a) Acute salicylate Poisoning.

3. ... circumstances ... in which injury was sustained: ... mother went to wake her at 8.25 am on 9 June. found sleepy, also several tablet foils. Admitted 9.05 am to SGI, died at 2030 hours. Note left.

4. Conclusion of the Coroner as to death:

Killed herself."

Those facts reflect evidence given at the inquest by Lucy's mother and the report of a post mortem examination. While the Deputy Coroner had Lucy's medical records he did not receive or call for any medical evidence in relation to Lucy's treatment between the time that she was admitted to Salisbury General Hospital at her death nearly 12 hours later. It is not necessary or appropriate to attempt to form any view as to whether the Deputy Coroner should have been put on inquiry as to the possibility that her treatment in hospital did not follow an appropriate course. What is beyond doubt is that this was certainly the position, it was known to be the position by a number of people within the hospital service, and no one thought to inform the Deputy Coroner of this fact.

In a recent affidavit the Coroner has made this comment:

"Section 11(2) of the Coroners Act 1980 provides that the Coroner shall 'examine on Oath concerning the death or persons who tender evidence as to the facts of the death and all persons having knowledge of those facts [that he] considered it expedient to examine'. This sub-section presupposes that by some means or other, the Coroner will first become aware of such matters in order for him to summon the relevant witness who may then disclose the information or at least indicate that he could disclose them if the questions are asked.

By common law all those who have knowledge of matters which could help a Coroner in the furtherance of his enquiries are supposed to volunteer and make disclosures thereof."

In a letter to Mr and Mrs Clegg dated 3 May 1966, Mr Alan Langlands, the Chief Executive of the National Health Service, commented:

"I should also confirm that I have been unable to trace any specific written guidance for NHS staff in relation to giving evidence to the Coroner. Staff are simply expected to do what the law requires; that is to answer the questions which are asked truthfully and to cooperate to the extent they are required to do so."

Without hearing submissions on the matter it would not be right to express an unqualified conclusion as to whether this state of affairs is satisfactory. My provisional view is that it is not, and that the National Health Service should give consideration to the appropriate approach of its staff to providing information to a Coroner.

In the present case, as will appear, the manner in which Lucy was treated at Salisbury General Hospital should properly have been the subject matter of investigation by the Deputy Coroner and it is regrettable that no one drew this area of inquiry to his attention.

As a result of complaints about Lucy's treatment made by her parents, an Independent Professional Review ("the Review") was undertaken pursuant to the Health Service Complaints Procedure by the Wessex Regional Health Authority. I would like to interject that Mr and Mrs Clegg appear to have acted throughout in a rational and dignified manner.

The Review was published in August 1994. It suffices for present purposes to cite a number of his conclusions. At page 32:

"Miss Clegg was seriously ill when admitted to the Accident and Emergency Department, Salisbury General Infirmary on 9th June 1992 at 09.05 hr. She manifested the features of severe salicylate poisoning. She was assessed incorrectly, investigated and monitored inadequately and treated poorly."

At page 36:

"We concur with Mr and Mrs Clegg that, 'there was complete failure at every stage of Lucy's treatment to appreciate the importance of the aspirin overdose'. Specifically, 'no steps were taken to (a) prevent possible further absorption, (b) to enhance elimination of salicylate, or (c) provide adequate support measures in the Accident and Emergency Department';

We agree that, 'Lucy's condition, which exhibited some of the classic symptoms of salicylate poisoning, deteriorated steadily throughout the afternoon... ;

We agree that, 'even at this stage no active intervention beyond a saline drip was instituted'. Furthermore, the amount of fluid administered at 18.10 hr was too little to effect the clinical outcome;

...

We agree that 'Lucy died at about 8.00 pm having received no treatment which had a significant chance of helping her through the salicylate poisoning."

A Complaint Panel ("the Panel") was appointed by the Board of Salisbury Health Care of the National Health Service Trust to consider the Review. The Panel summarised their findings as to Lucy's treatment with this general comment:

"There can be no doubt that the treatment of Miss Clegg was grossly inadequate. A series of errors or failures compounded to produce a disastrous result."

The Panel made a number recommendations in relation to both procedure and trading in the light of its finding, and ended its report with the following conclusion:

"Each member of the Panel has been much saddened by the failure of the hospital to help Miss Clegg and has noted the ongoing remorse of those whom it has interviewed. It does believe that Salisbury Health Care, both as a result of her death and by a more active managerial influence, has put into place systems which will make such a tragedy much less likely to occur and if it should do so, much easier to identify what went wrong and to learn lessons therefrom.

