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IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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KING'S BENCH DIVISION
(JUDICIAL REVIEW)

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IN THE MATTER OF AN APPLICATION BY MARIE FERGUSON FOR LEAVE TO APPLY FOR JUDICIAL REVIEW

AND IN THE MATTER OF THE FACTUAL FINDINGS OF A CORONER IN AN INQUEST TOUCHING UPON THE DEATH OF RAYCHEL ZARA FERGUSON

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Mr Heraghty KC (instructed by Elev8law Group Ltd T/A Elev8Law) for the Applicant
Mr Chambers KC with Ms Herdman (instructed by Solicitor to the Coroner) for the Respondent
Mr Henry KC with Ms Gallagher (instructed DLS) for Western Health & Social Care Trust, Notice Party
Mr Boyle KC with Ms Smyth (instructed by Ms McAnallen for the Royal College of Nursing) for Nurse Noble, Nurse Gilchrist, Nurse McAuley, Nurse Roulston, Nurse Brice and Nurse Kirk

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KINNEY J

Introduction

[1] The applicant is the mother of Raychel Ferguson who died on 10 June 2001 from a cerebral oedema caused by hyponatraemia. The proposed respondent is Mr McCrisken who was the coroner appointed to conduct the inquest into Raychel's death (the coroner).

[2] An inquest was held in 2003 relating to the circumstances surrounding Raychel's death. A public enquiry was then set up which reported in January 2018. The applicant applied to the Attorney General for a fresh inquest which was granted in October 2019.

[3] I have taken the essential facts from the coroner's verdict. Raychel was born on 4 February 1992. On 7 June 2001 when she was 12 years old, she complained of

stomach aches. This was in late afternoon. Her condition did not improve and she was taken to the Altnagelvin Hospital where she arrived at approximately 7pm. She was seen in the emergency department at 8pm and after various tests and assessments, it was concluded that Raychel had appendicitis. She was taken to theatre at 11:40pm and the procedure concluded around 12:20am the following morning. The coroner's verdict records in detail the treatment that was administered to Raychel throughout this period and into the morning of 8 June.

[4] Raychel first vomited at approximately 8am on 8 June and after the ward round the surgical SHO directed a gradual reduction in intravenous fluids with a staged encouragement to take fluids orally. The Inquest verdict made it clear that there were significant shortcomings and deficiencies in the recordkeeping in hospital and of significance is that the quantification of vomit was obscure. The volume was simply recorded by a shorthand notation using the + or ++ sign.

[5] Raychel's fluid balance chart for 8 June recorded nine vomits in the 15 hours between 8am and 11pm. The coroner noted that in addition the Inquiry concluded there were at the very least three additional vomits. Over the course of Friday Raychel became increasingly ill. She was lethargic and vomited repeatedly. It was not until 4am on the Saturday morning that the results of a blood test came back demonstrating acute hyponatraemia. She was taken to the Royal Victoria Hospital later that Saturday morning but by then she had no purposeful movement. Further tests administered in the hospital led to the conclusion and pronouncement of death at 12.09 on 10 June 2001.

[6] The coroner made a very comprehensive analysis of the events surrounding Raychel's death including significant findings of fact arising from the evidence he had heard. At paragraph 114 of his verdict the coroner set out the cause of death as follows:

> "Accordingly, the cause of death will be recorded as:
>
> (a) Cerebral Oedema
> due to or as a consequence of
>
> (b) Hyponatraemia
> due to or as a consequence of
>
> (c) Inappropriate infusion of hypotonic fluids, Syndrome of Inappropriate Anti-diuretic Hormone (SIADH) secretion following surgery and post-operative vomiting."

[7] The applicant seeks to challenge the coroner's recording of the cause of death.

[8] Paragraph [5] of the amended order 53 statement contains the following:

"5. The primary grounds on which the said relief is sought are as follows:

(a) irrationality: in declining to record hospital-acquired hyponatraemia as a component cause of death for the purposes of the death certificate, the proposed respondent acted unlawfully and Wednesbury unreasonably.

