Neutral Citation Number: [2024] EWHC 2673 (Admin)

(1) Case No: AC-2024-LON-002695
(2) Case No: AC-2024-LON-002697

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 22 October 2024

Before:

LORD JUSTICE HOLROYDE
MRS JUSTICE McGOWAN

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Between:

HM SENIOR CORONER FOR CORNWALL AND THE SCILLY ISLES	**Claimant**
- and -	
(1) ELAINE ROWE **(2) HELEN PRICE** **ROYAL CORNWALL HOSPITALS NHS TRUST**	**Interested Parties**

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Rachel Spearing (instructed by **HM Senior Coroner for Cornwall and the Scilly Isles**) for the **Claimant**

Hearing date: 22 October 2024

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Approved Judgment

Lord Justice Holroyde and Mrs Justice McGowan:

1. His Majesty's Senior Coroner for Cornwall and the Scilly Isles applies for orders quashing an inquest held on 29 June 2017 into the death of Edward John Masters and directing a fresh investigation into his death. A similar application is made in respect of an inquest held on 12 December 2013 into the death of Mary Helen Rooker. Each of the deceased died whilst a patient of the vascular surgery unit at the Royal Cornwall Hospital ("the hospital"). The applications raise issues in common, and it is convenient to hear both together and to address the issues in this single judgment of the court.

2. The applications are made pursuant to section 13 of the Coroners Act 1988 which, so far as is material for present purposes, provides –

> "**13. Order to hold investigation.**
>
> (1) This section applies where, on an application by or under the authority of the Attorney-General, the High Court is satisfied as respects a coroner ("the coroner concerned") …
>
> (b) where an inquest or an investigation has been held by him, that (whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise) it is necessary or desirable in the interests of justice that … another investigation should be held.
>
> (2) The High Court may—
>
> (a) order an investigation under Part 1 of the Coroners and Justice Act 2009 to be held into the death either—
>
> (i) by the coroner concerned; or
>
> (ii) by a senior coroner, area coroner or assistant coroner in the same coroner area;
>
> (b) order the coroner concerned to pay such costs of and incidental to the application as to the court may appear just; and
>
> (c) where an inquest has been held, quash any inquisition on, or determination or finding made at that inquest."

3. Each of the applications is made pursuant to section 13(1)(b) on the ground that new facts and evidence make it necessary and desirable for a fresh investigation into the death to be held.

4. The hospital is managed by the Royal Cornwall Hospitals NHS Trust ("the Trust"), one of the Interested Parties. In January 2019 the Trust requested the Royal College of Surgeons to carry out an Invited Service Review of aspects of the work of the vascular surgery unit at the hospital, including the work of one particular consultant vascular surgeon ("the surgeon"). Those conducting the Review identified, amongst

other concerns, serious patient safety issues in relation to patients of the surgeon, and a need for improvement in multi-disciplinary processes at the hospital. The findings of that Review, and fresh expert evidence which has become available as a result of it, have led to the present applications.

5. Mr Masters was aged 80 at the time of his death on 17 January 2017. On that day, he underwent elective surgery by the surgeon to repair an abdominal aortic aneurysm. After an initial recovery from that surgery, his condition suddenly deteriorated. He suffered internal bleeding, which could not be stopped. The bleeding led to a cardiac arrest, and sadly Mr Masters died later that evening. We offer our condolences to his daughter Elaine Rowe, who is an Interested Party in these proceedings.

6. Mr Masters' death was referred to HM Coroner due to the recent operation. Post-mortem examination of Mr Masters' body did not identify any clear cause of the internal bleeding.

7. The inquest was conducted by the claimant, then sitting as an Assistant Coroner. He concluded that Mr Masters had died from a known complication of the elective surgical procedure. The record of the inquest states the medical cause of death to have been

> "1a Intra-abdominal haemorrhage;
>
> b Aortic aneurysm (operated on January 2017)".

8. The fresh evidence which is now available, but which was not available at the time of the original inquest, reveals shortcomings in the consent process which was carried out before the operation and in the care and treatment of Mr Masters during his operation. It raises the possibility that the death was contributed to by acts and/or omissions of the surgeon.

9. With the fiat of the Law Officers, a Part 8 claim form was issued on 8 August 2024. There is no defendant to the claim, as the claimant seeks the quashing of his previous determination.

10. Ms Spearing, for whose submissions on behalf of the claimant we are grateful, submits that this fresh evidence calls into question the medical cause of death recorded at the initial inquest, and undermines the factual findings and conclusion recorded. She further submits that there should be a public examination of the systems in operation at the hospital which may have contributed to the death.

