Neutral Citation Number: [2025] EWHC 935 (Admin)

Case No: AC-2024-LON-000417

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 15 April 2025

Before :

LADY JUSTICE WHIPPLE
and
MR JUSTICE GOOSE

- -

Between :

Shaun Morrow — **Claimant**

- and -

HM Assistant Coroner for Merseyside (Sefton, Knowsley and St Helen's) — **Defendant**

-and-

Mersey Care NHS Foundation Trust — **Interested Party**

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Shawn Morrow (appeared in person) for the **Claimant**
David Illingworth (instructed by Sefton Council) for the **Defendant**

Hearing date: 3 April 2025

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Approved Judgment

This judgment was handed down remotely at 10.30am on 15 April 2025 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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Lady Justice Whipple:

Introduction

1. The Claimant seeks an order for a fresh inquest into the death of his sister, Ms Zoe Morrow. The Claimant proceeds with the Attorney-General's fiat dated 20 November 2023.

2. Zoe was found dead on the floor of her bedroom on 12 April 2021. Medication was found in her pockets, an empty daily medication container was found on the bed, a number of empty blister packs were in the waste bin in the bedroom and a quantity of prescription medication was found in her living room. A post-mortem examination and toxicology analysis indicated the presence of multiple drugs in her blood at the time of death. Those drugs were at fatal levels and, taken together, they are known to have overlapping adverse effects. Zoe was 41 years old when she died.

3. Prior to her death, Zoe had been under the care of Mersey Care NHS Foundation Trust, named as the Interested Party. Following her death, the Trust undertook a rapid review (the "72 hour review"). It then conducted a root cause analysis which was finalised on 15 March 2022 (the "comprehensive review"). The Trust identified a number of gaps, shortcomings and missed opportunities in the care provided to Zoe. But the Trust concluded that none of these identified gaps, shortcomings or missed opportunities caused or contributed to Zoe's death.

4. An inquest into Zoe's death was held on 31 March 2022, presided over by Mr Graham Jackson, Assistant Coroner (the "Coroner"). The Coroner concluded that the cause of death was "1A Mixed Drug Toxicity".

5. The Claimant is Mr Shaun Morrow, Zoe's brother. He is not legally represented. He was supported at the hearing by other family members, including Zoe's other brother, Keith, and Zoe's mother, Jane. I would like to pay tribute to this family. They hold Zoe's memory close to their hearts. They have pursued this application because they want to ensure that Zoe's death was not in vain and that the Trust learns appropriate lessons from what happened. They have presented their case clearly and persuasively, and I am grateful to them for the attention they have given to this case.

6. The Coroner appears by counsel, Mr David Illingworth, who takes a neutral stance on this application. The Trust did not appear and has played no part in this application.

Legal Framework

7. The legal framework is not disputed. The application is made under section 13 of the Coroners Act 1988. It provides:

> "**Order to hold investigation**
>
> (1) This section applies where, on an application by or under the authority of the Attorney-General, the High Court is satisfied as respects a coroner ("the coroner concerned") either -

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

8. Where problems of process are relied on, a fresh inquest will only be required where those problems meant that justice was diverted or the inquiry was insufficient (*HM Attorney General v HM Coroner of South Yorkshire (West)* [2012] EWHC 3783 (Admin) at para 10).

9. Section 10(2) of the Coroners and Justice Act 2009 prohibits coroners from determining any question of civil or criminal liability. Beyond that limitation, coroners have a wide discretion to determine the scope of an inquest. Chapter 7 of the Coroners' Bench Book (which was in the bundle of authorities for this hearing) provides a helpful summary of the law.

Claimant's Challenge

10. The Claimant advances 9 grounds for seeking a fresh inquest in his Claim Form. Those grounds are supplemented by 23 numbered paragraphs set out in a document headed "Particulars of Claim" which is itself helpfully supplemented by the Claimant's skeleton received on 2 April 2025. The Claimant has also submitted extensive written evidence, from him and members of his family and Zoe's friends, to support this application.

