Challenging the coroner's narrative

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Personal Injury analysis: How was the issue of a practitioner's right to challenge evidence at a coronial inquest treated in the case of Wilson v HM Senior Coroner for Birmingham and Solihull? Daniel Machover, head of civil litigation and partner at Hickman & Rose, comments on this judgment.

Original news

Wilson v HM Senior Coroner for Birmingham and Solihull [2015] EWHC 2561 (Admin), [2015] All ER (D) 38 (Sep)

The claimant consultant cardiothoracic surgeon issued proceedings, contending that a sentence should be removed from the defendant coroner's narrative conclusions as to his three patients. The Divisional Court, in dismissing the application, held that on the evidence before her, the coroner had been entitled to come to the conclusion that she had and it could not be described as irrational.

What were the issues at the heart of this case?

Background

Mr Wilson is a consultant cardiothoracic surgeon who was employed by the University Hospitals Birmingham NHS Foundation Trust (the Trust). Mr Wilson previously had an exemplary track record. In a piece in the *Guardian* to mark the 60th anniversary of the NHS in 2008, Mr Wilson was singled out for unbridled praise by one of his former patients, Lisa Kitteridge, whose life he saved when she was pregnant and had developed a rare heart condition called cardiomyopathy. Mr Wilson led a team of 15 doctors who performed emergency surgery to save her life and that of her unborn child. Notwithstanding this, the Trust's computer claimed that Mr Wilson's patients had too high a mortality rate. On the basis of what the Trust's computer said, Mr Wilson was dismissed from his post.

Application for judicial review

Mr Wilson applied for judicial review of a coroner's decision following an inquest into the deaths of three of his patients. He had carried out surgery on the three patients, each of whom died within a few weeks of this surgery. The hospital's computerised internal monitoring system registered a higher than expected mortality rate among the claimant's patients and on the basis of this computerised data alone he was later dismissed.

Mr Rosser is the trust's medical director. His witness statement alleged that Mr Wilson had previously significantly over-reported angina and pulmonary hypertension rates among his patients--raising the predicted death rate and making his actual mortality rate look artificially low. Mr Rosser alleged that with the correct data, the Trust's internal monitoring process would have or could have triggered an alert earlier with the result that Mr Wilson's practice would have been restricted. However, at the inquest hearing, Mr Rosser sought to avoid answering difficult questions by deferring to another report that had been produced by Professor Wallwork on Mr Wilson's surgery.

Mr Wilson received Mr Rosser's witness statement before the inquest, but neither he nor his solicitors or counsel had access to the underlying original source data, such as patient records or indeed the methodology by which the trust's computer computed that Mr Wilson's patients' mortality rates deviated from any norm. Mr Wilson submitted that without access to that source data his counsel was unable to properly cross-examine the hospital's witnesses at the inquest.

Coroner's verdict

The coroner stated she was not interested in seeing that source data, but was interested in knowing when an alert would have been raised had the correct data been recorded. The coroner concluded that for each of the three patients the historic failure to accurately record the data resulted in a missed opportunity to identify the problems earlier which could have led to the operations being carried out by a different surgeon. Mr Wilson submitted that in the absence of the source data the coroner had failed to properly explore the evidence and had correspondently reached irrational conclusions. Mr Wilson submitted that the coroner had incorrectly implied that Mr Wilson himself had entered inaccurate patient data.

The application for judicial review was refused. It was for the coroner to set the bounds of the inquiry. Evidence taken at inquests often called for a degree of procedural flexibility and the rules of neither criminal nor civil evidence applied. Questions of fairness to those involved had to be judged in light of those features and the fact that the statutory scheme prohibited a finding of criminal or civil liability on the part of a named person. Mr Wilson had been aware of the suggestion that the data had been inaccurately recorded--the evidence had been provided to the General Medical Council (GMC) and served on him with detail of the underlying analysis albeit without the source data in the underlying medical records. He was not taken by surprise when the matter emerged in Mr Rosser's statement for the inquest. The court found that Mr Wilson's aim had been to keep the issue out of the inquest and reserve it for the GMC. There were mechanisms under which he could have deployed the additional material, but he had not taken up the opportunity and had not explained his view about the evidence.

There were inconsistencies in the data which could have been dealt with without the patients' medical details. Mr Wilson had mentioned his reservations about them but had not provided an explanation. The coroner had decided that the purpose of exploring the data was to determine when an alert would have been triggered. The coroner was careful not to identify Mr Wilson as the person who had recorded the inaccurate data.

To what extent must someone be given the opportunity to challenge evidence at a coronial inquest?

This depends on a variety of factors including:

- the circumstances of the case
- the nature of the criticism
- whether the person has prior notice of the criticism

Here, it was not in fact the case that the claimant had no opportunity to challenge the evidence, but that he said he was hampered in doing so effectively by a lack of access to underlying material.

However, that lack of access was not deemed unfair by the court. The court considered that the question of giving a fair opportunity to a person who may be criticised--albeit not by name--in the conclusions as to death had to be assessed with regard to the fact that fairness:

'in an inquest must be fashioned in an environment where there are no pleadings and in which those given leave to appear as interested persons do not have a case to put. The evidence at inquests often takes an unexpected turn and calls for a degree of flexibility in the procedure to be followed as a consequence. The rules of evidence applied in criminal and civil proceedings do not apply. Questions of fairness to those involved in inquest proceedings must be judged against all these essential features and also in the context that the statutory scheme prohibits a finding of criminal liability on the part of a named person, or of civil liability.' (para 27)

How were the Vogon principles approached in this case?

In *Vogon International Limited v The Serious Fraud Office* [2004] EWCA Civ 104, [2004] All ER (D) 58 (Feb) the Court of Appeal ruled on the amount due under a contract to extract email data from a computerised database. The contractor (Vogon) submitted an invoice for over £314,000 when the Serious Fraud Office (SFO) expected the work to cost £22,500. However, the trial judge had made a finding in his judgment on costs that Vogon's action in tendering its invoice for such a large sum had been an opportunistic and dishonest attempt to exploit the SFO--although this matter had not been previously raised. Although the appeal was dismissed, the Court of Appeal said the judge below had been wrong to make the finding against Vogon that it had been opportunistic and dishonest where dishonesty had not been argued by SFO and Vogon had been given no warning or opportunity to defend itself against such findings.

This case was distinguished from the facts in Vogon, with the court finding at para [35] that it was:

'...unable to accept the submission made on behalf of Mr Wilson that he did not have adequate notice of the point or have an opportunity to deal with it before the coroner came to her narrative verdict.'

Does this case offer any lessons on the delivery of narrative conclusions as to death by coroners?

This case supports coroners in exploring a wide range of issues, perhaps going far back in history, that may be relevant when answering how and why a death has come about. It demonstrates that on judicial review the courts are prepared to support coroners in reaching conclusions in such cases that touch on the root causes of a death, including systemic historic failings, even where by implication this identifies individuals who may be at fault.

What should lawyers take from this case?

Lawyers representing persons whose conduct may be criticised will want to ensure that they always secure as much advance disclosure of underlying material as possible and to test that--and any basis on which criticisms are made--as far as the coroner will allow. When there can be no real surprise about points of criticism any holding back is inadvisable as the courts will not readily find procedural unfairness. Lawyers representing interested persons who seek conclusions that go as wide and deep as possible, will want to hold up this case as an example of why a wide scope can enable important evidence to be considered and conclusions being reached that point to historic systemic failings, sometimes pointing by implication to the individuals concerned.

Interviewed by David Bowden.

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