IN THE SUPREME COURT OF BERMUDA

Civil Jurisdiction

2009: No. 156

BETWEEN:

MARION BISHOP, KATHLEEN PALMER and HEATHER CARBERRY

Applicants

-and-

H. M. CORONER

Respondent

-and-

BERMUDA HOSPITALS BOARD

First Interested Party

-and-

DR. MONICA HOEFERT

Second Interested Party

JUDGMENT

Date of Hearing: 2 September 2009

Date of Judgment: 11 September 2009

Mr. Jeffrey Elkinson, Conyers Dill & Pearman, for the Applicants

Mr. Huw Shepheard and Ms. Shakira Dill, the Attorney-General's Chambers, for the Respondent

Mr. Delroy Duncan and Mr. Allan Doughty, Trott & Duncan, for the Bermuda Hospitals Board

Mr. David Kessaram, Cox Hallett Wilkinson, for Dr. Hoefert

Introduction

1. These judicial review proceedings concern an inquest held in the Magistrates' Court between 15 and 26 January 2009 into the death of Norman John Palmer ("the Deceased"), who died on 12 April 2008. The coroner, the Worshipful Khamisi Tokunbo ("the Coroner"), sitting without a jury, delivered his report and conclusion on 26 February 2009. The critical part of the Coroner's conclusion was that the Deceased's death was due to natural causes, which causes were set out in the conclusion, with the added rider that the Deceased's death was contributed to by self-neglect. It is that rider which has led to the issue of these proceedings, which seek to quash that part of the Coroner's conclusion.

Procedural History

2. The proceedings were issued by way of notice of originating motion on 21 May 2009, following the grant of leave the previous day. The applicants served both the Attorney-General for the Coroner and the Bermuda Hospitals Board ("the Board"). At a directions hearing held on 18 June 2009, the Board was added to the proceedings as an interested party, and leave was given to the parties to file affidavit evidence; in the event none of the parties chose to do so.

3. Very late in the day, on the afternoon before the start of the scheduled hearing, Mr. Kessaram for Dr. Hoefert made application by way of notice of motion for leave to be heard on behalf of Dr. Hoefert. In support of that application there was filed an affidavit sworn by Dr. Hoefert on 1 September 2009, which affidavit addressed various matters which had not been covered in the Coroner's detailed

report. Mr. Kessaram also filed written submissions which did not rely upon those matters which were not in the Coroner's report, and he indicated that the affidavit had been sworn in support of the application to be heard, and that he would place no reliance upon the contents of the affidavit thereafter. I made an order in terms of the application, allowing Mr. Kessaram to address the Court on behalf of his client, but not on the basis of any reliance upon Dr. Hoefert's affidavit.

4. One other matter to which I should refer is that the record of the proceedings before the Coroner was his report, and a short and formal affidavit from one of the Deceased's sisters. There was no transcript of the relatively lengthy proceedings before the Coroner.

Factual Background

5. The Coroner set out the relevant facts in his report, first in relation to the events commencing on 6 April 2008, and then dealing specifically with the events of 12 April 2008. On the basis of this recitation of the evidence, the Coroner then made his findings of fact between paragraph 42 and 67 of his report. I now set out those paragraphs, as follows:-

> "42. That the Deceased was Norman John Palmer of #6 Leafy Way Lane, Paget Parish, Bermuda. He was born in England on 1st February, 1951 but resided in Bermuda where he held permanent residence.
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> 43. That the Deceased was the owner/operator of an excavating business in Bermuda at the time of his death.
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> 44. That he died at the King Edward VII Memorial Hospital in the Emergency Department on 12th April, 2008. Death was declared at 17:25 hours.

45. That he had asthma and an upper airway obstruction and had been feeling unwell since the end of February 2008, and this continued until the date of his death on 12th April 2008.

46. That he was under the medical care of his general practitioner, Dr. Monica Hoefert, who treated him specifically for asthma between March and April 2008 and for flu.

47. That on April 6, 2008 his condition deteriorated and he went into respiratory distress while at home. He was rasping from the throat. At this time telephone advice from his general practitioner was sought. He was told that he was having an asthma attack and that he should attend the hospital Emergency Department.