11. Mrs Rooker was aged 71 at the time of her death. She too underwent elective surgery for the repair by the surgeon of an abdominal aortic aneurysm. There had been a multi-disciplinary meeting to discuss her suitability for the procedure, because of a number of risk factors and a particular concern in relation to her low platelet count. In the event, her platelet count was low when the surgeon operated on 8 May 2012. Post-operatively, Mrs Rooker suffered internal bleeding. The surgeon carried out a laparotomy but could not identify any obvious bleeding point. Mrs Rooker's condition declined over the following days. She underwent a further procedure when a scan on 18 May 2012 revealed a perforation of the bowel. Sadly, she died on 20

May 2012. We offer our condolences to her daughter Helen Price, who is an Interested Party in these proceedings.

12. Mrs Rooker's death was referred to the coroner. Post-mortem examination of Mrs Rooker's body showed the presence of faecal peritonitis, secondary to sigmoid colon perforation.

13. The original inquest was conducted by an Assistant Coroner. He recorded that the surgery had resulted in peritonitis, and concluded that death from peritonitis is a recognised complication of that form of surgery. The record of the inquest stated the medical cause of death as

> "1a Peritonitis
>
> b Large bowel perforation
>
> c Abdominal aortic aneurysm with repair"

14. The fresh evidence which is now available, but which was not available at the time of the original inquest, includes an expert report by Professor Bradbury, a professor of vascular surgery and a consultant vascular and endovascular surgeon. This expert evidence points to negligence on the part of the surgeon in proceeding with the operation despite Mrs Rooker's low platelet count, to a lack of informed consent by Mrs Rooker having regard to the risks involved in the procedure, and to an unacceptable standard of aspects of Mrs Rooker's treatment by the surgeon. The evidence also raises the possibility that her death was contributed to by acts and/or omissions on the part of the surgeon and by a collective failure of care and systems at the hospital.

15. With the fiat of the Law Officers, a Part 8 claim form was issued on 8 August 2024. As in Mr Masters' case, there is no defendant to the claim.

16. Ms Spearing submits that there is now cogent evidence of shortcomings in the care and treatment of Mrs Rooker which may have contributed to her death. She submits that there is evidence of shortcomings in the consent process which was carried out, in the assessment of the risks and benefits of surgery in Mrs Rooker's circumstances, and to the standard of medical care during the surgery. She further submits that a fresh investigation is necessary in relation to Mrs Rooker's death, for reasons similar to those which she has put forward in Mr Masters' case.

17. All of the Interested Parties are aware of, and support, these applications.

18. Ms Spearing has helpfully reminded us of the principled approach to applications such as these which was explained by Lord Judge CJ in *HM Attorney General v HM Coroner of South Yorkshire (West)* [2012] EWHC 3783 (Admin) at paragraph 10:

> "We shall focus on the statutory language, as interpreted in the authorities, to identify the principle appropriate to this application. The single question is whether the interests of justice make a further inquest either necessary or desirable. The interests of justice, as they arise in the

> coronial process, are undefined, but, dealing with it broadly, it seems to us elementary that the emergence of fresh evidence which may reasonably lead to the conclusion that the substantial truth about how an individual met his death was not revealed at the first inquest, will normally make it both desirable and necessary in the interests of justice for a fresh inquest to be ordered. … [I]t is not a pre-condition to an order for a further inquest that this court should anticipate that a different verdict to the one already reached will be returned. If a different verdict is likely, then the interests of justice will make it necessary for a fresh inquest to be ordered, but even when significant fresh evidence may serve to confirm the correctness of the earlier verdict, it may sometimes nevertheless be desirable for the full extent of the evidence which tends to confirm the correctness of the verdict to be publicly revealed."

19. We respectfully agree, and adopt that approach.

20. We have not found it necessary or appropriate, in this short judgment, to rehearse in detail the evidence which is now available. In each case, it is clear that the Assistant Coroner who conducted the original inquest did so, through no fault of his own, on the basis of an incomplete picture of the circumstances surrounding the death. In each case, cogent evidence has subsequently become available which points to the death having been contributed to by unacceptable standards of treatment and care by the surgeon and by deficiencies in the processes then in operation at the hospital. We accept Ms Spearing's submissions in each case that both the interests of the bereaved, and the public interest, require a fresh investigation. As we have said, it is not necessary for the claimant to show that it is probable that fresh investigations would lead to different findings; but on the evidence now before this court, it seems likely that the findings recorded at a fresh investigation would in each case differ from those made at the original inquest.

21. In each case, therefore, we are satisfied that by reason of the discovery of new facts and evidence, it is both necessary and desirable in the interests of justice that another investigation should be held. In each case, we accordingly allow the claim. We quash the determination and findings of the original inquest, and we direct that a fresh investigation and inquest be held. That fresh inquest may in each case be held before the claimant. We make no order as to costs. In each case we direct that an order be drawn and sealed in the terms helpfully drafted by Ms Spearing.