11. The Claimant and his family are of the view that Zoe's mental health was not properly managed by the Interested Party and that failures by the Interested Party contributed to her death. The Claimant asks this Court to order a fresh inquest to address the various points which he says were overlooked by the Coroner, to put right the various

procedural failings at the first inquest and to offer him and his family the opportunity to argue for a conclusion of suicide.

12. The Coroner has responded to the claim with two witness statements. The first is dated 1 February 2024, setting out the Coroner's answers to the various challenges by the Claimant, and attaching the transcript of the inquest as an exhibit. The second is dated 10 March 2025 and although the Claimant objected to the Court seeing it (because it was served late), I have decided that the Court should admit it because the statement itself is short and factual, and its exhibit includes information which is helpful to the Court on some of the points of detail raised by the Claimant. The Claimant has had sufficient time to consider the contents of it and is not prejudiced by its admission.

The Inquest

13. The inquest took place on 31 March 2022. The Coroner explained that its purpose was to find out who had died, how, when and where that person had died. He described it as a "very limited inquiry into the circumstances". He said that two witnesses would give evidence in person, his own officer Mr James Martindale, and Ms Claire Dougherty of the Trust who was appearing remotely on a Teams link. He said that the remainder of the evidence would be read. The Claimant questioned the Coroner's decision not to call the two witnesses from the Trust's mental health team who had treated Zoe (namely, Ms Kate McGlue and Dr Feroz Abdoola), but the Coroner confirmed his decision and said that only Ms Dougherty from the Trust would give evidence in person.

14. Mr Martindale was called first and he provided information he had gathered about the circumstances of Zoe's death. Amongst other things, he recorded information obtained from Zoe's mother Jane, to the effect that Zoe had suffered with mental health problems for a number of years, she was bipolar and suffered from depression and anxiety and she had twice this year attempted suicide including taking an overdose three to four weeks before she died. Mr Martindale noted that no suicide note was found with Zoe's body, that Zoe had made a number of attempts on her life, including recently, and that it was believed that she had taken an overdose on medication. The Coroner then read a number of statements from witnesses who were not called: he read the police statements from Jane Morrow (Zoe's mother) and Frances Finney (Zoe's aunt, who found Zoe's body). Those statements had been taken by the police very shortly after Zoe's death. He read the statement of Det Sgt Mark Lawrenson who summarised the evidence of the police officers who had attended when the body was discovered. He read out the diagnosis of death report by the paramedics who attended. He read the witness statements of Ms McGlue, a mental health nurse with the Trust, and Dr Abdoola, a locum consultant psychiatrist with the Trust, both of whom had been involved in aspects of Zoe's care. He read the post-mortem report by Dr Rose, pathologist, who said that toxicology tests showed elevated alcohol levels and significantly elevated levels of gabapentin, hydroxyzine and chloraphenamine in Zoe's system and recorded his view was that the likely cause of death was the consequence of mixed drug toxicity.

15. Ms Dougherty was called to give evidence for the Trust. Ms Dougherty is the Quality Matron for the Mental Health Urgent Care Services. She had only worked for the Trust for a short time and had no personal knowledge of Zoe. She gave evidence about the comprehensive review (including its action plan and learning statement). She had

provided a witness statement but that was only available on the morning of the inquest. The Coroner registered his dissatisfaction with the late provision of her witness statement and asked Ms Wheeler, counsel for the Trust, to pass on his concerns to those instructing her. The Coroner asked Ms Dougherty some questions. Her answers included the following points: she did not think that Zoe should have been sectioned under the Mental Health Act 1983 in the months before her death because although she was expressing suicidal thoughts to her treating medics, she had no active plans and expressed no intent during her assessments and treatment in the community was appropriate; there had been no contact between Zoe and the mental health team between 26 February and 9 March 2021 due to a breakdown in communication; on 10 March 2021 Zoe had requested an appointment with a psychiatrist which took place on 16 March 2021; a further appointment with the psychiatrist was booked for 6 April 2021 but Zoe did not attend that appointment; efforts to contact Zoe about that missed appointment failed (due to her mobile phone not accepting calls from a "number withheld" caller); another appointment was scheduled for 12 April 2021 but she failed to attend that appointment. When Zoe failed to appear on 12 April 2021, the Trust contacted Zoe's next of kin which led to the discovery of her body by her aunt later that day. The Trust had changed its processes in light of Zoe's death as reflected in the learning issues document. She said that the offer of a meeting with the family remained open.