The Panel, has detected no complacency on this point in those whom it has interviewed and all have recognised the need for constant vigilance in maintaining standards and attitudes."

As I understand the position, the reason why Mr Clegg is pursuing this application is that he is not wholly satisfied with the response of the Panel to the Review and its recommendations, nor to a situation where the National Health Service appears to take the view that it is no part of the professional duty of those who have treated a patient who has died to draw to the attention of a Coroner conducting an inquest into the death, matters which they would reasonably appreciate would be of relevance to the Coroner's task. We have also been told by Ms Weereratne that Mr Clegg is concerned that the inquiries to date have been internal inquiries rather than the public inquiry, which is the subject matter of an inquest.

The jurisdiction of this court

Section 13 of the Coroners Act 1988 provides:

"This section applies where, on an application by or under the authority of the Attorney-General, the High Court is satisfied as respects a coroner ('the coroner concerned') either -

(a) ...

(b) where an inquest has been held by him, that (whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise) it is necessary or desirable in the interest of justice

that another inquest should be held.

(2) The High Court may- (a) order an inquest, or, as the case may be,

another inquest be held into the death either- (i) by the coroner concerned; or (ii) by the coroner for another district in the same administrative area; (b) order the coroner concerned to pay such costs of and incidental to the application as to the court may appear just; and (c) where an inquest has been held, quash the inquisition on that inquest."

It is submitted on behalf of Mr Clegg that it is necessary or desirable in the interest of justice that another inquest should be held by reason of the discovery of the new facts relating to the treatment of his daughter that have formed the subject of the Review and the Panel's report. It is submitted that these facts might well lead to the recording of a different verdict and that it is, in any event, in the public interest that they should be the subject of investigation by the Coroner.

In his affidavit of 31 July 1996 Mr Masters concluded as follows:

"(a) I accept that the findings of the Independent Review were not available to Mr Bache at the Inquest on 11 June and 6 July 1992. However, that does not in my respectful opinion mean that there was insufficient inquiry requiring a fresh Inquest, given that the deficiencies in the hospital treatment did not cause the death;

(b) I verily believe that there is no real possibility of a different verdict in the light of the current authorities and it is unnecessary therefore for a fresh Inquest to be held."

That conclusion was based on a consideration of the following authorities: R v Southwark Coroner, ex parte Hicks [1971] 2 All ER 383, [1971] WLR 1624; R v Portsmouth Coroner, ex parte Anderson [1988] 2 All ER 604, [1987] 1 WLR 1640; R v Coroner for North Shields and Humberside, ex parte Jamieson [1995] 1 QB 1; R v Birmingham Coroner, ex parte Cotton (unreported) (Divisional Court 1995); and R v Coroner for Surrey, ex parte Wright (unreported) transcript, dated 18 June 1966.

In my judgment the correct approach to this court to the question of whether the discovery of fresh evidence should lead to an order for a new inquest is as follows. The court should consider whether it is possible that the fresh evidence may lead to a different verdict. If it is, this will point towards the desirability in the interests of justice of a fresh inquest. If it does not, a fresh inquest will be unlikely to be necessary or desirable. But the possibility of a different verdict will not be a conclusive factor. It will always be necessary to bear in mind the purposes of an inquest and to consider the extent to which, if at all, an order for a new inquest will further those purposes so as to render a new inquest necessary or desirable in the interest of justice.

Is it possible that the fresh evidence will affect the verdict?

The authorities cited by Mr Manners are all concerned with the question of when it is proper for a Coroner or his jury to record a verdict that a death has been caused in whole or in part by "lack of care". In R v Coroner for North Shields and Humberside, ex parte Jamieson [1995] 1 QB 1at 25 Sir Thomas Bingham MR, expressed the hope that:

"... in future the expression 'lack of care' may for practical purposes be deleted from the lexicon of inquests and replaced by 'neglect'."

In the present case Ms Weereratne submits that the new evidence may well lead to a finding that Lucy died as a result of neglect, and that Mr Masters was mistaken to conclude that the authorities to which he referred indicated to the contrary.

