Neutral Citation Number: **[2025] EWHC 357 (Admin)**

Case No: AC-2024-BHM-000013

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

Birmingham Civil and Family Justice Centre
33 Bull Street
Birmingham B4 6DS

Date: 20/02/2025

Before:

MR JUSTICE JAY

- -

Between:

R (EILEEN HENSHAW) **Claimant**

- and –

HM ASSISTANT CORONER FOR DERBY AND DERBYSHIRE **Defendant**

- and –

(1) MINISTRY OF JUSTICE
(2) PRACTICE PLUS GROUP

Interested Parties

- -
- -

Alex Littlefair (instructed by **Hudgell Solicitors**) for the **Claimant**
Michael Walsh (instructed by **Derbyshire County Council**) for the **Defendant**
The **Interested Parties** were neither present nor represented

Hearing date: 12 February 2025

- -

Approved Judgment

This judgment was handed down remotely at 10.30am on 20 February 2025 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MR JUSTICE JAY

MR JUSTICE JAY:

1. Ms Georgina Henshaw died in her cell at HMP Foston Hall on 31 August 2018. She was just 37. The cause of death was sudden cardiac arrythmia. Ms Henshaw had been held at this prison since July 2017, first in remand and then, after 27 February 2018, as a convicted prisoner. She had received a life sentence with a 16-year minimum term for the murder of a man by stabbing.

2. Given the circumstances surrounding Ms Henshaw's death, an Article 2-compliant inquest was held by an Assistant Coroner for Derby and Derbyshire ("the Defendant") between 2 and 9 October 2023.

3. By these judicial review proceedings, Mrs Eileen Henshaw ("the Claimant"), Ms Henshaw's mother, challenges the following aspects of the Inquest:

   (1) the direction given by the Defendant to the jury in relation to natural causes ("Ground 1").

   (2) (i) the direction given to the jury that the failings regarding an ECG were not to form part of the findings;

   (ii) the Defendant preventing the jury from reaching conclusions on factual matters central to the Inquest and/or from entering judgmental conclusions of a factual nature ("Ground 2").

   (3) the Defendant not making Ms Henshaw's community GP an interested person in the Inquest and/or not calling a live witness from the GP practice ("Ground 3").

4. I am grateful for the assistance I received from both counsel, Mr Alex Littlefair (for the Claimant) and Mr Michael Walsh (for the Defendant), both in writing and orally. Mr Littlefair appeared at the Inquest and, in circumstances where the recording of the Inquest malfunctioned and no transcripts of the live evidence and the Defendant's oral directions to the jury and summing-up are available, was able to assist me with factual matters within his recollection. Mr Walsh, who did not appear below, adopted a neutral stance, as is standard practice.

5. In order to understand the Claimant's Grounds it is necessary to set out some essential factual background.

ESSENTIAL FACTUAL BACKGROUND

6. Ms Henshaw had a complex medical history. It is unnecessary to dwell on much of the detail. She had been prescribed anti-psychotic medication (quetiapine and risperidone) by her GP, and she was also under the care of a psychiatrist.

7. Anti-psychotic medication is associated with long QT syndrome which is a condition giving rise to an abnormally lengthy QT interval. This results in an increased risk of irregular heartbeat which can in turn lead to fainting and even sudden death. Long QT syndrome is a rare condition which in most cases is congenital. The position in relation to Ms Henshaw is unclear.

8. I do not have all of Ms Henshaw's medical records. I do not know for how long she was taking anti-psychotic medication and in what dose or doses. What the medical records do show is that Ms Henshaw had repeatedly overdosed her medication (not limited to her anti-psychotic medication) and that she had repeatedly failed to engage with her GP and/or psychiatrist. An ECG was carried out in April 2017 on account of the risk of long QT syndrome. According to the community GP's letter dated 18 April 2017, the results were 484 and 451 (the Defendant's notes of her summing-up contain an unfortunate typographical error in relation to the second result). The normal range is up to 470, although the 484 reading was obtained after one of Ms Henshaw's overdoses (although it is unclear from the information I have whether the overdose related to the anti-psychotic medication rather than anything else).

9. According to an entry in Ms Henshaw's GP records dated 21 June 2017:

> "Reminder/alert: patient not to be issued any further anti-psychotics until review with Dr Salvi [the psychiatrist] on 23/6. Has prolonged QTc and recurrent overdoses. Priority – high."

10. Ms Henshaw was not seen by Dr Salvi on 23 June. On 5 July she was seen at her GP practice. There was evidence of significant alcohol abuse. On 7 July she was taken into police custody in connection with the fatal stabbing.

