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THE HUMAN RIGHTS ACT AND CLINICAL NEGLIGENCE - The Return?

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There are a number of clinical negligence claims against the NHS that are based upon, or supported by, alleged breaches of the Human Rights Act 1998 ("HRA"). The acts and omissions of those employed by the State in the field of healthcare may engage the European Convention on Human Rights ("ECHR"). Section 7 HRA has a relatively wide definition of who can be a 'victim' for the purposes of launching a HRA claim. Moreover, causation under the ECHR is regarded as a lower obstacle to surmount than in the common law.

Lord Roger summed up the general position under the HRA back in *Savage v South Essex Partnership NHS Foundation Trust [2008] UKHL 74*: "… the duty to protect the lives of patients requires health authorities the hospitals for which they are responsible employ competent staff and that they are trained to a high professional standard. In addition, the authorities must ensure that the hospitals adopt systems of work which will protect the lives of patients. Failure to perform these general obligations may result in a violation of Article 2." We will return to what systemic failure means later in this article.

First, we note that the Covid-19 crisis is leading to potential innovative ways that the HRA is being deployed in this field:

Any potential right to specific treatment, even experimental treatment, is being analysed more in the current climate. There are few authorities from Strasbourg on this subject and those that exist usually support the view that it is unlikely that the State will be seen to breach its Convention obligations by denying experimental treatment: *Hristov v Bulgaria (2012) and Durisotto v Italy (2014).* Such claims would usually be more successful only if it is shown that there is in fact some particular private life characteristic that is being infringed or discriminated against when the State denies treatment.

Nevertheless, although there is plainly no right to health, there is some support for the view that a wholly ineffective or inaccessible health system, could lead to a finding against the State. Where there is a systemic failure to diagnose, with unjustified removals and failures to take into account matters such as mental disability, there could be liability under the Convention: *Centre of Legal Resources v Romania (2014 & 2016).*

There is a long line of authority under Article 8 ECHR concerning use of confidential information, which has come under greater scrutiny recently during arguments about information held for the purposes of tracking and tracing those with Covid-19. Naturally, the case-law is against abuse of private information but does allow a margin of appreciation pursuant to Article 8(2) of the ECHR, providing that there is a legitimate aim: *LH v Latvia (2014) and PT v Moldova (2020).*

It is of course to be hoped that there will soon be an effective vaccination against Covid-19. Some, however, will be concerned about potential side-effects of a vaccine and/or could have a religious objection to the same. We have seen a number of challenges in the UK to forced medical intervention, as there have been in Strasbourg. Therefore, any compulsory vaccination programme initiated by the State could itself be the subject of a challenge: *Vavricka v Czech Republic (2019).*

Exposure to hazards can also be a violation of the ECHR, whether Article 2 or 3 or 8. Much of the jurisprudence from the ECtHR centres around what information was given to employees and what risks were known about. There are cases ranging from asbestos to environmental waste: *Vilnes v Norway (2013)* and *Brincat v Malta (2014).* Obviously the issue of exposure of employees to Covid-19 could well soon form the basis of future litigation in the UK.

Naturally, the common law provides a remedy for medical negligence in this country, and normally involves actions against the local body or Trust concerned, hence the Convention has hitherto usually been of greater import here where the investigation into clinical negligence by the State has purportedly beendeficient and/or there has been alleged systemic failure.

Article 2 & DNRs

Accordingly, we now return to systemic failure and look specifically at the positive obligations under Article 2 ECHR and R *(on the application of Antonia Iroko) (Claimant) v (1) Senior Coroner for Inner London South (2) HM Assistant Coroner For Inner London South (Defendant) & Lewisham & Greenwich NHS Trust (Interested Party) (2020).*

There have been several key judgments this year concerning Article 2 and medical mishaps in inquests. Following the High Court's recent decision in *R (Maguire) v HM Senior Coroner for Blackpool and Fylde [2020]* EWCA Civ 738, a further judgment has emerged considering Article 2 in the context of Do Not Resuscitate Directions ("DNR Directions").