48. That he had a history of a gun shot wound to the neck from over 40 years ago and was aware of same. That he was also aware of some movement in his throat prior to April 6, 2008 and had earlier expressed this to Marion Bishop, his sister, when she saw him at his warehouse.

49. That the Deceased attended the hospital Emergency Department with family members on April 6, 2008 and was attended to by Dr. Ashfaq Syed. He was diagnosed as not having asthma at time of presentation but rather inspiratory stridor. An x-ray revealed metallic foreign bodies in his neck causing airway obstruction. He was treated with 20 mg of dexamethasone injections and twice with racemic epinephrine nebulizers. His condition improved and the stridor almost disappeared.

50. That Dr. Syed suggested that the Deceased see the on duty ENT for further investigation, airway management and admission. But the Deceased refused when he was told that the ENT was Dr. Wesley Miller.

51. That Dr. Syed emphasized the importance of the Deceased's condition and the necessity of seeing an ENT the next day at the least. This included stressing that the condition was potentially life threatening/dangerous. He also told the Deceased to return to the Emergency Department if his condition deteriorated. That this was all explained to the Deceased on the basis that he insisted that he knew Dr. Vallis and would arrange to see him the next day, a Monday. That the Deceased fully understood Dr. Syed's instructions.

52. That the Deceased turned to and relied on his general practitioner thereafter to refer him to Dr. Vallis, and this appointment was scheduled for April 18, 2008; and he was not seen by his doctor until April 9th. That when he was seen by Dr. Hoefert he was prescribed an inhaler for asthma and scheduled to have some form of scan of his throat on April 14, 2008. That after seeing his doctor he was now under the impression (or confused) that she was in disagreement with the diagnosis made by Dr. Syed on April 6, 2008.

53. That he continued to feel unwell but never returned to the Emergency Department of the hospital between April 6, 2008 and April 12, 2008.

54. That following his treatment of the Deceased in the Emergency Department on April 6, 2008, Dr. Syed completed his notes outlining the treatment and history of the Deceased in the Hospital Emergency Record. As a matter of procedure the blue carbon copy of the completed record would have been left for Dr. Hoefert to collect the next day (or posted to her if not collected). This record, and the details thereon, particularly the mention of upper airway obstruction, would have been sufficient to alert the urgency of getting the opinion of an ENT.

55. That on April 12, 2008 the Deceased continued feeling unwell and when his condition deteriorated, he went into respiratory distress while at home.

In an attempt to obtain some relief the Deceased took a shower, at some point was breathing into a brown paper bag. He was in distress for at least one hour before emergency assistance was sought through a 911 call. By this time he was cyanose, wheezing or having stridor or both.

56. That the 911 call was made at 16:45:33 hours and EMTs and ambulance left the hospital at 16:49:39 hours and arrived at the Deceased's residence at 16:51:49 hours. That the ambulance left with the Deceased and arrived at the hospital's Emergency Department at 17:07:32 hours.

57. That while at the Deceased's residence the EMTs did all that was reasonably expected of them in the circumstances by way of treatment and transport of the Deceased.

58. That on arrival in the hospital's Emergency Room the Deceased was immediately attended to by the on duty physician who was soon assisted by two other on duty physicians. That all three physicians were highly experienced and specially trained to deal with the condition which the Deceased presented.

59. That the Deceased on arrival in the Emergency Room presented in severe respiratory distress with inspiratory stridor due to an airway obstruction, had no air entry to lungs, was sweating, cyanosed and cardio-respiratory arrest was imminent and did in fact occur. That CPR was commenced.

60. That every effort was made to appropriately medicate the Deceased and to take care of his airway with oxygen using a bag mask valve device. That efforts were made to pass an endotracheal tube into his upper airway. This was unsuccessful. That the vocal cords could not be seen, the upper airway was swollen, oedematous and completely blocked. That an emergency cricothyroidotomy was performed with difficulty, but an incision was made on the midline between the cricoid cartilage and the

thyroid cartilage. It was extended down to the trachea, cutting through the tracheal rings.