11. The GP summary sent by the practice to the prison on 10 July 2017 did not contain the GP record dated 21 June 2017 and its accompanying warning, or any gist of it. Until the Inquest started it had been assumed that this record had been sent. However, evidence submitted by Practice Plus Group demonstrated that this was not the case. Dr David Chambers, a GP practitioner at the prison, gave evidence to the Inquest that shortly after Ms Henshaw's arrival he prescribed the two anti-psychotic drugs I have mentioned together with sertraline in the maximum dose. On 12 July 2017 Ms Henshaw underwent further healthcare screening and the presence of ischaemic heart disease was noted.

12. According to Dr Chambers, had he been aware of the record dated 21 June 2017 he would not have prescribed anti-psychotic medication without psychiatric input. However, a balance would have had to been struck between the risk of continuing on the drugs and the risk of not taking them. Furthermore, Dr Chambers was aware that a request for blood tests and an ECG was made in May 2018. These were not carried out and Dr Chambers conceded that "admin" should have arranged a review appointment. Had that occurred Dr Chambers would then have realised that the ECG and blood tests had not been performed.

13. The Inquest also heard evidence from Dr Tarrant, a psychiatrist working within the prison. His evidence was that Ms Henshaw was on a relatively low dose of these drugs. My interpretation of his evidence is that, had he been aware of the GP warning, he would have requested an ECG before any anti-psychotic drugs were prescribed. Dr Tarrant described the GP summary as "pretty basic and scant". Given that Ms Henshaw was on anti-psychotic drugs, he requested an annual ECG on 22 May 2018. As I have said, no ECG was carried out and it is not suggested that this was owing to Ms Henshaw's failure to attend healthcare, albeit there were numerous examples of those.

14. Before I address the expert evidence heard at the Inquest, I need to deal with what happened on the day Ms Henshaw died.

15. The evidence before the Inquest was that at around 8:10am Female Officer #1 opened Ms Henshaw's door and placed some post beneath it. Female Officer #1 looked through the observation panel in the door, and she saw Ms Henshaw shrug or move her shoulder. That evidence was not doubted by anyone, and the experts therefore proceeded on the basis that Ms Henshaw was not in cardiac arrest at 8:10am.

16. At approximately 8:25am Male Officer #1 can be seen on CCTV entering Ms Henshaw's cell. His written evidence to the Inquest was that he had no recollection of seeing Ms Henshaw at the time. Unfortunately, in her summing-up to the jury the Defendant misdescribed Male Officer #1's evidence, stating that he had seen Ms Henshaw at that time. His evidence is noted by the Defendant as follows:

> "He opened the door, asked her to get up to attend the activity, she did not respond and appeared to be sleeping facing the window."

Mr Littlefair informs me, and I accept, that this was not Male Officer #1's oral evidence.

17. At approximately 8:40am Male Officer #1 found Ms Henshaw unresponsive in her cell. He issued a code blue emergency response. Before external paramedics arrived, a nurse within the prison inserted an I-gel device to secure an airway and facilitate CPR. Unfortunately, the I-gel device was wrongly inserted and from that moment CPR was doomed to fail.

18. Although not all the witnesses who saw Ms Henshaw after 8:40am said precisely the same thing, the preponderance of evidence was that her body was purple and mottled. There was no pulse. Ms Henshaw was still warm and CPR was attempted after her removal to the floor. The ambulance arrived within less than 20 minutes, and shortly thereafter life was pronounced extinct.

19. The Inquest heard expert evidence from three individuals: Professor G.N. Rutty, Chief Forensic Pathologist; Mr Kirby, Consultant in Emergency Medicine; and Professor Suvarna (now deceased), Consultant histopathologist/senior cardio-thoracic pathologist.

20. As I have said, no transcripts of their evidence are available. I have not seen copies of any reports they prepared. I have to say that the Defendant's notes of her summing-up to the jury are sub-optimal. Either the evidence was unclear or her summing-up was unclear, or both. Maybe the summing-up as given *viva voce* to the jury was better.

21. Mr Walsh has provided a helpful summary of the expert evidence before the jury. I agree with most of that summary, but will adapt it slightly to reflect my interpretation of what the experts said.

22. First, Ms Henshaw probably suffered a cardiac arrest between 8:10am and 8:40am, but the experts could not say when. However, it is possible that at 8:40am Ms Henshaw was in peri-arrest.

23. Secondly, at the time the I-gel was inserted, Ms Henshaw was still alive albeit probably in cardiac arrest. As for the first part of this proposition, the presence of bruising in the throat, brought about by the incorrect insert of the I-gel, proves that Ms Henshaw was not dead. As for the second part, the ease of insertion of the I-gel is further support for the conclusion that Ms Henshaw was deeply unconscious because she was in cardiac arrest. There was no gag reflex.