Iroko was a claim concerning the death of Mrs Iroko, who died following a cardiac arrest on the 13th December 2017 at Queen Elizabeth Hospital, Woolwich ("QEH Woolwich"), for which the Interested Party had responsibility. Her death was reported to the First Defendant ("the Senior Coroner") and an inquest was subsequently opened. As a preliminary ruling, the Senior Coroner held that there was no evidence that any failure or dysfunction in the treatment of Mrs Iroko was systemic, or due to a failure to put in place a regulatory framework. As such, Article 2 was not deemed to be engaged. When the inquest was heard, the Assistant Coroner hearing the inquest declined to make a finding of neglect and did not make a Prevention of Future Death Report ("PFD Report").

The Claimant, Mrs Iroko's daughter, averred that there were three errors of law in the inquest, namely that: the Senior Coroner erred in deciding that Article 2 was not engaged; the Assistant Coroner failed to explore neglect; and, the Assistant Coroner failed to make a Prevention of Future Death Report ("PFD Report"). This article seeks to set out how the High Court reached their decision. It is another important case for practitioners to have to hand, particularly when assessing or dealing with questions of engagement of Article 2.

Factual background

On the 10th December 2017, Mrs Iroko attended the Urgent Care Centre at Queen Mary's Hospital. She presented with a history of vomiting, abdominal bloating, and pain, that had arisen over the previous 12-hour period. Following an examination, a working diagnosis of gastroenteritis was made. Before she was discharged, Mrs Iroko was advised to drink liquids and take Dioralyte. She was told that if any signs of dehydration developed or her condition worsened, she should attend her local A&E Department.

On the 12th December 2017, Mrs Iroko attended QEH Woolwich. She complained of vomiting, abdominal bloating, and pain, as well as an inability to keep fluid down. She had only passed urine twice in the previous 12 hours. Other than her blood pressure being high, Mrs Iroko's vital signs were normal.

Mrs Iroko was referred to A&E. Her vital signs were stable, except for her heart rate, which was raised. Antibiotics were prescribed. Mrs Iroko was moved to a chair in the Clinical Diagnostic Unit ("CDU") when she was stable. However, she continued to complain of abdominal pain and was consequently prescribed Oramorph. During her period in the chair in CDU, the Claimant recalled that her mother did not eat, drink, get up from her chair, or urinate. However, this was contradicted by evidence of an A&E Consultant, who stated that he recalled Mrs Iroko both drinking from a plastic cup and walking independently. Mrs Iroko was later discharged with a diagnosis of gastroenteritis. It was noted in her medical records that a Do Not Resuscitate CPR had not been agree.

Unfortunately, the following evening, Mrs Iroko went into a cardiac arrest. 40 minutes after her arrest, her pulse returned, but she could not breathe independently. She was transported back to QEH Woolwich, where she was taken to the Resuscitation Room. Dr Foster was in charge of the Resuscitation Team. Dr Foster considered a further cardiac arrest was imminent and decided to speak to Mrs Iroko's relatives. There was considerable dispute as to what was said between Dr Foster and Mrs Iroko's family. Mrs Iroko's family denied that they were informed that CPR would not be attempted if she would suffer a further cardiac arrest. They averred that, in any event, it would have been contrary to Mrs Iroko's religious beliefs and the family would not have agreed to such a decision.

At the inquest, Dr Foster explained that he had informed the family that he did not think it was appropriate to perform further CPR in the light of her clinical picture. When he returned to Mrs Iroko, she had suffered a further cardiac arrest and his colleagues had restarted CPR. Dr Foster explained in his evidence that he informed the team that he had spoken to her family and he did not think it would be appropriate for CPR to continue. Consequently, CPR was stopped and Mrs Iroko was declared deceased.

The decision of the High Court

The matter came before LJ Hickinbottom, Mrs Justice Whipple, and the Chief Coroner of England and Wales, HHJ Lucraft QC, with LJ Hickinbottom giving the lead judgment.

The Court first looked at Article 2, setting out the substantive positive obligations it imposes upon the state not to take life without justification and the consequential procedural obligation to establish a framework of laws, procedures and means of enforcement to protect life. As many practitioners know, the procedural obligation requires the state to initiate an investigation into a death for which it may bear responsibility (*Middleton* [2004]).