61. That it was a difficult procedure due to the gross scar tissue and distorted or abnormal anatomy. That throughout the procedure the Deceased was in asystole and did not respond to full CPR measures that were being performed. He was also deeply cyanosed.

62. That neither the individual nor combined efforts of three experienced Emergency Room physicians were successful at intubating the Deceased. That CPR measures continued for 15 minutes, after which the Deceased was declared dead at 17:25 hours.

63. That the emergency care and treatment that the Deceased received in the Emergency Room on April 12, 2008 was the appropriate care and treatment according to currently accepted medical practice and standards. This included the emergency performance of a cricothyroidotomy and CPR while the Deceased was in asystole.

64. That an autopsy was conducted on the Deceased by the Chief of Pathology of the Bermuda Hospitals Board. The conclusion was that the cause of death was due to natural causes, namely:

A	I	Respiratory Failure
	II	Asthma related mucous, plugging of bronchi
	III	Extreme laryngeal fibrosis
B	I	Laryngeal carcinoma in situ with extreme ulceration
	II	Pulmonary infarct

That these findings of the Chief of Pathology are hereby accepted as the cause of death in this instance.

65. That on or by April 12, 2008 the Deceased's condition had deteriorated to a stage which rendered emergency medical treatment to save his life

hopeless, given the history of gun shot wound to his neck and the distorted anatomy/extensive fibrosis of the larynx. On that day, time was of no consequence to the outcome.

66. That the decisions of the Deceased not to be admitted to hospital on April 6, 2008 nor to return to the Emergency Department for care sometime between April 6 and April 12, 2008, bore a significant and unfortunate nexus to the outcome and events of April 12, 2008. It was "**a gross failure to obtain basic medical attention."**

67. That (a) the Hospital's Emergency Record that contained the diagnosis of the Deceased on April 6, 2008, in particular the carbon copy blue sheet, and; (b) the communications between the Deceased and his family with Dr. Monica Hoefert and/or her office between April 7th and 9th 2008, ought to have been sufficient to convey the urgency of the Deceased's condition to Dr. Hoefert and his need for attention. That Dr. Hoefert, at least implicitly, accepted that there was a need for further investigation of the Deceased's upper airway because she (or her office) arranged the Deceased's appointments for April 14 and April 18, 2008."

Submissions of Counsel to the Coroner

6. The Coroner then turned to the submissions made to him by counsel appearing before him, being Mr. Elkinson for the family of the Deceased and Mr. Doughty for the Board. The family were pressing for a rider that the Deceased's death had been contributed to by neglect on the part of Dr. Hoefert, who had not taken any part in the inquest, while counsel for the Board had submitted that the evidence supported a rider of self-neglect, to the effect that the Deceased's own conduct had contributed to his death. Counsel drew the relevant authorities to the attention of the Coroner, who referred in his report only to the judgment of Sir Thomas Bingham, MR in the case of *R –v- HM Coroner for North Humberside Council Ex parte Jamieson* [1995] 1 QB 1 at 25.

7. The Coroner then asked himself whether there was medical neglect of the deceased by Dr. Hoefert in the context defined by the Master of the Rolls in *Jamieson,* and concluded that there was not. In so doing, the Coroner found that for neglect to arise, there needed to be a dependency between the Deceased and Dr. Hoefert, and although he accepted that the Deceased was a person who trusted Dr. Hoefert and relied upon her medical judgment, the Coroner took the view that the Deceased was not a person who could not provide for himself, and hence there was not the necessary dependency to found neglect on the part of Dr. Hoefert. I should pause at this point to refer to the distinction raised before me by counsel, between the Coroner's finding that the Deceased relied upon Dr. Hoefert and a position of dependency on his part. There is no issue before me in relation to any alleged neglect as against Dr. Hoefert, and I do not regard the issue as a productive one for me to explore.

8. The Coroner then addressed the issue of self-neglect. He referred to the fact that in paragraph 66 of his report, which is set out above, he had found that there was a nexus between the Deceased's decisions on 6 April and thereafter, and the events of 12 April. This led the Coroner to conclude that the evidence supported a finding that there was self-neglect, by way of a rider to his primary finding that death was due to natural causes, and that finding appeared in the Coroner's conclusion.