24. Thirdly, even if the I-gel had been inserted correctly, she would probably not have survived. The chances of surviving an "out of hospital" cardiac arrest are under 50%. By the time the paramedics arrived with their advanced life-saving equipment, it was far too late.

25. Fourthly, the cause of Ms Henshaw's sudden cardiac arrythmia and consequent cardiac arrest could not be ascertained.

26. Fifthly, it could not be established on the balance of probabilities that the prescribed anti-psychotic medication caused long QT intervals and/or, by extension, the episode of acute or sudden cardiac arrythmia which led to Ms Henshaw's death.

27. This fifth point requires closer analysis. Contrary to what is said in the GP record dated 21 June 2017, it is far from clear that Ms Henshaw did have long QTc. The only evidence of this is to be found in one reading of the ECG carried out in April 2017. That one reading could be attributed to an overdose, taking into account the caveat I have already made that it was far from clear that the 484 reading was attributable to an overdose of anti-psychotic medication rather than anything else[1]. Professor Suvarna told the Inquest that her previous high readings (in the plural, although I have seen evidence of only one) "may have been abnormal due to the overdose", whereas Mr Kirby's evidence was more forthright. He believed that an overdose was the reason for the high reading.

28. I do not accept Mr Walsh's summary of the expert evidence to the effect that it was their view that Ms Henshaw's anti-psychotic medication did not contribute to (as opposed to cause) any long QTc intervals in Ms Henshaw's case. Professor Suvarna did not go that far.

THE DEFENDANT'S DIRECTIONS TO THE JURY AND SUMMING-UP

29. The Defendant directed the jury on the issue of natural causes. She did not leave accidental death as a possible verdict. She stated that in this case there were two possible conclusions, viz. a short form conclusion of natural causes or a narrative conclusion. The Defendant directed the jury that they should consider natural causes as a conclusion first. The Defendant defined natural causes to mean "the normal progression of a natural illness(es) which has/have led to death with or without any significant intervention." She said that a narrative conclusion gave the jury the opportunity to "set out a short factual account of how the death came about", and then gave the jury a possible form of words. She emphasised that a narrative conclusion should only reflect the central issues and those matters which, on balance, caused Ms Henshaw's death.

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[1] I have seen nothing to suggest that an overdose of paracetamol, for example, is associated with long QT syndrome.

30. The Defendant directed the jury that the questions they might like to ask themselves included "when, where and how did Ms Henshaw come by her death – consider only those matters which more than minimally caused or contributed to her death on the balance of probabilities, the actions of prison staff when she was found unresponsive in her cell, and whether the incorrect insertion of the I-gel caused or contributed to her death." On the other hand, the jury should not consider the "wider circumstances" including the GP summary sent in July 2017, whether the anti-psychotic medication was the cause of QTc syndrome, the failure to conduct the ECG and blood tests and what the results may have shown, and the adequacy of checks by the prison officers and the promptness of their actions "once" Ms Henshaw was found unresponsive.

31. There appears to be a contradiction between the Defendant's positive suggestion that the jury would want to consider "the actions of prison staff when she was found unresponsive in her cell" but should not consider their actions "once" she was found unresponsive. Mr Littlefair did not pick up on this point. He submitted, and I am inclined to agree, that the Defendant's exclusion was at least intended to relate to the period between 8:10am and 8:40am.

32. I have to say that I do not think that the Defendant's legal directions are particularly clear or easy to follow. They contain legal language and references that would make little or no sense to a jury. For example, the references to "Article 2" and to "Galbraith/Galbraith plus" could not, without more, have meant anything to them. The directions contain concepts which are not properly explained. For example, the Defendant did not clearly explain the difference between a short-form conclusion and a narrative conclusion, both of which were consistent with a finding of natural causes. Even so, Mr Littlefair confined his submissions to a narrower criticism of the Defendant's directions, and I will therefore proceed on that basis.

33. I have already commented that the Defendant's summing-up of the expert evidence was far from ideal. However, on the I-gel issue I consider that, if anything, it was overly favourable to the Claimant. I take the point, however, that accidental death was not left to the jury as a possible verdict.

34. The Defendant's reason for withdrawing various matters from the jury's consideration appears in her second witness statement:

> "I recall saying, "I am guided by the pathologists and the evidence of all the doctors as to what caused Georgina's death. That is my clear recollection from memory."