The cases of ex parte Hicks and ex parte Anderson were considered by the Master of the Rolls in a comprehensive survey of the important authorities covering this area of law in Jamieson. While most of his judgment has relevance to this application, the passage beginning at page 25 has particular relevance to the verdict of neglect. It begins with the eighth of a number of general conclusions:

"(8) Much of the difficulty to which verdicts of lack of care have given rise appear to be due to an almost inevitable confusion between this expression and the lack of care which is the foundation for a successful claim in common law negligence. Since many of those seeking that verdict do so as a stepping-stone towards such a claim the boundary is bound to become blurred. But lack of care in the context of an inquest has been correctly described as the obverse of self-neglect. It is to be hoped that in future the expression 'lack of care' may for practical purposes be deleted from the lexicon of inquests and replaced by 'neglect'.

(9) 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. So it may be if it is the dependent person's mental condition which obviously calls for medical attention (as it would, for example, if a mental nurse observed that a patient had a propensity to swallow razor blades and failed to report this propensity to a doctor, in a case where the patient had no attention to cause himself injury but did therefore swallow razor blades with fatal results). In both cases the crucial consideration will be what the dependent person's condition, whether physical or mental, appeared to be.

(10) As in the case of self-neglect, neglect can rarely, if ever, be an appropriate verdict on its own. It is difficult to think of facts on which there would not be a primary verdict other than neglect. But the notes to form 22 in the Rules of "1984, although in themselves have no binding force, are correct to recognise that neglect may contribute to a death from natural causes, industrial disease or drug abuse. Want of attention at birth, also mentioned in the notes, may itself be regarded as a form of neglect. A verdict that, for instance, 'the deceased died from natural causes [or industrial disease, or drug abuse] to which neglect contributed' would seem perhaps more apt than a verdict that 'the deceased died from natural causes [or industrial disease, or drug abuse] by neglect,' since "aggravated" in this context means 'made worse,' and in truth the neglect probably did not make the fatal condition worse but sacrificed the opportunity to halt or cure it.

(11) Where it is established that the deceased took his own life, that must be the verdict. On such facts, as the applicant in the present case accepted, there is no room for a verdict of neglect (or, as he would have put it, lack of care). It is also inappropriate in such a case, as the applicant also accepted, to describe that cause of death as aggravated by neglect (or lack of care). On certain facts it could possibly be correct to hold that neglect contributed to that cause of death, but this finding would not be justified simply on the ground that the deceased was afforded an opportunity to take his own life even if it was careless (as that expression is used in common speech or in the law of negligence) to afford the deceased that opportunity. Such a finding would only be appropriate in a case where gross neglect was directly connected with the deceased's suicide (for example, if a prison warder observed a prisoner in his cell preparing to hang a noose around his neck, but passed on without any attempt to intervene).

(12) Either neglect or 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."

The important points to be gleaned from this passage in the context of this application seem to me to be the following:

(1) Failure to provide appropriate medical attention to a dependent patient in hospital is capable of constituting 'neglect'.

(2) Where it is established that the deceased took his or her own life, that must be the verdict, but:

(3) Rare circumstances can exist where it is appropriate to make a finding that neglect was a cause that contributed to the death of a person who killed himself or herself.

The example given by the Master of the Rolls of such circumstances was one of neglect which preceded the act of suicide. What he did not consider was a case such as the present, where the act of suicide did not result immediately in death, but in the victim becoming a patient in hospital dependent on the care of the hospital staff. In such circumstances it is much easier to conceive of neglect having a direct causal connection to the death.

In Wright the deceased died when unconscious under general anaesthetic in the course of dental surgery, as a result of an obstruction to his airway. Tucker J held, having referred to Jamieson, that there was no basis in such circumstances for contending that the verdict of accident should have been that of neglect. I think it arguable that that conclusion did not inevitably follow from Jamieson, but, in any event, the facts of that case are very different from the present case. In this case the deceased was dependent upon the hospital staff for a period of nearly 12 hours before she died. If the findings of the Review and of the Panel are correct, and there has been no suggestion that they are not correct, the care which she received during that period suffered from a continuous sequence of shortcomings. Those findings suggest that it is at least possible that, but for those shortcomings, her life would have been saved. In these circumstances my conclusion is that, applying the approach in Jamieson, it is possible that if a new inquest were to be held the verdict would be that Lucy killed herself but that neglect contributed to her death.

Is it necessary or desirable in the interest of justice that a new inquest should be held?

In Jamieson the Master of the Rolls said:

"It is the duty of the Coroner as the public official responsible for the conduct of inquests, whether he is sitting with a jury or without, to ensure that the relevant facts are fully, fairly and fearlessly investigated."