(b) Procedural impropriety and unfairness: in deciding not to find hospital-acquired hyponatraemia was a component cause of death, the proposed respondent considered Department of Health guidance from the Department of Health entitled "death certification- issuing MCCD using NIECR" (the guidance). In so doing, the proposed respondent breached the applicant's right to a fair hearing in the following ways-

(i) in advance of making a determination on this issue, he did not provide the guidance to the applicant, otherwise notify her of its existence or of his intention to rely on it and

(ii) he did not provide the applicant with any opportunity to make written and/or oral submissions on the issue.

(c) unlawful failure to take into account relevant evidence/making findings of fact unsupported by evidence:-in failing to include severe and profuse vomiting as a factor causative of death for the purposes of the death certificate, the proposed respondent has acted unreasonably in *Wednesbury* terms."

[9] In short the applicant is objecting to the wording used by the coroner in paragraph 114 of his verdict setting out his findings. The coroner is criticised in not describing the hyponatraemia as "hospital-acquired" hyponatraemia and in not describing the vomiting as "severe and profuse." The applicant had added the third ground relating to the improper use of Department of Health guidance without notifying the parties, as part of the amended order 53 statement. This was added after argument on the point had completed.

The law

[10] The test for granting leave for judicial review, set out in *Sharma v Antoine* [2006] UKPC 57, is whether there is an arguable ground for judicial review having a realistic prospect of success and not subject to a discretionary bar such as delay or an alternative remedy. This formulation was affirmed in this jurisdiction in *Re Chuinneagain's Application* [2021] NIQB 79.

[11] In *Craig Thompson's Application* [2022] NIKB 17, the court considered the test for irrationality. It said at paragraph [33]:

> "In *Re McKinney's Application* [2022] NIQB 23, the Divisional Court recently approved the rationality test espoused by Lord Woolf in *R v North and East Devon HA ex parte Coughlan* [2001] QB 213:
>
> > 'Rationality, as it has developed in modern public law, has two faces: one is the barely known decision which simply defies comprehension; the other is a decision which can be seen to have proceeded by flawed logic.'"

[12] The particular circumstances of coroner's inquests have also been considered by the court in recent cases. In *M4 V the Coroner's Service of Northern Ireland* [2022] NICA 6, the court said at paragraph [18]:

> "A coroner is required to answer specific statutory questions by virtue of Rule 15 of the Coroner's Rules. This provision states that the proceedings and evidence at an inquest shall be directed to ascertain the following matters namely: (a) who the deceased was; (b) how, when and where the deceased came by his death; (c) the particulars for the time being required by the Births and Deaths Registration Acts (Northern Ireland) 1863 to 1956 to be registered concerning the death. By virtue of Rule 16 of the Coroner's Rules the coroner is specifically precluded from any determination of criminal or civil liability."

[13] The role of this court in a judicial review challenge to the verdict of a coroner was considered in *Re Jordan* [2017] NIQB 135. The court observed in that case that an inquest is not a civil trial or a criminal trial and that judicial review is not an appeal. A reviewing court does not quash a decision simply because it might have reached a different conclusion nor should it substitute its own reasoning. The issue of weight to be applied to relevant factors is a matter for the decision-maker and is not

interfered with in judicial review. The court also noted that considerable deference must be paid to a fact-finding tribunal. It said at paragraph 17(v):

> "The decision-maker has to be afforded considerable latitude to decide on the facts of the case having seen and heard witnesses unless the verdict can be categorised as unreasonable in the Wednesbury sense or irrational. This is a high threshold."

The coroner's findings

[14] The coroner provided a comprehensive and detailed verdict and I will only record aspects of it in this decision insofar as relevant to the questions the court must answer.

[15] The coroner made it clear that the verdict should be read in conjunction with the Hyponatraemia Inquiry Report. He set out the expert evidence, written and oral, that was considered. He set out the role of the coroner, which was to examine the evidence, consider the facts in detail and to decide what form of verdict should be given.

[16] The coroner then set out the background facts. Included in those facts was the history of vomiting in the morning after the appendectomy. He noted that there was post-operative vomiting just after 8am and that there were at least 12 episodes of vomiting between 8am and 11pm that day. He noted that the Inquiry had found that the record keeping in hospital was poor and there was likely under recording of Raychel's vomiting. The coroner considered material from various experts in determining the cause of Raychel's death. Amongst those were reports from Dr Simon Haynes who is a consultant in cardiothoracic anaesthesia and intensive care. By the agreement of all parties only Dr Haynes gave oral evidence to the inquest.