35. During the hearing Mr Littlefair applied to the Defendant that she direct the attendance of a witness from Ms Henshaw's GP practice to deal with the "sparse" GP summary and its failure to include the GP record for 21 June 2017. The Defendant's reason for rejecting that application is not available, but one may reasonably suppose that it was the same as her reason for withdrawing certain issues from the jury's consideration.

THE JURY'S CONCLUSION

36. At the conclusion of the inquest the jury were directed in respect of a medical cause of death that they should find it was "sudden cardiac arrythmia".

37. The contents of Box 3 (how, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 ("the 2009 Act") applies, in what circumstances, the deceased came by his or her death) were found by the jury as follows:

> "Georgina Wendy Henshaw passed away in cell 10 at HMP Foston Hall, Foston, Derby on the morning of 31 August 2018 due to a sudden cardiac arrhythmia. She was deemed to be responsive to prison officers at 8:10 AM but was reported as being unresponsive in her cell at 8:40 AM by prison officers.
>
> Prison officers called for medical assistance from the Practice Plus Health Nurses who arrived in a timely manner.
>
> The Nurses assessed Georgina Wendy Henshaw to be in a cardiac arrest, they carried out CPR, inserted an I-gel to clear her airway and applied a defibrillator.
>
> The I-gel was subsequently found to have been inserted incorrectly thus obstructing airflow.
>
> The exact time at when the cardiac arrest occurred was not determined but believed to be between 8:10 AM and 8:40 AM.
>
> It has not been possible to determine, on the balance of probabilities the exact time when the cardiac arrest occurred but had Georgina Wendy Henshaw still been alive at the point the I-gel was inserted incorrectly, then that incorrect insertion would have meant that death was inevitable. Death was likely inevitable irrespective of the incorrect insertion of the I-gel."

38. Box 4 (Conclusion as to the death) recorded "natural causes".

GOVERNING LEGAL FRAMEWORK

39. I may take this with adaptations from Mr Littlefair's skeleton argument, including additional matters drawn to my attention by Mr Walsh.

40. Section 1(2)(c) of the 2009 Act provides that an inquest must be held when a death occurs in custody or state detention. Pursuant to section 7(2), the Inquest in the instant case had to involve a jury.

41. Section 5 the 2009 Act provides:

> "(1) The purpose of an investigation under this Part into a person's death is to ascertain —
>
> (a) who the deceased was;
>
> (b) how , when and where the deceased came by his or her death;

> (c) the particulars (if any) required by the 1953 Act to be registered concerning the death.
>
> (2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.
>
> (3) Neither the senior coroner conducting an investigation under this Part into a person's death nor the jury (if there is one) may express any opinion on any matter other than —
>
> (a) the questions mentioned in subsection (1)(a) and (b) (read with subsection (2) where applicable);
>
> (b) the particulars mentioned in subsection (1)(c).
>
> This is subject to paragraph 7 of Schedule 5."

42. Section 10 provides, so far as material:

> "(1) After hearing the evidence at an inquest into a death , the senior coroner (if there is no jury) or the jury (if there is one) must —
>
> (a) make a determination as to the questions mentioned in section 5(1)(a) and (b) (read with section 5(2) where applicable), and
>
> (b) if particulars are required by the 1953 Act to be registered concerning the death, make a finding as to those particulars.
>
> (2) A determination under subsection (1)(a) may not be framed in such a way as to appear to determine any question of —
>
> (a) criminal liability on the part of a named person, or
>
> (b) civil liability."

43. Rule 33 of the Coroners (Inquests) Rules 2013 (S.I. No.1616 of 2013) provides:

> "Where the coroner sits with a jury, the coroner must direct the jury as to the law and provide the jury with a summary of the evidence."

44. Rule 34 provides:

> "A coroner or in the case of an inquest heard with a jury, the jury, must make a determination and any findings required under section 10 using form 2."

45. I deal now with the relevant jurisprudence in chronological order.

46. In *R v Birmingham and Solihull Coroner Ex p. Benton* (1997) 162 J.P. 807, Kay J (as he then was) quashed a jury verdict of natural causes. The pathologist's opinion was that death was due to:

> "l (a) Bilateral tension Pneumothorax,
>
> (b) Artificial Ventilation,
>
> (c) Acute Tracheobronchitis and Bronchiolitis."

47. Importantly, the pathologist also said it was not possible to assess whether an identified delay in treatment was a factor in the death. The challenge to the coroner's decision was that all verdicts other than "death by natural causes" were withdrawn from the jury.