16. The Claimant asked Ms Dougherty questions. At times, other family members interjected and at some points the Coroner stopped the Claimant's line of questioning.

17. The Coroner invited Ms Wheeler, the Trust's legal representative, to make submissions on the law. Then the Coroner summed up the evidence, found the facts and stated his conclusion that Zoe's death had been drug-related. He rejected the conclusion of suicide: although he was satisfied on balance of probabilities that Zoe had consumed the drugs and alcohol deliberately, he was not satisfied on balance of probabilities that she had intended to take her own life, which is one of the necessary ingredients for a conclusion of suicide. He rejected accident or misadventure, because he could not know if she mistakenly consumed that quantity of drugs. He reached the conclusion that this was a drug-related death because the quantity of drugs within her system was the only thing which caused her death.

18. The Coroner offered his condolences to Zoe's family and encouraged them to speak to her treating healthcare professionals if they still had concerns about the care and treatment she received, indicating that those concerns lay outside the scope of the inquest. The Claimant said that the Coroner's decision would "make it very difficult for the family to take it further with the Mental Health Team" and suggested the Coroner was "in cahoots" with the Trust. The inquest concluded.

Key issues raised by the Claimant

19. I hope the Claimant and his family will not mind if I rearrange their case a bit, to explain what I think are their key complaints. In my view, there are two: the first is that the Coroner did not allow the family to give evidence, or question witnesses, about Zoe's treatment by the Trust in the months leading up to her death; the second is that the Coroner did not properly consider whether Zoe's death was a suicide. Those issues are connected but it is easier to look at each separately.

First key issue: overlooked evidence of treatment failures

20. The answer to the first complaint must start with a clear understanding of the scope of this inquest. The Coroner told the family that the purpose of the inquest was "quite simple", it was to "do no more than find out who has died, how, when and where that person died" and that this was "a very limited inquiry into the circumstances". When challenged by the Claimant about his decision not to call the Trust witnesses who had treated Zoe before she died, he said:

> "In my opinion, because of the treatments and the intervention they afforded, that is background information relating to her condition and therefore I did not intend to bring those practitioners to court to read their statements when I can properly do that…." [internal p 3, timing 00.60].

21. Later on, he said that there were often things that families wanted to ask at inquests but sadly that was not possible and that these things had to be taken up outside the inquest, because his statutory function was "very limited. Who has died, how, when and where."

22. It is clear that the Coroner decided to limit the scope of this inquest to the circumstances immediately surrounding Zoe's death – namely, how she came to be found dead on the floor of her bedroom on 12 April 2021. He was not going to investigate whether there had been failings in Zoe's care by the Trust, or look at whether any such failings might have contributed to Zoe's death.

23. The Claimant is dissatisfied with the Coroner's decision to draw the inquest narrowly, and to answer the question about "how" she died question by reference only to the physical cause of death, rather than the circumstances which might have led up to that point. However, as a matter of law, the Coroner was entitled to narrow the scope of the inquest in that way. Indeed, most coroners would, I believe, have made a similar decision in these circumstances. The Coroner would have been concerned not to stray into an investigation into issues of civil liability which would breach the prohibition in section 10(2) of the 2009 Act.

24. The Claimant questioned why, if the Coroner had decided that the scope of this inquest was so narrow, he had called Ms Dougherty given that she was coming to speak about the comprehensive review, which was undertaken by the Trust in part to identify any shortcomings in the care afforded to Zoe. Mr Illingworth, who appeared for the Coroner, said that Ms Dougherty's evidence was relevant to the question whether the Coroner should make a Prevention of Future Deaths report following this inquest; but that, in any event, the Coroner has a discretion to call whoever he wants to, and if he wanted to call a witness from the Trust to speak about the comprehensive review, that was a matter for him and it does not serve to enlarge the scope of the inquest beyond the boundaries set by the Coroner. I agree with Mr Illingworth on this point.