The Court referred to the recent judgment of *Maguire*, as well as that of *Lopes de Sousa Fernandes v Portugal (ECtHR Application No 56080/13* (2018), both of which discussed the application of Article 2 ECHR in medical mishap cases. By way of a reminder, LJ Hickinbottom reminded the Court that *Fernandes* confirmed that in cases involving alleged medical negligence, a state may be responsible under the substantive limb of Article 2 if there were "very exceptional circumstances". Such circumstances may arise when a patient's life is knowingly put in danger by denial of access to life-saving emergency treatment, however that does not extend to circumstances where a patient has received deficient, incorrect or delayed treatment. Moreover, if a systemic or structural dysfunction in hospital services

results in a patient being deprived of access to life-saving treatment and the authorities knew or ought to have known about the risk and failed to undertake the necessary measures to prevent the risk from materialising, therefore putting patients' lives in danger, Article 2 may be engaged. To determine whether the exceptional circumstances were satisfied, the Court had to look at each of the four factors given in *Fernandes*:

- Did the acts/omissions of the health care provider go beyond mere error or medical negligence, in so far as the health care professionals, in breach of their professional obligations, denied a patient emergency medical treatment, despite being fully aware that the person's life is at risk if the treatment was not given?

- Was the dysfunction objectively and genuinely identifiable as systemic or structural in order to be attributable to the state authorities?

- Was there a link between the dysfunction complained of and the harm which the patient sustained?

- Did the dysfunction result from the failure of the state to meet its obligations to provide a regulatory framework?

Both the Senior Coroner and Assistant Coroner had considered whether the procedural obligation of Article 2 applied. The Senior Coroner had considered that there were no grounds for there being an arguable breach of Article 2, however invited further submissions on the point from the family. None were received. Consequently, the Senior Coroner ruled that the inquest would be held as a *Jamieson* inquest. In addition, at the inquest, the Assistant Coroner similarly confirmed her view that this was not an Article 2 inquest and no submissions were made on the issue during the hearing.

The key issue raised before the High Court was that the Trust's policy on DNR Directions stated that the views of relatives and carers must be obtained in cases where a patient lacks capacity. In this case, it was argued that there had been a false claim that the DNR Direction had been discussed with Mrs Iroko's family. As such, the Claimant averred that the fact the direction was acted upon met the threshold of an act which went beyond mere error or negligence and denied Mrs Iroko treatment knowing that her life would be at risk if that treatment was not given.

The Court did not accept that the Coroners erred in not holding an Article 2 inquest, considering that the DNR Direction was not a material circumstance. LJ Hickinbottom said that the he did not consider that Dr Foster had ever said that Mrs Iroko's family had expressly agreed to the DNR Direction. He simply said that he did not consider it would be clinically appropriate in the light of her clinical condition. Upon returning to the Resuscitation Room, it became apparent that Mrs Iroko had suffered a second cardiac arrest and a decision was made by the team performing CPR to cease further attempts. In any event, the Court was satisfied that there had been no systemic failure to prompt an Article 2 inquest.

Turning to neglect, the Court noted that this issue was raised by Counsel for the family at the inquest, specifically in relation to: an alleged failure to monitor urine output, repeat venous gas analysis, and note and document that she had previous abdominal operations; and the decision to discharge Mrs Iroko on the 12th December 2017. The Assistant Coroner had declined to make a finding of neglect. However, she had expert evidence before her which considered that Mrs Iroko ought not to have been discharged on the 12th December 2017 without an abdominal x-ray. The Court reminded itself that neglect meant far more than even gross negligence: it meant a gross failure to provide basic medical attention. LJ Hickinbottom did not consider that there was any gross failure to provide basic medical attention to Mrs Iroko, and that the case fell short of that high threshold.

Finally, the Court dealt with the issue of the PFD Report. The Court considered that the duty to issue a PFD Report was highly fact-specific and involved an exercise of judgment by a coroner. Given the above conclusions, the Assistant Coroner did not err in not issuing a PFD Report.