48. At 814C–F, Kay J contrasted 2 situations:

> "It is necessary to contrast two possible situations. The first is where a person is suffering from a potentially fatal condition and medical intervention does no more than fail to prevent that death. In such circumstances the underlying cause of death is the condition that proved fatal and, in such a case, the correct verdict would be death from natural causes. This would be the case even if the medical treatment that had been given was viewed generally by the medical profession as the wrong treatment. All the more so is this the case, where such a person is not treated at all, even if the failure to give the treatment was negligent. Thus, in such circumstances the recording of a verdict of death by natural causes is not in any way a finding that there was no fault on the part of the doctors. That question for the reasons already explained is not one that the inquest does, or is permitted to, address.
>
> On the other hand, where· a person is suffering from a condition which does not in any way threaten his life and such person undergoes treatment which for whatever reason causes death, then assuming that there is no question of unlawful killing, the verdict should be death by accident/misadventure. Just as the recording of death by natural causes does not absolve the doctors of fault, so the recording of death by accident/ misadventure does not imply fault."

49. Having considered the entire evidence Kay J held as follows (at 816G–817C):

> "I find it impossible to conclude that this case falls so clearly on one side of the divide between death by natural causes and death by accident/misadventure that it was not an issue for the jury to decide. On one view, Robert was a child with a potentially life threatening condition and the attempts to treat

> him simply failed to prevent his death. On the other, the treatment, whether it was the right treatment or not, actually brought about his death by causing the tear to the lung that in turn caused the pneumothoraces that resulted in death. Accordingly, the issue as to which was the correct verdict should have been left for the jury to decide with the distinction between the two being explained to them. Since they were not afforded the opportunity to reach that conclusion their verdict of death by natural causes has to be viewed as flawed and cannot be allowed to stand."

50. In *R. (Amin) v Home Secretary* [2003] UKHL 51; [2004] 1 AC 653 the House of Lords (Lord Bingham giving the judgment of the Appellate Committee) held that the purposes of an Article 2 investigation in a prison death case were:

(1) to ensure so far as possible that the full facts are brought to light;

(2) that culpable and discreditable conduct is exposed;

(3) that suspicion of deliberate wrongdoing (if unjustified) is allayed;

(4) that dangerous practices and procedures are rectified; and

(5) that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others.

51. From *R (Middleton) v West Somerset Coroner and another* [2004] UKHL 10; [2004] 2 AC 182 the following principles apply to an Article 2 inquest into a death in custody:

(1) the jury's conclusion as to the central factual issues in the case should "ordinarily" be expressed;

(2) the procedural obligation to determine the central issues applies to "cases in which a defective system operated by the state may have failed to afford adequate protection to human life";

(3) a short form "verdict" (now "conclusion") is appropriate when it enables a jury to express their conclusion on the central issue canvassed at the inquest (for example, whether the deceased was unlawfully killed);

(4) it is a matter for the coroner to decide how to elicit the jury's conclusion on the central issue or issues in the case.

52. The concept of "the central issues in the case" requires some elucidation. No problems arise in situations where the central issues all relate to matters which are obviously directly causative of or contributory towards the death under scrutiny. I do not read *Middleton* as providing a clear answer to the question of how a coroner may or must proceed in circumstances where the act or omission in question may, but probably did not, cause or contribute to the death at issue.

53. In *R (Hurst) v London Northern District Coroner* [2007] UKHL 13; [2007] UKHL 13; [2007] 2 AC 189, Lord Brown of Eaton-under-Heywood stated, at para 51:

> "Of course, the scope of the inquiry is ultimately a matter for the coroner. The 'verdict' and findings, however, are not. The Jamieson construction of 'how' severely circumscribes these. But where the Middleton construction applies, the verdict and findings are not merely permitted, but required to be wider…"

54. In *R (Maughan) v Oxfordshire Senior Coroner* [2020] UKSC 46 the Supreme Court approved the three-stage process for arriving at a conclusion set out in Chief Coroner Guidance 17, "Conclusions: Short – Form and Narrative". At Lady Arden JSC stated, at para 13

> "…(a) that the facts should be found (on the evidence); (b) that the manner in which the deceased came by his death should then be distilled from the narrative findings; and, (c) the conclusion flowing from (a) and (b) should then be recorded."

55. In *R (on the application of Lewis) v Mid and North Shropshire Coroner and another* [2009] EWCA Civ 1403; [2010] 3 All ER 858, the Court of Appeal determined that a coroner in an Article 2 inquest had a discretion but not a duty to leave possibly causative matters to a jury. As Sedley LJ explained, at para 28:

> "… I see the force of his foundational proposition that the circumstances of a death are not limited to probable causes: they extend as a matter of plain English to the surrounding facts; and while it is not contended for the present that this allows the jury to pronounce on facts, however close in time, that can have had no bearing at all on the death, it can be intelligibly said that, in a jurisdiction which is not concerned with the allocation of blame, potentially causative circumstances can be just as relevant as actually causative ones."