25. In summary, the Coroner was entitled to decide that issues relating to Zoe's treatment by the Trust in the months before she died were outside the scope of the inquest and formed part of the background facts only. That meant that witnesses from the Trust who had treated Zoe did not need to be called to give evidence in person (and face questions), because their evidence would not assist the Coroner in answering the "how" question in the narrow way he was approaching it. This was a proper and lawful exercise of the Coroner's discretion.

Second key issue: failure properly to consider a suicide verdict

26. The second complaint is that the Coroner did not properly consider a suicide conclusion, in large part because he failed to take any or sufficient account of the evidence that supported suicide.

27. The Coroner stopped the Claimant's questioning of Ms Dougherty when the Claimant suggested that Zoe had been actively planning suicide. The Coroner said there was "no evidence" before him that Zoe was actively trying to commit suicide and that "suicide is not something I am considering" (p 32 of transcript, line 01:57:30). In his self-directions on the law, the Coroner noted that suicide required not only a deliberate act but also an intention that the consequences of that act would be death. He was satisfied on balance of probability that Zoe had taken the drugs deliberately, but could not be satisfied on balance of probability that she had intended to take her own life when she did so. The Coroner referred to the Trust's evidence that Zoe could be cared for in the community and that despite that fact that there were indications she might self-harm and even had suicidal thoughts, there was no "clear indication" that she intended to take her own life (page 40 of the transcript, line 02:22:30); elsewhere he had noted that no suicide note was found.

28. The central dispute appears to be whether Zoe was, or was not, actively planning suicide in the months before her death, on balance of probability. Active planning is different from merely considering suicide. The Claimant and family say that she was actively planning her own death. Zoe's mother Jane had seen Zoe in a poor state in the weeks before she died and had heard her threaten to take her own life and succeed this time around. Zoe had made multiple previous attempts, some entered on her calendar, and had written at least one suicide note previously. She had consumed a very large amount of drugs and drank alcohol which was unusual for her. She had asked others to care for her animals (cats and tortoises). The family takes the view that this evidence all points one way.

29. However, the Coroner had other evidence which pointed in the other direction. The circumstances in which Zoe's body was found revealed no suicide note, which carries some significance although it is obviously not determinative either way. The Trust's evidence was that Zoe had been assessed as safe for care in the community and she did not require sectioning for her own protection; her treating clinicians did not think that Zoe was planning to kill herself, although they accepted that she had suicidal ideation and had made attempts (which had not succeeded) in the past. Their view does not accord with the family's view.

30. The Coroner was not in a position to resolve the dispute about whether Zoe was planning to end her life in the months and weeks running up to her death, because that dispute (and the evidence about it) lay outside the narrow scope of this inquest.

31. I think it was reasonable, taking account of all the evidence before him, for the Coroner to conclude that Zoe's death was drug-related. That conclusion was factually correct, because her death clearly was attributable to the quantity of drugs she had consumed. He was justified in not going further (to a suicide conclusion) because, taking all the evidence into account, he was not persuaded, on balance of probability, that she intended to kill herself. That was a rational and lawful position to take.

32. It is important to record that the Coroner did have before him the evidence of Zoe's previous suicide attempts in the recent past (from the evidence of Mr Martindale) and he knew the volume of drugs and alcohol in her blood (from the post-mortem and toxicology report). So he was aware in general terms of the points the family wished to make. There were other aspects which the family would have wished to underline if they had been called to give evidence, for example, Zoe's very low mood and disillusionment with her health care team as expressed to her mother in the weeks before her death and the fact that Zoe had marked her earlier suicide attempts in writing in her calendar and in at least one note. But I doubt that further evidence would have changed the Coroner's conclusion, because there would still have been evidence, circumstantial and from the Trust, which pulled in the other direction.

33. It follows that I am not persuaded that either key complaint advanced by the family lies on solid ground as a matter of law. I accept, of course, that the Claimant and Zoe's family members are very sure, in their own minds, that she took her own life intending to end it, in part because of the failings they identify in the care provided by the Trust.