[17] In his detailed verdict the coroner referred to Dr Haynes's original reports to the Hyponatraemia Inquiry. He referred to Dr Haynes's oral evidence to the Inquest and in particular the aspect of post-operative vomiting. The coroner recorded Dr Haynes' evidence that post-operative vomiting was more common in children and also for certain operations including appendectomies. Any post-operative vomiting usually settled in the first six hours and definitely within 12 hours. Dr Haynes's evidence was that any vomiting by Raychel before 2pm on 8 June 2001 could be attributable to her surgery. However, vomiting after 2pm was likely to be caused by her evolving low sodium concentration. Hyponatraemia then developed and caused the vomiting to persist. Dr Haynes said that he would exclude any post-operative vomiting as part of the cause of death. He felt that protracted vomiting was consequential to low serum sodium.

[18] Having considered all of the evidence the coroner concluded that all of the experts agreed that there was post-operative vomiting. However, the coroner relied on Dr Haynes' evidence to the inquest that post-operative vomiting continued up to lunchtime on 8 June 2001. He was satisfied vomiting thereafter was due to the developing hyponatraemia. He noted that the Inquiry report set out three episodes of post-operative vomiting on the morning of 8 June at approximately 8am, 10am and 1pm. The coroner concluded that this vomiting was not profuse or severe but that it contributed to Raychel's condition. It is of note that at the inquest the applicant argued against the inclusion of vomiting as a potential cause of hyponatraemia.

[19] The coroner also considered the use of the term "hospital-acquired hyponatraemia."

[20] At paragraph 111 of the verdict he said:

> "The NoK asked that I consider using the term "hospital-acquired hyponatraemia" in the cause of death to record that Raychel suffered from hyponatraemia while a patient in hospital – that the condition was iatrogenic. They say that this term is frequently used to differentiate where a person may have contracted an infection like pneumonia. While it is correct to say that medics will often complete a cause of death and use terms like "community-acquired" or "hospital-acquired" in relation to infection, there is a specific rationale for doing so, in terms of infectious diseases. Guidance from the Department of Health and completing a death certificate says:
>
> > 'It is important to identify, if possible, the source of a (Health Care Associated Infections) HCIA as either Community Acquired or Hospital Acquired. This will allow Trusts to identify learning to inform and underpin continuous improvement. Therefore, it is incumbent on clinical staff, when completing a MCCD for patients who require the entry of an infection, for example COVID-19, into either Part I or Part II, that they qualify the entry with where the infection originated – from the Community, the Hospital environment (probable or definite) or as Indeterminate.'
>
> 112. It would not be usual to include the source in other circumstances. For example, if a person died as a result of a fall, the death certificate would not contain details of the

> location of the fall, care home, at home, hospital et cetera. I see no reason that I should include this information in Raychel's cause of death."

Hospital-acquired hyponatraemia

[21] The applicant argues that the coroner was *Wednesbury* unreasonable in declining to record the hyponatraemia suffered by Raychel as "hospital-acquired" for the purposes of the death certificate. The applicant argues that the use of the descriptors is not simply to inform a reader of the location of an event, it is also communicating the fact that the disease was acquired in a hospital. The applicant argues further to say that the use of the descriptor evidences that the condition was caused by hospital treatment. The applicant argues that it is of great importance that a disease caused by deliberate acts of healthcare professionals should be described as "hospital-acquired." It would not be immediately clear on reading the death certificate to appreciate that Raychel's hyponatraemia was iatrogenic. The death certificate is of prime importance. Failing to use the descriptors inhibits further learning and continuous improvement and finally anyone researching death records for whatever reason is hindered by the lack of specificity. The applicant noted that the phrase "hospital-acquired hyponatraemia" has been used in historic documents relating to this case including expert reports and the Hyponatraemia Inquiry Report itself.