56. As Toulson LJ (as he then was) explained in *R (Mack) v HM Coroner for Birmingham* [2011] EWCA Civ 712, the coroner has in relation to witnesses:

> "… a wide discretion – or perhaps more appropriately a wide range of judgment – whom it is expedient to call. The court will only intervene if satisfied that the decision made was one which was not properly open to him on Wednesbury principles."

57. In *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin); [2016] 4 WLR 157 the Divisional Court (Sir Brian Leveson P. and Kerr J) held, at para 74:

> "Putting the point another way, in an inquest such as this, where the possibility of a violation of the deceased's right to life cannot be wholly excluded, sections 5(1)(b) and 5(2) of the 2009 Act should require the inclusion in the Record of Inquest

> of any admitted failings forming part of the circumstances in which the deceased came by his death, which are given in evidence before the coroner, even if, on the balance of probabilities, the jury cannot properly find them causative of the death."

58. The Court added this, at para 83:

> "… a fresh inquest is unnecessary and would serve no useful purpose … The present application before the court, and the court's judgment , suffice to make good the deficiency, without any further order or relief being granted. The Record of Inquest should therefore not be quashed, and subject to hearing counsel, we do not consider that any further relief is required beyond a declaration that the application is well-founded to the extent identified in this judgment."

59. In *R (Worthington) v HM Senior Coroner for Cumbria* [2018] EWHC 3386 (Admin) the Divisional Court (Hickinbottom LJ, Farbey J, HHJ Lucraft QC (Chief Coroner)) held (at para 46) – in the particular circumstances of the case before it - that a coroner (in a *Jamieson* inquest) is entitled to include (and may be obliged to include) conclusions as to a matter which did not cause death.

60. Mr Walsh also drew my attention to *R (Smith) v HM Assistant Coroner for NW Wales* [2020] EWHC 781 (Admin); 174 BMLR 142, but in my opinion that case addresses a slightly different issue.

61. In January 2025 the Chief Coroner published fresh guidance. It post-dated the Inquest in the present case but is relevant to the law governing the Defendant's decision-making in 2023, the common law adopting the fiction that it is no more than declaratory. The Chief Coroner's interpretation of *Tainton* is not that admitted failings *must* be recorded in the Record of Inquest but that there is a power to do so in circumstances where that failing cannot be established on the evidence to have been causative. In the circumstances of the instant case, it is unnecessary for me to reach a definitive conclusion on the issue of duty versus power, although I would incline to the view that there may be situations where the power effectively translates into a duty because there is only one reasonable exercise of it in public law terms. That may well be the correct interpretation of *Tainton*, inasmuch as if failings are admitted, there is no possible reason for excluding them from account.

THE CLAIMANT'S SUBMISSIONS

62. Mr Littlefair submission on Ground 1 changed somewhat in oral argument. In his Statement of Facts and Grounds and skeleton argument he submitted that the Defendant should not have directed the jury that they first consider the issue of natural causes. Mr Littlefair has adhered to that submission throughout. However, in writing his primary complaint was that the Defendant's misdirection on natural causes, in terms of the sequencing of the jury's reasoning, led to the jury failing to consider properly whether they should reach a narrative conclusion as opposed to a short-form conclusion. In oral argument Mr Littlefair indicated that his main bone of contention was that the jury was not directed to consider the possibility of reaching a different

verdict altogether, namely accidental death, on the premise that the incorrect insertion of the I-gel may significantly have hastened Ms Henshaw's demise.

63. Mr Littlefair's submissions under the banner of Ground 2 essentially fell under two sub-headings. First, he submitted that the issue of whether Male Officer #1's 8:25am check was adequate and/or potentially causative should not have been withdrawn from the jury's consideration. Secondly, he submitted that the whole issue of long QT syndrome should not have been withdrawn from the jury's consideration. That issue encompassed: (1) the inadequate nature of the GP summary, in particular the absence of the warning contained in the GP record of 21 June 2017, and (2) the failure to carry out ECGs in July 2017 and May 2018, in particular in circumstances where the second failure was admitted.

64. Mr Littlefair's submission on Ground 3 was adjunctive to the second limb of Ground 2. Given that the saliency of the inadequate GP summary was only appreciated very late in the day, because until the Inquest opened the Claimant in particular believed that the GP record dated 21 June 2017 had been sent to the Practice Plus Group, it was *Wednesbury* unreasonable not to accede to the Claimant's application for a live witness to be called from the GP practice to explain the position.