Conclusion

This case yet again emphasises the high hurdle parties face when seeking to persuade a Court that Article 2 is engaged in a death resulting from a medical mishap. The Court itself considered that, in the light of the decisions of *Fernandes and Maguire*, the question as to whether Article 2 is engaged in such cases is now *"well-settled"*. Practitioners should bear the jurisprudence in mind before seeking to challenge whether an inquest should remain as a *Jamieson* inquest.

Missed Meningitis: clinical examination performed without accounting for broader medical context fell below reasonable standard

THOMAS YARROW

Consider the following circumstances underpinning a claim in clinical negligence: a fifteen-month-old child is taken to a GP; the GP examines her, suspects meningitis and sends her under blue lights to hospital; on examination in hospital, however, tonsillitis is diagnosed and the child is discharged without a lumbar puncture; days later she is readmitted, a lumbar puncture is performed and a serious bacterial infection is identified; she suffers a stroke as a result of a bacterial meningitis leaving her with a permanent neurological defect.

At first glance it looks as though establishing a breach of duty ought not to present significant difficulty. If the GP was in a position to suspect meningitis, which was the ultimate diagnosis, while the doctors in the hospital missed it, an instinctive prediction might be that this was a case which would never reach trial (at least on liability). As Mr Justice Johnson said, however, when these facts came before him in the case of SC *(by her mother and litigation friend AC) v University Hospital Southampton NHS Foundation Trust [2020] EWHC 1610 (QB)* last month, "it is much more complicated than that".

Confounding the simplicity of the above summary, meningitis in children of under three months is notoriously difficult to diagnose through clinical examination. Symptoms are often generalised, and consistent with many pathologies. There are certain 'classic' markers of a serious bacterial infection, being fever, neck rigidity, photophobia, non-blanching rash, headache and vomiting, but especially in infants and toddlers these features may be absent or (for reasons of communication) difficult to interpret.

In the claimant's case, when she was initially seen by a GP, he noted her to have vomited three times that day and to have a temperature of 40.1°C; she was lethargic and floppy with a 'glazed look'; and she showed signs of possible photophobia. Owing to his suspicion of meningitis (or a meningococcal septicaemia) he administered an intramuscular injection of antibiotics and instructed that the claimant should be given Calpol before arranging an ambulance to take her to hospital.

In the ambulance the claimant was said to be almost lifeless, at one point feared dead, but by the time of reaching the hospital she was described as being 'alert but very quiet'; she continued to have a temperature of above 40°C; oral paracetamol and ibuprofen were given. On examination by a Senior House Officer ("SHO"), who clearly had the GP's impression in mind, it was noted that the claimant was alert, that she had no rash and had no neck stiffness (i.e. some of the typical signs of meningitis were not clinically observed). Instead, the SHO noted that the claimant had large inflamed red tonsils with a few dots of exudate and her impression was that the claimant had tonsillitis and that meningitis was 'unlikely', though not formally ruled out. She admitted the claimant for observation and fluids.

Four hours later, the claimant was seen by a consultant. The consultant was in his first six months working as such, but as Mr Justice Johnson pointed out, the objective standard of reasonableness against which a doctor is compared in such claims is that of a reasonably competent practitioner at the relevant seniority irrespective of experience at that level. When observed by the consultant the claimant was again noted to be alert and walking around the play area, her temperature had come down to around 37°C, she had no neck stiffness, and had large inflamed pussy tonsils. His impression, like that of the SHO, was therefore of tonsillitis. Unlike the SHO, however, he

did not expressly note the possibility of another diagnosis (in particular, a diagnosis of a serious bacterial infection) and he discharged the claimant with a review scheduled for the next day.

The following day, he noted her as being 'better' and his impression was of a resolving viral illness. He discharged her with no follow up. It was not until 4 days later after a further GP referral to hospital that a lumbar puncture was eventually performed and a pneumococcus was found.