[22] At the inquest the coroner provided a provisional view of the cause of death after having listened to the submissions of the parties. He said:

> "So I'll give you all my provisional cause of death having listened to the submissions, and it's: 1a brainstem death; 1b cerebral oedema; 1c hospital-acquired hyponatraemia following inappropriate infusion of IV fluids. And this is provisional because I want to go away over the summer, of course, and read the evidence again."

[23] The submissions referred to included a debate which centred on whether or not the words "hospital-acquired" infringed Rule 16 of the Coroner's Rules (which precludes any determination of civil or criminal liability by the inquest). The parties had different views and provided oral and written submissions. It would appear that the submissions did not consider the issues outside of the narrow focus on Rule 16.

[24] The applicant also asserted that the coroner inappropriately used Department of Health guidance in making his findings regarding the terminology without providing that guidance to any of the parties or notifying the parties of his intention to rely on it. The applicant was deprived of the opportunity of making any submissions on the issue.

[25] It is accepted by all the parties that the coroner's findings make it abundantly clear that Raychel's hyponatraemia was acquired when she was in hospital. That has never been in dispute. What the applicant seeks to do is to show that it was irrational for the coroner not to append the words "hospital-acquired" in the recorded cause of death. There was some debate before the coroner around the consideration given to the Rule 16 implications of using this wording. The coroner ultimately resolved not to include the words hospital-acquired. He, however, went on to say that the hyponatraemia was caused by the "inappropriate infusion of hypotonic fluids, syndrome of inappropriate antidiuretic hormone (SIADH) secretion following surgery and post-operative vomiting" in his recording of the cause of death. Any doubt in the mind of the reader as to how and where the hyponatraemia was acquired is set to rest by that paragraph. The words the applicant seeks to add are simply descriptors. A further argument was made that the use of such descriptors is essential for statistical purposes in the future. That was not an argument made before the coroner and in my view carries little weight. In any event the coroner had absolutely no evidence of how such a term would be used for statistical purposes in the future.

[26] A core aspect of the applicant's argument is that extending the wording to include hospital-acquired demonstrated that it was caused by hospital treatment. These two statements are not synonymous and if that is the argued meaning then it also potentially runs foul of Rule 16. The detailed findings of the coroner are contained within a comprehensive and detailed verdict which is there for all to read. There is no basis to say that it was irrational not to include such qualifying words in the cause of death. It was open to the coroner to use the descriptors requested. He decided not to do so. That was neither illogical or irrational on the basis of the evidence he received and the facts that he had found. I consider this point has no arguable prospect of success.

[27] The applicant also argues that the use of the Department of Health guidance by the coroner was his sole reason for not using the descriptors. The issue of the use of the descriptors had been a matter of submissions before the coroner. The applicant did not identify the prejudice that allegedly arose in not being able to provide submissions on the use of the guidance. It is common ground that the coroner did not refer any of the parties to the Department of Health guidance before including a reference to it in his verdict. The coroner clearly articulated his reasons for his decision not to include the descriptors at the time of the decision.

[28] In his verdict he considered the argument made by the applicant that the term is frequently used to differentiate where a person may have contracted a particular infection. The coroner reflected that whilst doctors may complete a cause of death using terms like community-acquired or hospital-acquired this was in relation to infectious diseases and that there was a specific rationale for doing so. He then set out a quote from the guidance from the Department of Health to amplify that point. He commented that it would not be usual to include the source of a condition in

other circumstances. He concluded that there was no reason that he should include this additional information on Raychel's cause of death.

[29] I do not accept that it is reasonable to read the coroner's verdict in a way that renders the Department of Health guidance as the sole factor in reaching this decision. I am satisfied that the coroner's decision is neither unlawful nor *Wednesbury* unreasonable and that this point has no arguable prospect of success. I, therefore, refuse leave on this point.