DISCUSSION

65. My criticisms of aspects of the Defendant's legal rulings and summing-up need to be placed in context. To be fair to the Defendant, this was a difficult case which would have challenged even the most experienced coroners.

66. The iteration of Ground 1 that is set forth in Mr Littlefair's skeleton argument is not persuasive. In my judgment, the jury's conclusion, as set out in Box 3, did amount to a narrative conclusion which went beyond a short-form conclusion properly so called. Mr Littlefair's complaint that the narrative did not go far enough because it did not cover the long QT syndrome issue falls to be addressed not under Ground 1 but Ground 2. It is true that the narrative conclusion does not appear under Box 4 but that is a point which goes not to substance but form. Had Box 4 contained the wording "see Box 3" there could have been no complaint. In my judgment, the absence of such wording does not matter.

67. In my view, whether it was correct to direct the jury that the issue of natural causes should be considered first is a point which is entirely academic in the circumstances of this case. Loyal to the Defendant's direction, the jury must be deemed to have considered it first, but they went on to deliver a narrative conclusion.

68. The iteration of Ground 1 that Mr Littlefair developed orally raises a rather different point. It is correct that the jury were not directed to consider the possibility of accidental death, on the basis that the incorrect insertion of the I-gel materially hastened a death that was inevitable. The issue which arises is whether this omission raises a point of law.

69. The jury's conclusion does address the potential causative potency of the incorrect insertion of the I-gel, but in a somewhat unfocussed way. The jury were given a direction as to the meaning of "natural causes" which was not incorrect, but in

circumstances where the jury were not given any other option a conclusion of natural causes was inevitable.

70. That having been said, Mr Littlefair's submissions about the I-gel had an air of unreality about them. The probabilities are that Ms Henshaw had suffered her cardiac arrest before the I-gel was inserted. Her chances of survival outside a hospital setting were below 50%. Subject to Mr Littlefair's Ground 2, Ms Henshaw's cardiac arrest could have been sustained at any time between 8:10am and 8:40am, with her chances of survival rapidly decreasing – from a datum point already below 50% - the further one moved backwards in time from 8:40am. The sad reality of this case is that the incorrect insertion of the I-gel may well have hastened Ms Henshaw's inevitable death, but it would defy common sense to conclude that this could have been by more than very few minutes. She was, of course, already deeply unconscious at the time of insertion.

71. On these premises, a conclusion of accidental death was simply not realistic in this case, and the Defendant was right not to leave it for the jury to consider. It therefore did not matter that the jury were directed to consider natural causes first: it was the only rational conclusion the jury could have reached. In the overall scheme of things, the incorrect insertion of the I-gel had no more than a *de minimis* impact: the case fell into Kay J's first scenario. Put another way, it would not be right for me to quash the Record of Inquest in this case to reflect the extremely low chance that a different coroner might direct the jury differently and the equally low chance that the jury might reach a conclusion of accidental death.

72. I am also completely unpersuaded that the issue of Male Officer #1's check on Ms Henshaw should have been left to the jury on some basis. As I said in oral argument, it is unthinkable that Male Officer #1 saw Ms Henshaw in a collapsed state at 8:25am, knew that she was unconscious, and did nothing. We know that he responded immediately to her desperately ill condition at 8:40am. On the other hand, Male Officer #1's claim to have no recollection of the 8:25am check is unconvincing. The events of that morning must have been, and no doubt still are, etched on his memory. For him, these events did not begin at 8:40am. The reality of the matter is that either Male Officer #1 did not check on Ms Henshaw at all or that he did cast an eye towards her and believed her to be asleep. On all possible scenarios, it is surprising that Male Officer #1 did not attempt to rouse Ms Henshaw at 8:25am, but the fact remains that he did not.

73. I accept that, had the matter been left to the jury, they might well have concluded that the check that he carried out was inadequate. However, I cannot accept the submission that this would or could have had any material impact on the issue of causation in this case. If, *ex hypothesi*, the check were inadequate, what an adequate check would or might have revealed is purely speculative. In these circumstances, it simply cannot be said with any conviction that Male Officer ir#1's oversight, if that is what it was, was even possibly causative. Further, if Male Officer #1 did check Ms Henshaw (in the sense that he cast an eye in her direction) and believed that she was still asleep, the correctness of that belief cannot be tested evidentially. The alternatives are that she was asleep or that she may have appeared to be asleep, but was in fact already in cardiac arrest. Put another way, it would not be appropriate for the Record of Inquest to be quashed and a fresh inquest be held simply for this matter

to be considered by a jury (either in its own right, or in conjunction with the I-gel issue).