In this case I am satisfied that the Coroner failed to investigate a substantial area of relevant fact, because he failed to appreciate that such an area existed. In consequence he failed to apply his mind to the question of whether the verdict should record that neglect was a cause which contributed to death.

What has troubled me is that the treatment that Lucy received in hospital has now been thoroughly investigated by the Review and reconsidered by the Panel. I do not understand that there is any challenge to the conclusion reached by those bodies as to the treatment that Lucy came to receive. Over four years have now passed since the relevant events. Many of those involved have left Salisbury. The site of the hospital has itself been moved. A new verdict might put the record straight, if the verdict should properly have recorded neglect, but would it achieve anything more and, if not, does that fact alone justify ordering a fresh inquest? Were we to order such an inquest it would involve the Coroner in considering what appears to me to be a very difficult question, namely whether the lack of care that it is plain existed in this case had a causative effect in relation to Lucy's death, ie. whether, on balance of probability, had due care been exercised in Lucy's treatment she would have survived. I do not believe that it would be likely that the Coroner would reach a conclusion on that question with confidence. I ask myself what purpose would such a change of verdict serve?

Ms Weereratne has urged that it is desirable that inquiries into an occurrence such as this should be in the public arena, and with that I agree. But the purpose of an Inquest is not to identify individual fault on the part of those involved. On the contrary it is expressly not concerned with that question. It is much more important that it identifies any deficiencies of the system and ensures that steps are recommended to deal with those deficiencies. It seems to me that the deficiencies in the system have been clearly identified and that this court has now, in a public hearing, described those deficiencies, albeit in general terms, in no uncertain terms.

In those circumstances, and having regard to the passage of time, it does not seem to me that the genuine desirability of public hearings renders it necessary or desirable in the interest of justice for a fresh inquest to take place at this late stage.

I have given consideration to the question of whether, were an inquest to take place, it might lead to recommendations

additional to those that have been made by the Panel and implemented over the last four years. Again my conclusion is that in a situation such as this a Coroner cannot be expected to do more than to make general recommendations and that it must, at the end of the day, be for the National Health Service to give detailed consideration to how their recommendations should be implemented. Detailed consideration has been given to the lessons to be learned from this case and steps have been taken to remedy the shortcomings that occurred over four years ago. It does not seem to me that, if an inquest were now held, an investigation into the adequacy of these steps would be an appropriate exercise for the Coroner to undertake.

In these circumstances, and with the greatest sympathy for the parents who have made this application, I have reached the conclusion that it should be dismissed.

HOOPER J

I agree.

Application dismissed

CMO's Update 20

a communication to all doctors from the Chief Medical Officer

Chief Medical Officer:
Professor Liam Donaldson
MSc,MD,FRCS(Ed),FRCP,FFPHM

Richmond House
79 Whitehall
London SW1 A 2NS

Personal note from the Chief Medical Officer

CMO's Update was established in January 1994 by my predecessor, Sir Kenneth Calman, to communicate more effectively with all doctors in England. Its introduction led to a considerable reduction in the number of individual messages sent out by the Department in relation to professional matters, and also to considerable cost savings for the Department of Health (DH). It is intended to incorporate some topics that might otherwise have required an individual CMO Letter, progress reports on earlier CMO Letters, and other information from DH that should be of interest to practicing doctors.

All communication strategies will be kept under continual review, particularly with the advance of electronic communication within the National Health Service and more generally, but I am happy to introduce this first communication to all doctors under my name.

Liam Donaldson

Information to the Coroner

About 190,000 deaths are reported to the Coroner annually in England and Wales. Approximately 70% result in post-mortem investigations, comprising 90% of all necropsies[1]. National confidential inquiries indicate that such examinations provide essential information not only to the Coroner but also to clinicians - informing bereavement counseling, improving clinical care and supporting clinical audit.

The Select Committee on Public Administration earlier this year stressed the need for clinicians to disclose all relevant information to the Coroner to ensure a fully informed decision on cause of death'. While there is no specific duty on clinicians to do this, all those who have information which could help Coroners' inquiries should disclose it voluntarily and not only when requested.

The General Medical Council has updated', and the United Kingdom Central Council for Nursing, Midwifery and Health Visiting will shortly be publishing, amended professional guidance emphasizing the need to inform the Coroner.

DH liaison: Dr Mike McGovern, Room 412 Wellington House, 135-55 Waterloo Road, London SE1 8UG.