Vomiting

[30] The applicant argued that various experts had considered the extent of Raychel's post-operative vomiting. Other experts had used such descriptors as severe, protracted, or prolonged in relation to vomiting. There was evidence of coffee ground vomiting indicative of gastric bleeding and also the presence of petechia on Raychel's neck being a consequence of straining. The applicant argues that although the coroner set out his conclusions on the various clinical issues, including his agreement with Dr Haynes' evidence that vomiting after 2pm was not attributable to the surgery itself and his conclusion that vomiting after this time was due to developing hyponatraemia, he should nevertheless have described the vomiting as profuse or severe. The adjectives "profuse" and "severe" referred to the entire period after the operation and it was essential that the coroner addressed the global picture on vomiting. The applicant asserts that it was incumbent upon the coroner to explain why he preferred one strand of evidence given by one of many experts rather than considering the evidential picture on vomiting as a whole. The applicant then argued that Dr Haynes' written reports to the hyponatraemia enquiry were not entirely consistent with his oral evidence. Those reports had been adopted in evidence at the inquest. The applicant points to the terminology used by other experts who considered that severe post-operative vomiting was a component cause of hyponatraemia.

[31] In submissions it was clear that all of the experts agreed that there was post-operative vomiting and also that at some point the continuing vomiting was due to the developing hyponatraemia. Counsel for the applicant at this hearing accepted this point and also accepted if there were only the three episodes of vomiting attributable to the post-operative period as set out in the coroner's verdict then it would not be severe and profuse. Of course, a significant difficulty for the applicant is that at the inquest her lawyers argued that the vomiting should not be included at all as a cause of death. The coroner was thus not privy to the arguments now being made by the applicant on the issue of vomiting and in fact was addressed on behalf of the applicant in an entirely different vein.

[32] Dr Haynes was the expert agreed by all of the parties as the only expert required to give oral evidence. It was neither illogical nor irrational for the coroner to accept the very clear evidence Dr Haynes provided to the inquest. It was neither

illogical nor irrational for the coroner to conclude that vomiting after 2pm on 8 June 2001 was a consequence of, rather than a cause of, the hyponatraemia.

[33] There was a common framing by the applicant during the course of the hearing as to what rational reason there was for the coroner not including the descriptors sought. That, of course, is not the test this court must apply. The question is whether there was a compelling reason for including them and whether its omission was irrational or illogical. The coroner did not discount or disregard the severity of Raychel's vomiting after 2pm on 8 June but clearly concluded that it was not relevant to his statutory task and was not a causative factor of the hyponatraemia. In fact, the coroner went further than the applicant had argued at the inquest. This ground of challenge is clearly unarguable and has no prospect of success.

[34] The applicant in final submissions also argued that there was a breach of the duty of candour by the respondent in that he did not disclose all material facts known to him.

[35] The applicant contends that in the original skeleton argument of the respondent there was an excerpt of the transcript of Dr Haynes' evidence given on 2 May 2023. In fact Dr Haynes gave evidence on three different days. Some of the relevant evidence was given on 2 May but the transcript was not placed in evidence before the court by the respondent. The witness' evidence on 9 May was also not before the court. Only the transcript of his evidence on 3 May 2023 was in evidence. The applicant argued that the respondent was uniquely in possession of all three transcripts. The applicant further argued that the excerpt from the evidence on 2 May was utilised to support a submission that Dr Haynes' evidence established that any vomiting caused by the operation would only have persisted for 12 hours. Consideration of the other transcripts and his reports prepared for the hyponatraemia enquiry show that this was not the complete picture and that he had on other occasions referenced both 24 and 48 hour periods.

[36] I consider that this is a makeweight ground which is not included in the Order 53 statement even as belatedly amended. The inquest proceedings were transcribed. All parties were equally able to access copies of the transcripts and indeed the applicant in moving the application for leave appended to their affidavit only the partial evidence that Dr Haynes provided on 3 May 2023. Whilst the applicant may not have had transcripts of the other two days of evidence she and her advisers were perfectly aware of those other days of evidence and did not draw those to the attention of the court. The two reports by Dr Haynes, referred to in support of the argument of a breach of duty of candour, were referenced during the course of the inquest and were available to assist the applicant's legal team should they have wished to cross-examine Dr Haynes on any aspect. However, at the time of the inquest Dr Haynes excluded vomiting as a cause of death which was also the position taken at that time by the applicant.

[37] It is self-evident that no material was withheld from the applicant, that all of Dr Haynes' evidence was known to the applicant and her lawyers through their participation in the inquest proceedings and that this ground of challenge, albeit not brought appropriately before the court, has no arguable prospect of success.

[38] I, therefore, refuse leave on all grounds.