74. By contrast, what I am calling the second limb of Ground 2 has greater force, at least in terms of the admitted failings. Assuming for present purposes that the GP summary should have contained a reference to the June 2017 warning, it is unclear on the evidence what would have happened in the prison. We know that an ECG should have been carried out in July 2017 (and therefore for present purposes it is right to proceed on the basis that one would have carried out), but its results and their interpretation are unknowable. Whether Ms Henshaw's anti-psychotic medication would and/or should have been restarted can only be a matter of complete speculation. There is no evidence either way. We also know that an ECG should have been carried out in May 2018 and that omission has been admitted by the prison. The causative potency of that omission is uncertain on the available evidence. I interpret Professor Suvarna as telling the jury that it is possible that Ms Henshaw had long QT syndrome and that it may have had a contributory role to play in the onset of her sudden cardiac arrythmia. The premise of his expert opinion was not spelt out, but it may have been that the 484 reading or something close to it would have been replicated, and that it was not an artefact. Mr Kirby, and probably Professor Rutty, were of a different view. Of course, if an ECG had been carried out in May 2018 and its results were available, the experts' views may have shifted in light of what these results actually were. Mr Littlefair submitted that the prison's admitted failings have denied the Claimant the possibility of investigating that possibility. The difficulty with that submission is that the evidential lacuna that existed in 2023 at the time of the Inquest will never be filled. The present evidential uncertainty will always remain.

75. There is force in Mr Littlefair's submission that the present case may be brought within the principle of *Tainton*: that is to say, of an admitted failing which may have had a causative impact. That is the very best interpretation of the evidence from the Claimant's perspective, but it is at least a tenable interpretation. It is clear from the Defendant's second witness statement that she did not believe that she had a discretion in the matter. Her reasoning appears to have been that, given that the pathology excluded long QT syndrome on the balance of probabilities, the jury's consideration of the issue should be precluded. In my judgment, that was too narrow an approach and amounted to an unlawful fettering of her discretion. Possible causes, particularly in the context of admitted failings, are potentially within the ambit of an Article 2-compliant Inquest.

76. Be that as it may, I am not satisfied on the basis of my findings that the Record of Inquest should be quashed and a fresh inquest be held. That would be as disproportionate as it is unnecessary. This judgment sets out the position very fully and declaratory relief will be ordered. I would refuse any further relief, in particular a quashing order, in circumstances where no reasonable jury could reach more favourable conclusions from the Claimant's perspective than I have done. The evidential gaps will never be filled and speculation is impermissible.

77. Ground 3 does not materially add to Ground 2. There is some force in Mr Littlefair's submission that the Defendant ought to have directed that a relevant GP witness be called for the matter to be investigated properly. In my judgment, for the same reason that I have already given in the context of Ground 2, the Defendant's approach amounted to a fetter of her discretion. However, the Defendant, lawfully directing

herself on the relevant law, could properly have decided that a GP witness was unlikely to assist so many years after the events in question. In any event, I have a discretion as to whether to quash the Record of Inquest to enable this point to be investigated properly, and in my judgment it would be both disproportionate and unnecessary to follow such a course. In reaching that conclusion I take into account: (1) the unlikelihood of anything concrete emerging from the GP practice at this distance in time, (2) in the absence of any evidence from the practice either way (effectively the current position), the reasonably solid inference that there was a breakdown in communication or of systems somewhere along the line, and (3) the lack of causative potency of this omission or series of omissions. As I have already explained, the case on causation is stronger in relation to May 2018 because less speculation is required and Professor Suvarna has expressed an expert opinion. The Claimant now has the benefit of this public judgment which should be read in conjunction with the jury's conclusion. Paragraph 83 of *Tainton* is on point.

DISPOSAL

78. I have identified errors in the Defendant's legal directions to the jury, being errors more of omission that commission. Many of those errors lead down an alleyway of speculation, but I have highlighted the error that should formally be part of the Order in this case as well as her erroneous approach to not calling a GP witness. The parties should draw up a form of Order which contains declaratory relief in the following terms:

> "1. the Defendant erred in failing to direct the jury that they should consider whether to include in any narrative conclusion whether the prison healthcare's admitted failure to arrange an ECG of Ms Henshaw in May 2018 was a possible causative or contributory factor in the onset of her sudden cardiac arrythmia leading to her death.
>
> 2. the Defendant fettered her discretion and therefore acted unlawfully when deciding whether to call a witness from Ms Henshaw's GP practice in the community to explain why the GP summary sent to the prison on 10 July 2017 contained no reference to the warning not to prescribe anti-psychotic drugs without a psychiatric review."

79. But, for the reasons I have given, I am refusing the Claimant's application for a quashing order. It follows that there will not be a fresh Inquest.