Possible causation and Art 2 conclusions: Was Lewis possibly wrong?

written by Bridget Dolan QC | 17 June 2016

***R (Tainton) v Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin)**

The Court of Appeal in *Lewis*[1] made it clear that there is a power, but not a duty, to leave to an inquest jury findings regarding non-causative shortcomings which only may have led to or hastened death. A coroner has discretion to leave to the jury causes of death that are merely possible and not probable.

However the Divisional Court have now taken an interesting side-step around *Lewis* by deciding that, in an Art 2 inquest where a shortcoming has been admitted then, even if it is only possibly causative of the death, the jury should be directed to record it.

> *"Where the possibility of a violation of the deceased's right to life cannot be wholly excluded, section 5(1)(b) and 5(2) of the 2009 Act should require the inclusion in the Record of Inquest of any admitted failings forming part of the circumstances in which the deceased came by his death, which are given in evidence before the coroner, even if, on the balance of probabilities, the jury cannot properly find them causative of the death." [74]*

The background facts

Mr O'Neill was serving a prison sentence when he died from oesophageal cancer. The diagnosis of his cancer had been delayed due to shortcomings by prison health care staff.

The clinical reviewer for the PPO was of the view that the prison health care "fell significantly below an acceptable standard", the PPO agreed. The NHS Trust providing the prison healthcare admitted the failing in correspondence, acknowledging that were it not for their staff's shortcomings the cancer would have been diagnosed five months sooner. That admission was repeated in open court at the beginning of the inquest and also by the relevant staff members when they gave their oral evidence.

If this particularly aggressive cancer had been amenable to chemotherapy, and had Mr O'Neill been fit enough for chemotherapy five months prior to his actual diagnosis, and had he then accepted chemotherapy if offered to him, and had he not dropped out of treatment (as the majority do) then chemotherapy might have extended his life by two to three months. His oncologist's view was that with so many imponderables it would be "speculative" to say that earlier diagnosis of the cancer would have led to a measurably longer life.

The conclusions left to the jury

At the end of the inquest the Senior Coroner determined that the oncology evidence could not establish that the delay to diagnosis had probably made any difference to Mr O'Neill's life expectancy and so withdrew from the jury the issue of whether the delayed diagnosis caused or accelerated the death on a "Galbraith plus" basis: as such a finding would be unsafe.

The Divisional Court agreed with the coroner stating that they were "*firmly of the view that the coroner was right to reach that conclusion, and that he was not bound to leave the issue of causation of death to the jury. We agree with his analysis: there were too many unknowns in the factual history; it would not be safe for a jury to accept the family's contention that Mr O'Neill's death was measurably hastened as a result of the admitted shortcomings in his medical care*." [68]

Applying *Lewis* the coroner also declined to leave the issue of whether the delayed diagnosis 'possibly' accelerated this death, saying he would not leave open a narrative conclusion "when so much of the evidence is missing."

Again the Divisional Court agreed that the coroner was correct, stating that "*in our judgment, the coroner was entitled to exercise his discretion in that way, and properly did so. We would not interfere with the coroner's decision on that issue*." [71]. The Divisional Court also dismissed the family's application that neglect should have been left to the jury, saying the coroner "*was justified*" in not doing so.

So, in line with the coroner's analysis above, which the Divisional Court accepted was correct, the inquest jury had been left to return only a short form conclusion. Unsurprisingly the jury found that this was a death from 'natural causes'.

The Divisional Court did not agree, however, that this was a sufficient conclusion for an Art 2 inquest where there had been admitted failings on the part of the State.

Despite holding that the coroner was entitled to exercise his discretion so as not to permit the jury to consider whether or not the delayed diagnosis was a possible cause of death, the Court found that at the same time, he was obliged to direct the jury to record on the Record of Inquest the admitted shortcoming of staff, just so long as that statement was coupled with a rider that they could not say that the late diagnosis shortened life.

> *"We consider that the coroner should have directed the jury to include in the Record of Inquest a brief narrative of the admitted shortcomings of the health care staff responsible for the late diagnosis of Mr O'Neill's cancer. In the light of the fact that the coroner withdrew the issue of causation from the jury, such a statement would have to have been supplemented by an explanation that it could not be concluded that these shortcomings significantly shortened Mr O'Neill's life."[74]*

How this finding can be squared with *Lewis* and the Court holding that this coroner had correctly exercised his discretion not to leave a possible cause to the jury is less than clear. The Court's reasoning appears to be that a simple 'natural causes' conclusion was not a fair reflection of the issues that the inquest had focussed upon.

> "The material facts leading up to the deceased's death included substandard care by agents of the state which, if they were to pass unmentioned, would render the bland short form "natural causes" verdict inadequate to describe properly the circumstances in which the deceased met his death [80]. In our judgment, the admitted failings of the Trust's staff… should have formed part of the inquest findings precisely because they were admitted, and formed part of the evidence heard by the jury." [81]

But if that is the case, then surely this point goes to how the coroner decided to exercised his discretion apropos *Lewis*.

Regardless of whether coroners follow this decision or whether *Lewis* prevails coroners will now no doubt face lengthy and detailed arguments about the difference between circumstances leading up to the death (which still don't need to be recorded) and the circumstances by which the deceased came by his death (which *Lewis* says only need to be recorded if causative, but this case suggests must be recorded if admitted and remain a possible or non-fanciful cause).

Where that leaves sub-standard care that is denied and non-causative remains wholly unclear. But it is of concern this decision may have the highly unwelcome effect of discouraging candour and becoming a powerful incentive for public bodies not to admit any shortcoming when it looks like causation will not be established.

Footnotes

[1] [2009] Inquest LR 294