1 Office for National Statistics. *Coroners' post mortems in England and Wales: a report for the Department of Health.* London: Stationery Office (in press),

2 House of Commons Public Administration Committee. *Second report of the Health Service Ombudsman for 1996-97 together with the proceedings of the Committee and minutes of evidence: report from the Public Administration Committee: Session 1997-98.* London: Stationery Office, 1998 (HC 352). Chair: Mr Rhodri Morgan.

3 General Medical Council. *Good medical practice (2nd edition).* London: General Medical Council, 1998.

For changes in address, please contact: The Medical Mailing Company, PO Box 60, Loughborough LE 11 OWP (or telephone Freephone [redacted]

November 1998

On the State of the Public Health

The Chief Medical Officer's Annual Report on the state of the public health for 1997, together with some comments on the more important developments and events in the first half of 1998, was published on 9 September'. This Report is the 140th of the series which began in 1858.

Health continued to improve overall during the year: infant mortality reached its lowest recorded rate, and perinatal mortality also fell. Progress continued to be made towards more integrated working to maintain the public health, and for more efficient communications between all those involved. The importance of an underlying strategy to enhance public health, not just to treat illness, was further emphasised by the setting out of a new public health strategy to tackle the underlying causes of ill-health, and to break the cycle of social and economic deprivation and social exclusion, in the Green Paper, *Our Healthier Nation'*. The multi-disciplinary nature of health care was also addressed.

The Report is not simply a document of record, but also tries to interpret and to explain changes in those factors that are known to influence and to determine health, and to identify areas where improvements could be made. As in previous years, some issues are highlighted for special mention, and progress on topics identified in earlier years is discussed. As well as discussion of the 150th anniversary of the 1848 Public Health Act, the four key issues identified for particular attention were: health and the environment; autism; screening; and diabetes mellitus.

1. Department of Health. On *the State of the Public Health: the annual report of the Chief Medical Officer of the Department of Health for the year /997.* London: Stationery Office, 1998. (Available priced £18.50 from Stationery Office Bookshops or Agents; ISBN o- I 1-3221 13-4).

2. Department of Health. *Our Healthier Nation: a contract for health.* London: Stationery Office, 1998 (Cm. 3852).

Men and cancer

European Union (EU) Member States adopted a programme of action to combat cancer in 1986, and the theme for each 'Europe against cancer week' reflects the topic chosen for the annual work programme.

This year's week, from 5-11 October, had the theme 'Men and cancer'. A conference was held at the Royal Marsden conference centre, London, on **8** October, and copies of a poster and booklet' were sent to health promotion units for onward distribution. The booklet identifies eight symptoms of cancer in men, and encourages them to seek appropriate advice. In support of the 'Men and cancer' campaign, the United Kingdom Health Departments have also agreed to fund three projects to raise awareness of cancer issues among men, organised by Cardiff Community Health, the Ulster Cancer Foundation, and Scunthorpe Health Promotion.

DH liaison: Dr Sunjai Gupta, Room 546 Wellington House, 135-55 Waterloo Road, London SE18UG.

1. Cancer Education Co-ordinating **Group.** *Don't delay: get informed about cancer in men today* **London: Europe Against Cancer, 199x.**

Recent publications

Copies of Department of Health publications can be obtained from the Department of Health, PO Box 410, Wetherby, West Yorkshire LS23 7LN (tel: [redacted]; fax [redacted]). Stationery Office (formerly HMSO) publications are available from: Stationery Office Publications Centre, PO Box 276, London SW8 5DT.

CMO Letters

Department of Health. *Influenza immunisation. extension of current policy to include all those aged 75 years and over*. London: Department of Health, 1998 (Professional Letter: PL/CMO(98)4, PL/CNO(98)6).

Department of Health. *Carbon monoxide poisoning: the forgotten killer,* London: Department of Health, 1998 (Professional Letter: PL/CMO(98)5, PL/CNO(98)8).

Department of Health. *Antimicrobial resistance.* Department of Health, 1998 (Professional Letter: PL/CMO(98)6, PL/CNO(98)7, PL/CDO(98)4, PL/CHPO(98) 1).

CMO's Update is a newsletter sent by the Chief Medical Officer of the Department of Health to all doctors in ngland. It will incorporate some topics that might otherwise have required an Individual letter, progress reports on earlier letters, and other reformation from the Department of Health that should be of interest to practicing doctors.

CMO's Update is also available on the Internet at: http://www.open. gov.uk/doh/cmo/cmoh.htm.

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