Emergency Hospital Treatment & Article 2 Inquests: Fernandes applied to domestic law

written by Bridget Dolan QC | 17 June 2018

***R (Parkinson) v HM Senior Coroner Kent, Dartford and Gravesham NHS Trust and Dr Hijazi (Interested Parties)* [2018] EWHC 1501 (Admin)**

In a tour de force judgment, that deserves plaudits for its several pages of lucid exposition of the application of Art 2 in respect of deaths associated with medical treatment, the Divisional Court have re-affirmed that the Art 2 investigative obligation will not be engaged if what is being alleged amounts to no more than medical negligence by healthcare staff.

Although Art 2 rights could be infringed if an individual's life is knowingly put in danger by the denial of access to life-saving emergency treatment, the state's Art 2 obligations do not extend to circumstances where a patient is considered to have received deficient, incorrect or delayed treatment.

That conclusion is perhaps of little surprise given the very recent and authoritative statement of the relevant principles set out by the Grand Chamber of the European Court in *Fernandes v Portugal*[1] (see our earlier blog). Indeed once *Fernandes* was decided in December 2017 the main part of the Claimant's judicial review claim was already thoroughly holed below the water line. Mr Parkinson nevertheless sought to urge upon the Court that, if necessary, it should decline to follow decisions of the ECtHR.

Launching the final torpedo, the Divisional Court made it clear that only in exceptional circumstances would the courts in this country decline to follow the jurisprudence of the European Court of Human Rights. *Fernandes* was to be followed: and, on the facts, there had been no arguable breach of Art 2.

The facts

Mrs Parkinson was 91 years old when she died in hospital in 2011. She had been brought to A&E where Dr Hijazi determined that her agonal breathing indicated that she was in the process of dying, and that there was little that could be done to save her. The Claimant, her son, did not accept the doctor's opinion and he wanted his mother treated. Mrs Parkinson was provided with intravenous fluid, antibiotics and gelofusine. Whilst there were tests that could have been conducted, from a practical point of view there would not have been sufficient time for these to be carried out and completed and treatment provided prior to her death to realistically have affected the outcome. The Claimant attempted to perform mouth to mouth resuscitation, although advised against this by the A&E staff. He made threats towards the doctor and was obstructive. Sadly, his mother deteriorated rapidly and died soon after arriving

At the inquest in 2016 the Coroner determined that the investigative obligations under Art 2 were not engaged. The Coroner did not find any evidence that Mrs Parkinson was neglected in terms of the treatment and care provided. The cause of death was determined to be "bronchopneumonia combined possibly with right lung pulmonary thrombi" and, despite the Claimant urging that this had been unlawful killing by gross negligence manslaughter, a conclusion of natural causes was returned.

The JR challenge

The Claimant brought five grounds of challenge seeking to either quash the inquest or remedy the purported defects on the Record of Inquest:

1. That it was wrong in law to hold that the Art 2 enhanced investigative duty did not arise;
2. The finding regarding the medical cause of death was irrational;
3. The use of a short form conclusion of "natural causes" did not constitute a sufficient discharge of his duties under the legislation and at common law; and/or was irrational;
4. The finding that the Claimant's conduct obstructed the care which would otherwise have been provided to his mother was irrational;
5. The Coroner should have made a Prevention of Future Death ('PFD') Report.

The jurisprudence of Article 2 ECHR

Giving the judgment for the whole Court (which included the Chief Coroner) Lord Justice Singh noted how it was long established that, in general, courts in this country should follow the clear and consistent jurisprudence of the European Court of Human Rights. It is only if the existence or otherwise of a Convention right is unclear, then it may be appropriate for domestic courts to make up their minds whether Convention rights should or should not be understood to embrace it. However, such circumstances would be exceptional.

In the present case great importance was placed on the *Fernandes v Portugal* case which represented the latest, very recent and authoritative summary of the applicable principles under Article 2. In *Fernandes* the Grand Chamber had "self-consciously" decided to review the ECtHR case law on Art 2 and restate it.