What had happened? Had the Claimant had a serious bacteria infection when she was first seen by the GP or had it come later? If she had an infection, how and why had this been excluded by the SHO and the consultant? Was viral tonsillitis a misdiagnosis? Mr Justice Johnson, after considering expert evidence from consultant paediatricians and microbiologists, made findings of fact that the claimant did in fact have viral tonsillitis and that this had been missed by the GP (or had significantly developed in the time between GP and hospital examinations), but this did not preclude her having, and indeed she did have, a *co-existing* pneumococcal bacteraemia: co-incidence of bacterial and viral infections in this way was well recognised. It was the pneumococcal disease which ultimately had pierced the blood-brain barrier, forming a pneumococcal meningitis which had led to the brain injury in this case.

Crucially, Mr Justice Johnson made a finding that the bacteraemia was symptomatic at the time of observation by the GP but that the intramuscular injection and the oral anti-inflammatory and anti-pyretic drugs (ibuprofen and Calpol/paracetamol) administered by the GP and on arrival in hospital had had rapid effect on the claimant's symptomology, lowering her temperature and bringing her from arguably the lowest point on the AVPU scale (alert; responsive to voice; responsive to pain; unresponsive) to the foremost. Although the experts had agreed that the bacteraemia was present in the claimant's body at the relevant time, they had disagreed on it being clinically observable and on the probability of symptoms abating so quickly after the medical interventions.

There was therefore nothing inherently unreasonable in the impression noted by the hospital doctors that the claimant had tonsillitis, or indeed that the symptoms she was displaying on examination were not typical of a serious bacterial infection – they were not: by the time of being examined by the consultant, the observations did not indicate that a lumbar puncture should be performed. But both the GP's noting of the symptoms of possible photophobia, poor floppiness, lethargy, vacant expression and vomiting and/or the possibility that medical interventions had altered those symptoms appear to have been disregarded. What needed to be compared to the objective reasonable standard in this case was therefore not a failure of, or a failure to act upon, clinical observation per se, but a failure to take into account the wider context which included (1) the notes provided by the GP indicating certain symptoms not consistent with a tonsillitis and (2) the possibility that the medical interventions had had an early clinical effect on the claimant's bacterial infection.

With regard to the SHO, Mr Justice Johnson found that she did not fall below the reasonable standard. Indeed she had indicated in her notes that meningitis was 'unlikely' implying it was not fully excluded. Her examination had been careful, thorough and appropriate and she had admitted the claimant for observation. There was a question of whether she should have ensured that the claimant was seen by the consultant earlier in the afternoon but this could not be said to have been causative of the injuries complained of, so was disregarded. Interestingly, although in a different section of the judgment he noted that a temperature of 40°C was not consistent with a tonsillitis, he made no criticism in his conclusions on the SHO's care in apparently not identifying such an inconsistency.

With regard to the consultant, however, the Judge found that the exclusion of the possibility that the claimant was suffering from a serious bacterial infection was not supported by a responsible body of medical opinion; or to the extent that a body of medical opinion might support the view that such an infection could have been excluded then it would not withstand logical analysis. The standard of medical care provided by the consultant therefore fell below what was reasonable. In particular, the only safe way to proceed, given that the symptomatic history was not obviously consistent with

tonsillitis but was with a serious bacterial infection, was to perform other diagnostic tests – namely a lumbar puncture – to exclude other possible diagnoses.

Having found such a breach, causation of the neurological injury was not in dispute: if such a lumbar puncture had been performed, it would have identified a pneumococcus, treatment would have commenced, and the relevant neurological damage would have been prevented.

There was also a claim with regard to the general care given by the Trust defendant to the claimant in the period between examination by the SHO and by the consultant, which the judge heavily criticised but this was not causative of the injuries in question. The failures were not failures of observation but of investigation.

The case highlights that in some circumstances, in order to meet the reasonable and competent standard of care, clinicians will have to consider not only their own observations when decision making, but to also consider the wider medical context presented to them, which in this case included the symptoms observed by the GP. The consultant's examination in isolation had been perfectly reasonable, both in its process and conclusions, but it had been unreasonable not to address symptoms noted by a respectable medical colleague and to at least consider why these might no longer be observable.

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