Submissions of Counsel to this Court

9. It was accepted on all sides that for the applicants to succeed, it is necessary for them to establish that the Coroner had reached a conclusion which no reasonable coroner could have reached, the test being what is now frequently referred to as "*Wednesbury* unreasonableness" after the case of *Associated Provincial Picture Houses Ltd –v- Wednesbury Corporation* [1948] 1 KB 223. It is no doubt appropriate for this Court to remind itself how onerous the burden upon an applicant is, and in his submissions, Mr. Elkinson helpfully set out part of the judgment of Lord Greene MR in *Wednesbury*, in the following terms:

> "It might be useful to summarise once again the principle, which seems to me to be that the court is entitled to investigate the action of the local authority with a view to seeing whether it has taken into account matters which it ought not to take into account, or, conversely, has refused to take into account or neglected to take into account matters which it ought to take into account. Once that question is answered in favour of the local authority, it may still be possible to say that the local authority, nevertheless, have come to a conclusion so unreasonable that no reasonable authority could ever have come to it. In such a case, again, I think the court can interfere. The power of the court to interfere in each case is not that of an appellate authority to override a decision of the local authority, but is that of a judicial authority which is concerned, and concerned only, to see whether the local authority have contravened the law by acting in excess of the powers which Parliament has confided in it."

There is no question in this case of the Coroner taking into account matters which he ought not to have taken into account or refusing to take into account matters which he ought to have taken into account. In consequence, to interfere with his decision would require me to hold that no reasonable coroner could ever have reached the conclusion which he reached, namely that the Deceased had contributed to the cause of his death by self-neglect. Given the facts of this case, that seems to me to be a very high burden indeed.

10. The basis upon which Mr. Elkinson contended that the Coroner had been unreasonable was that he had accepted that the Deceased had trusted Dr. Hoefert and relied upon her medical judgment. After that, urged Mr. Elkinson, it could never reasonably be said that the Deceased had been guilty of self-neglect when he had been following Dr. Hoefert's advice. In regard to this advice, there was of course only the second-hand version of what the Deceased had reported following his meeting with her on 9 April 2008, but it seems reasonable to infer that Dr. Hoefert had not directed the Deceased to return to the Emergency Department of

the hospital, because she had given him an inhaler, had made an appointment for a scan on 14 April 2008, and had made an appointment for him to see Dr. Vallis on 18 April 2008. Further, the Coroner found as a fact that the Deceased did not return to the Emergency Department (paragraph 53 of his report).

11. From the outset I was concerned (and expressed the concern) that the Coroner had over-simplified the timeline of the events between 6 April and 12 April 2008, so as to treat the periods both before and after the Deceased's visit to Dr. Hoefert in the same way. The starting point is to remember the advice given to the Deceased by the Emergency Room physician, Dr. Syed, on 6 April. As the Coroner found, Dr. Syed had initially suggested that the Deceased see the on duty ENT physician for further investigation, airway management and admission. This the Deceased declined to do, which led Dr. Syed to emphasise the potentially life-threatening and dangerous nature of the Deceased's condition, and the need to see an ENT physician the next day "at the least," which I understand to mean no later than the next day. Mr. Elkinson's contention that the Deceased was entitled to rely upon whatever advice he had been given by Dr. Hoefert could have no application for the period prior to his receipt of such advice, which must have been the time of the visit which took place on 9 April 2008. There was also an issue between the parties as to whether the Deceased should have called for emergency assistance as soon as he went into respiratory distress while at home on the 12 April. Mr. Shepheard and Mr. Duncan referred me to that part of the evidence indicating that the Deceased had become cyanosed while his wife was on the telephone to the emergency dispatcher, and to the evidence of Dr. Schultz, the Director of Emergency Services at the hospital, who said that it was already too late to save the Deceased once he had become cyanotic at his home. Mr. Elkinson relied upon the Coroner's finding set out in paragraph 65 of his report, that on or by 12 April, the Deceased's condition had deteriorated to a stage which rendered emergency medical treatment to save his life hopeless. Mr. Elkinson took the Coroner's statement that "on that day, time was of no consequence to the outcome" to mean at any time on that day, not the time approximately one hour after the Deceased had gone into respiratory distress, at the end of which hour he had started to

become cyanosed. If Mr. Elkinson is right in that submission, I am by no means satisfied that such a conclusion could properly be drawn from the evidence.