Happily for those of us who find ploughing through the 113 pages of the *Fernandes* decision rather daunting[2], Singh LJ provided a 'nutshells' guide to Art 2, distilling the principles from *Fernandes* as follows:

- Article 2 imposes both substantive positive obligations on the state and procedural obligations.
- The primary substantive positive obligation is to have a regulatory framework compelling hospitals to adopt appropriate measures for the protection of patients' lives.
- The primary procedural obligation is to have a system of law in place by which individual failures can be the subject of an appropriate remedy: by having a criminal justice system that can hold to account a healthcare professional who causes death by gross negligence; and a civil justice system which makes a claim for negligence available.
- The enhanced duty of investigation, requiring the state itself to initiate an effective and independent investigation, will only arise in medical cases in limited circumstances, where there is an arguable breach of the state's own substantive obligations under Article 2.
- Where the state has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, matters such as an error of judgment on the part of a health professional or negligent coordination among health professionals in the treatment of a particular patient are not sufficient of themselves to call the state to account under Article 2.
- However, there may be exceptional cases which go beyond mere error or medical negligence, in which medical staff, in breach of their professional obligations, fail to provide emergency medical treatment despite being fully aware that a person's life would be put at risk if that treatment is not given. In such a case the failure will result from a dysfunction in the hospital's services and this will be a structural issue linked to the deficiencies in the regulatory framework.

> ***"At the risk of over-simplification, the crucial distinction is between a case where there is reason to believe that there may have been a breach which is a "systemic failure", in contrast to an "ordinary" case of medical negligence."***

Applying those principles to the facts of the present case: there had been a policy based on a nationally recognised system which governed the A&E triage system. The court was not at all impressed by the argument that because other wards of the hospital used a different system to classify medical emergencies there was a lack of clarity about the relevant policies, such that there a systemic issue arose in this case. The two policies were distinct and were understood to be so. The medical emergency policy did not apply in A&E where all cases were approached as emergencies.

An alleged error in diagnosis leading to a delay in the administration of proper treatment, or an alleged delay in performing a particular medical intervention, could not in themselves constitute a basis for considering the facts of this case on a par with those concerning denial of healthcare. The court rejected any suggestion that the inclusion of the "do not resuscitate" notice in this case had the effect that Mrs Parkinson was denied appropriate medical treatment. Withholding CPR was a matter of clinical judgment.

The Senior Coroner was, therefore, perfectly entitled to reach the view that there was no systemic issue which arose and no arguable breach of the substantive obligations in Article 2.

Challenges to the facts

The Claimant also challenged the Senior Coroner's factual findings on three aspects: (1) the medical cause of death; (2) that no action that the hospital might reasonably have taken could have changed the outcome; (3) that the Claimant's behaviour obstructed examination of Mrs Parkinson.

When assessing factual conclusions the issue was not whether the reviewing court agreed or disagreed with the Coroner's conclusions: but whether his conclusions were ones that no reasonable coroner could have arrived at, being sufficiently at variance with the evidence as to be perverse. Ordinarily this threshold was extremely difficult for judicial review applicants to cross: the present case was no exception.

The Senior Coroner had considered the evidence of five pathologists, which was conflicting and extremely complex. He had in the end accepted the cause of death as given by an eminent pathologist who the claimant had initially instructed (but with whom the Claimant disagreed).

There had been ample evidence for the Senior Coroner to conclude that Mrs Parkinson was in an "advanced stage of dying" on her admission to hospital and that no treatment would have affected the outcome.

As to whether there had been obstruction of Dr Hijazi's examination, this was an issue that had to be addressed: not to have done so would have been odd in the circumstances of the sequence of events at the hospital that morning. There was a conflict in the evidence and the Senior Coroner was clearly entitled to come to a view on this evidence. Whilst others might not have come to the view that this coroner did, it was one that he was entitled to make, and was not irrational.

Given all the above findings a PFD report was not required.

Costs

Having lost on all grounds the Claimant was not only ordered to pay the costs of the Senior Coroner, but more unusually, required to pay the costs incurred by each of the interested parties.

It was common ground that costs were in the discretion of the Court and that the usual order is that costs should follow the event. However, the Claimant sought to avoid paying the Coroner's costs by arguing (among other points) that if the claim had succeeded the Defendant Coroner might well have been justified in submitting that there should be no order as to costs against him. The Court was not persuaded. It was important and necessary for the Coroner to defend his decision and to take an active part in these proceedings: the Coroner had been successful and the normal order as to costs should follow.

Although the Court would often make only one order as to costs in judicial review proceedings, in the particular circumstances of this case each of the Interested Parties should be awarded their costs where each had separate interests which needed to be protected by separate representation.

Footnotes

[1] *Lopes de Sousa Fernandes v Portugal* (Application no. 56080/13) ECtHR Grand Chamber (19 December 2017)

[2] 50 pages of which comprise the partly concurring and partly dissenting decision of the wonderfully named Judge Paulo Pinto de Albuquerque