Assessing complex inquest evidence: What if a different coroner might take a different view?

written by Bridget Dolan QC | 12 December 2016

***McDonnell v Assistant Coroner for West London* [2016] EWHC 3078 (Admin)**

Leo McDonnell died due to a fatal cardiac arrhythmia. At the time of his death he was prescribed nine items of medication including citalopram, amitriptyline, quinine and codeine. To prescribe citalopram alongside some of these drugs was contraindicated and his prescribed daily dose of citalopram was higher than the recommended maximum. There was a factual dispute between the treating doctors and the claimant regarding these prescriptions. In summary the doctors stated that they had explained the serious risk to the heart and risk of death to him in straightforward terms. The claimant's evidence was that the doctors had spoken in medical jargon and failed to convey that there was a serious risk. Her position was that the prescribing doctors should not have shifted responsibility by asking the deceased to consent to the continuing over-prescription.

There were two main candidates for the cause of Mr McDonnell's death. The first was the mixture of medication he was taking and the role of the 15 codeine tablets he had taken on the day of his death. The second was a vaso-vagal event. The Assistant Coroner found that the death was from a combination of both potential causes, citing a "fatal cardiac arrhythmia triggered by a vaso-vagal event in the presence of excessive codeine, together with citalopram, amitriptyline and quinine at levels consistent with prescribed medication." She concluded the death was by "misadventure".

Mr McDonnell's widow was not satisfied with these findings or the narrative conclusion and so applied under Coroners Act 1988 to quash the inquest. She argued that the coroner was not entitled to have found that an overdose of codeine contributed to death, as this was inconsistent with the post mortem evidence, nor to have found that the deceased had given his consent to the citalopram being prescribed alongside the other contraindicated medication.

Her challenge failed:

> *"That a different coroner might take a different view of the evidence does not mean that it is in the interests of justice to hold a new inquest."*

The principal criticism of the coroner's approach related to the content of the Record of Inquest rather than the sufficiency of her inquiry. Indeed the inquiry appears to have been a very detailed one with evidence having been heard from six doctors and a forensic toxicologist: these were Mr McDonnell's GP and two treating psychiatrists, about his medication and compliance; a forensic scientist, about the drugs found post mortem; a forensic pathologist, who dealt with the post mortem and causes of death; a cardiologist and a Professor of clinical toxicology, who dealt with the risks of citalopram and the cause of death.

Thankfully, in order to understand the legal issues considered by the court, it is not necessary to begin to try and explain that complex and convoluted medical evidence and the various competing opinions here. Suffice to say that the broad question before the court was whether it was open to the

coroner on the evidence before her to reach the conclusion that she did? The court found that it was. There was evidence which the coroner was entitled to accept to support her determination that this had been a vaso-vagal event with an excessive quantity of codeine playing a material role. Hence her conclusion that the cause of death was "misadventure" was not open to challenge.

As Lord Justice Beatson stated, in a case such as this, where the cause of death was complex and there was a range of medical opinion given in evidence, the possibility of a different verdict in a further inquest cannot be excluded. It may be that a different coroner might take a different view of the evidence; but that possibility does not mean that it is in the interests of justice to hold a new inquest. If it did, that would potentially be the case whenever there was complex and disputed medical evidence and if so finality could hardly ever be achieved.

It is of note that although some have suggested that "misadventure" is an outdated term Beatson LJ acknowledged its use uncritically, explaining how death by misadventure is a death in which some deliberate but lawful human act has unexpectedly resulted in death, whereas "accident" connotes something over which there is no human control. He notes, without comment, the previous criticism of the difference between these terms as being "without purpose or effect".

Extent of a *Jamieson* narrative

The widow's complaint about the narrative conclusion was the failure to refer to the combination of medication prescribed and the contraindication with citalopram. The court strongly hinted that matters of such importance in the inquiry might be addressed even in a *Jamieson* (non-Article 2) inquest, stating that it may have been "advisable" for the coroner to refer to the contraindicated citalopram medication in her conclusion. Indeed the coroner had accepted that something on the combination of drugs prescribed could have been properly included. However it would not be in the interests of justice to order a new inquest on that basis. It was no error of law for the coroner not to mention that issue. This being a *Jamieson* inquest any narrative conclusion should be short and focused on the immediate circumstance. The issue of the combination of medications was of less centrality to the relevant question of "how the deceased came by his death, i.e. the means of death". Whilst narrative conclusions are allowable in a *Jamieson* inquest in such cases a narrative verdict should be limited to the means of death. As was said in the *Jamieson* case:

> *"There can be no objection to a verdict which incorporates a brief, neutral, factual statement… But such verdict must be factual, expressing no judgment or opinion, and it is not the jury's function to prepare detailed factual statements."*

The widow's case was that the prescription should never have been given, but since this was a *Jamieson* inquest, the coroner was right not to specifically apportion blame in her conclusions. The statute and the authorities show that in such a case the determination must be non-judgmental and limited to the means of the death. In addition the coroner had made a Regulation 28 report that had referred to the absence of a system to make sure clinicians at GP practices and Trusts are aware of the full range of the medication a patient is prescribed. Taking that into account it was not desirable in the interests of justice to have a re-run of all the issues which had now been made public.