12. Ms. Dill referred me to the case of *R –v- H.M. Coroner for Coventry ex parte Chief Constable of Staffordshire Police* [2000] 164 JP 665, a case in which Tomlinson J had referred to the fact that the words "clear and direct causal connection" used by the Master of the Rolls in *Jamieson* were not to be understood in the same sense in which such words might be used when considering a claim for breach of contract or tort. Having made that point, Tomlinson J went on to say:

> "I make the point, however, to emphasize that the causal connection which is relevant in the context of consideration by an inquest jury of the addition of a neglect rider is, in my judgment, not the same as the causal connection for which one may look in the context of other, perhaps more familiar, enquiries. The touchstone in the present context is, I believe, the opportunity of rendering care, in the narrow sense of that word, which would have prevented the death. (See again per Croom-Johnson LJ in the Hicks case at p 1633.) That does not mean that a conscientious person would necessarily have done that which would have successfully prevented death. The question is whether he had the opportunity of doing something effective."

13. The *Coventry Coroner* case concerned an alcoholic who had been arrested and detained at a police station. The Police were informed by the deceased's family that he would "probably have the shakes". The following morning he spilled two cups of tea by reason of his shaking hands, and shortly thereafter was found on the floor having convulsions. He suffered further convulsions on arrival at the hospital, and died 24 hours later. The jury returned a verdict of accidental death aggravated by neglect. The Staffordshire Chief Constable applied for judicial review, contending that there was no clear and direct causal connection between the alleged neglect and the accidental death. Tomlinson J, emphasising that the

case turned on its particular facts, held that there was sufficient evidence from which a properly directed jury could conclude that, from the moment of the tea spilling on 5 August, there existed circumstances in which it was at least possible to say that the deceased would not have died had certain steps been taken. He consequently held that the jury was entitled to conclude that from that moment, events were in train which could be regarded as leading to death, such that they could be regarded as establishing a "clear and direct causal connection" between the conduct of the police and the death.

14. I commented to Mr. Elkinson during the course of the argument that it did seem to me that the effect of Tomlinson J's judgment was to reduce the burden required to reach the conclusion that self-neglect had contributed to the cause of death. Mr. Elkinson had attached substantial weight to the use of the words "gross failure", used by the Master of the Rolls in *Jamieson*. The reference by Tomlinson J to "the opportunity of doing something effective" does seem to connote a significantly less rigorous approach than the words used by the Master of the Rolls in *Jamieson*.

15. Tomlinson J also referred in his judgment to the judgment of Phillips LJ in the case of *R –v- H.M. Coroner for Wiltshire Ex parte Clegg* [1997] 161 JP 521 at 529. That was a case concerning the inquest on a suicide, where there had been a period of some 12 hours during which the care provided to the deceased was described by Phillips LJ as suffering from a continuous sequence of shortcomings. Phillips LJ went on to say:

> "those findings suggest that it is at least possible that, but for those shortcomings, her life would have been saved. In these circumstances my conclusion is that, applying the approach in Jamieson, it is possible that if a new inquest were to be held the verdict would be that Lucy killed herself but that neglect contributed to her death".

