The perils of fast-tracked documentary inquests

written by Bridget Dolan QC | 23 October 2020

***Rushbrooke v HM Coroner for West London* [2020] EWHC 1612 (Admin)**

With such a huge backlog of inquest cases waiting to be heard and the difficulties of convening inside a courtroom during the current pandemic, the appeal of holding a swifter, documentary only inquest is plain to see. However, the recent case of *Rushbrooke* is a timely reminder to coroners that they will run the risk of their findings being quashed if the haste to hold a paper-based inquest results in an insufficient investigation.

The background

Mrs Rushbrooke was an elderly lady who was suffering with dementia and living under a Deprivation of Liberty Safeguards Standard Authorisation ("DoLS authorisation") in a care home. She suffered an adverse reaction to her medication and was admitted to hospital experiencing breathing difficulties. Whilst at hospital an x-ray identified three separate leg fractures that were thought likely to be 4-6 weeks old. The care home had no record of any fall or incident and the fractures were unexplained: neither the hospital nor the care home accepted they occurred in their premises.

Mrs Rushbrooke was treated for aspiration pneumonia, in addition a CT scan also showed that she had suffered a stroke in the past. Sadly, after a few weeks in hospital, Mrs Rushbrooke died.

A 'documentary inquest' held by the Senior Coroner just 14 days after the death was attended by the Claimant, Mrs Rushbrooke's daughter. The Senior Coroner concluded that the death was from 'natural causes' citing the medical cause of death as "*1a aspiration pneumonia due to 1b stroke, on a background of atrial defibrillation and dementia*." This very closely followed the proposed cause of death identified by the reporting doctor. No post-mortem examination had been undertaken.

Insufficient inquiry

The Claimant's numerous complaints about the inquest fell under two broad headings. First, she pointed to several alleged procedural irregularities including that:

- The inquest was conducted under the DoLS fast-track procedure but the family were not given the required notice of the inquest;
- The family were not invited to make representations on the scope of the inquest;
- The family were not informed it would be a paper-only inquest; and
- The Claimant alleged that during the inquest she was interrupted by the Coroner and thus unable to properly give her own evidence.

Second, the Claimant complained that the investigation and inquest conducted were insufficient and that relevant evidence was not heard. In particular:

- '*Stroke*' was listed as a cause of death despite any stroke having taken place years earlier;
- The Coroner did not explore how the recent fractures were sustained;
- The Coroner did not consider whether the deceased's enforced immobility due to the fractures may have exacerbated her other medical conditions; and

- The coroner did not adjourn the inquest to await the outcome of a safeguarding investigation that had been instigated.

When the Clamant applied for a fresh inquest under Coroners Act 1988 the Senior Coroner did not defend the application. He frankly accepted the real possibility that a fresh investigation and inquest may give rise to an alternative outcome and, it appears, also agreed to pay the Claimant's costs of bringing the application.

The Decision

Given the coroner's concession there can have been little doubt that the High Court would make the order sought.

Applying the now familiar '*Hillsborough*' test [1] Lord Justice Hickinbottom noted that the court was required to answer a single question, namely whether the interests of justice made a further inquest either necessary or desirable. The answer to that question was clear. An order under was made quashing the determination of the earlier inquest and ordering a fresh inquest and investigation to be held.

Wider Lessons

Many cases which coroners deal with are straightforward and do not require witnesses to give live evidence. There is clearly a place for short form documentary inquests which can avoid the need for stressful attendance at an inquest for the family. However, the *Chief Coroner's Guidance #29* on 'Documentary Inquests' emphasises that fast track inquests are not suitable in circumstances in which the next of kin have expressed any concerns about the death, for example the hospital treatment the deceased received or the circumstances surrounding the death.

Coroners should only hold a documentary-based inquest where they are satisfied that a sufficient inquiry into the evidence can and will take place. Cutting corners may lessen the administrative burden initially, but may well instead lead to additional costs and an additional toll on a bereaved family.

Footnotes

[1] *Attorney General v HM Coroner of South Yorkshire (West)* [2012] EWHC 3783 (Admin)