16. Finally, Ms. Dill also drew my attention to a passage in the judgment of Dyson J in *R –v- Coroner for Exeter Ex parte Palmer* [1997] EWHC Admin 1031. That case concerned an application for the grant of leave to issue judicial review proceedings during the course of an inquest which had then been running for some 21 days, and in which the coroner was on the point of summing up to the jury. The coroner had made a decision that he did not intend to leave to the jury the question of unlawful killing. Having referred to the test of *Wednesbury* unreasonableness, albeit only on an arguable basis at the leave stage, Dyson J then said:

> "The Coroner clearly took the view that, having regard to the complexity of the issues that would have to be considered, the evidence upon which a jury could decide whether unlawful dangerous force and/or grossly negligent force was causative of death, was so tenuous that no jury, properly directed, could reasonably decide that causation was made out. The question for me is not whether I agree with the decision of the Coroner, in the sense that if I had been in his position I would have reached the same conclusion. I should say that I doubt whether I would feel able to express a view about that, because (unlike the Coroner) I have not had the benefit of 21 days of evidence. I have been struggling to try to get to grips with the details of this case in one afternoon. The question for me is whether this Coroner, having directed himself properly, reached a decision which no reasonable Coroner could have reached.
>
> I am in no doubt that the decision that he arrived at was one which was reasonably open to him. It was not perverse or irrational, and I therefore dismiss this application."

Conclusion

17. Paraphrasing the words used by Tomlinson J and Phillips LJ, and applying them to the facts of the instant case, it seems to me that they suggest that it is sufficient to add the rider if the Coroner was of the view that it was "at least possible" that, but for the Deceased's failure to follow Dr. Syed's advice, his life would have been saved. If that is the appropriate test, then it was clearly not unreasonable on the part of the Coroner to have added the rider as he did. The Coroner had referred in his findings of fact to the urgency of the Deceased securing the opinion of an ENT specialist the next day. The fact is that, whatever the reason, the Deceased did not secure the opinion of an ENT specialist the next day.

18. I am conscious that the Coroner did not seek to draw the distinction which I have drawn between the period before the Deceased saw Dr. Hoefert, and that afterwards. In relation to the latter period, it could no doubt be said that the Deceased was entitled to rely upon the course which had been mapped out by Dr. Hoefert on 9 April; such course included a scan on 14 April, a consultation with Dr. Vallis on 18 April, and presumably no recommendation to return to the Emergency Department of the hospital. However, for the former period, and particularly after the Deceased had not been able to see an ENT specialist on Monday, 7 April, there could be no such entitlement. I do, therefore, remain of the view that the distinction is valid.

19. That said, I have to consider whether the Coroner acted unreasonably (in the *Wednesbury* sense) in finding that the Deceased's action (or lack thereof) constituted self-neglect which contributed to his death. It is important to bear in mind the terms of the Coroner's finding of fact contained in paragraph 66 of his report, and his reference to "a gross failure to obtain basis medical attention" was clearly a reference which the Coroner made with the judgment of Sir Thomas Bingham MR in *Jamieson* in mind. Particularly, the Coroner referred to two different matters in paragraph 66. First was the Deceased's decision not to be admitted to hospital on April 6. Second was the Deceased's decision not to return to the Emergency Department of the hospital for care between 6 April and 12

April. I am inclined to the view that it could not reasonably be said that the Deceased was guilty of "a gross failure to obtain basic medical attention" after his visit to Dr Hoefert on 9 April. However, as I have indicated above, the same cannot be said for the period before the Deceased's visit with Dr. Hoefert, at a time when he would no doubt have had Dr. Syed's words clearly in mind, and would have appreciated that the timing of the appointments which had been obtained for him was such that he was putting himself at risk by failing to take the action which Dr. Syed had recommended.

20. Put another way, the Deceased clearly had the opportunity of doing something effective from the time that he learned that it was not possible for him to see Dr. Vallis on 7 April, as he had originally expected he could. And had he done so, the evidence of Dr. Shultz was that the Deceased **would have been saved** (emphasis added), if he had gone into the hospital or to an ENT office and had a fiber optic laryngoscopy and elective tracheostomy (paragraph 40 of the Coroner's report).

21. In these circumstances, my view is that it cannot be said that the Coroner was unreasonable in the *Wednesbury* sense in reaching the conclusion which he did, and adding the rider in relation to the contributory effect of self-neglect in his conclusion. It is not therefore open to me to interfere with his finding.

22. I would, therefore, decline to grant the relief sought in the applicants' notice of motion, and would dismiss the application. I will hear counsel in regard to costs.

Dated this day of September 2009.

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Hon. Geoffrey R. Bell
Puisne Judge