Claimant's Grounds

34. I turn then to consider the Claimant's grounds. Mr Illingworth helpfully gathers them together under six headings in his skeleton, and I will adopt that presentation.

Grounds 1 and 2: family prevented from speaking or giving evidence

35. By these grounds, the Claimant complains that family members and friends were denied the opportunity to speak or give evidence at the inquest. The Coroner, by Mr Illingworth, responds that family members, by the Claimant in the main, did speak at the inquest and none of them ever asked to give evidence orally.

36. In the course of discussing these grounds at the hearing, it became apparent that the family may not have received a communication intended for them on 14 March 2022, telling them that Mr Martindale and Ms Dougherty would give evidence in person, and a number of other witness statements would be read (including the police statements of Zoe's mother Jane and Zoe's aunt Frances). In his first witness statement, the Coroner suggests that this communication dated 14 March 2022 was sent to the family (represented by the Claimant) (para 20) but the Claimant says he never received that information, and on checking the correspondence disclosed for this application, I have been unable to locate an email or letter of that date to the Claimant containing that information. This may explain why the family were surprised that they were not invited to give evidence at the inquest. It may also explain why the family never raised with the Coroner, in advance of the inquest, their desire to give evidence about Zoe's last weeks and days.

37. There is a further point of confusion which surfaced during the Court hearing. It had been suggested by Mr Illingworth that the family had instructed a lawyer in preparation for the inquest; in fact, they had not, and they were unrepresented in preparing for and attending the inquest. The Claimant told the Court that references in the papers to Zoe's brother consulting a lawyer related to an action arising out of an incident involving Zoe before she died and had nothing at all to do with the inquest. I can see that point was clearly noted in the email correspondence between the Coroner's officer and the family.

It is unclear whether this was a misunderstanding at the time of the inquest or whether it has crept in since.

38. Accepting that there may have been some administrative oversights in the run up to the inquest, the Coroner was, as I have already said, entitled to call Mr Martindale and Ms Dougherty in person and read the other relevant witness statements (permitted by Rule 23 of the Coroner's (Inquests) Rules 2013 (2013/1616)). The family were allowed to question both witnesses. The Coroner was entitled to prevent questions being put which he considered inappropriate or irrelevant, including questions on matters outside the scope of the inquest. I can see no public law error in the way the Coroner handled this inquest.

39. It is easy to be wise with hindsight, but having the benefit of the Claimant's submissions on this application, and noting the family's frustration at the limited nature of the inquest, I think it might have been helpful for the Coroner to have taken the opportunity, at the beginning of the inquest, to explain why his inquiry was limited to looking at how Zoe died, in the narrow sense of identifying the immediate cause of death, and to check that the family understood the process and had received the relevant correspondence and papers; and at the end of the inquest to check that the family understood the conclusion reached and why suicide was rejected.

Ground 3: relevant evidence overlooked

40. The Claimant suggests that aspects of the toxicology evidence were overlooked, namely the part relating to alcohol. However, there was a reference to the amount of alcohol Zoe had consumed within the toxicology report and the Coroner was aware of it.

41. The Claimant also suggests that evidence from other family members would have assisted the Coroner and might have opened the possibility of a conclusion of suicide. However, in light of the Coroner's decision on the scope of this inquest (as to which, see above) and the fact that there was conflicting evidence on Zoe's mental state in the months and weeks before death, it is highly likely that the Coroner would still have decided this was a drug-related death (not a suicide), even if additional evidence from family members was given.

42. I record here in summary the evidence the family wanted to adduce: evidence from Zoe's mother about her mental state and her expressed intention to kill herself; evidence from Zoe's brother that he had found a suicide note 12-18 months earlier; evidence from Zoe's calendar found after her death noting the dates when she had attempted to take her life; and evidence about Zoe's frustrations at her changed diagnosis, introducing a suggested personality disorder, leading to the prescription of multiple drugs in combination.

Grounds 4 and 8: alleged collusion between the Defendant and the Trust

43. The Claimant suggests that there was collusion between the Coroner and the Trust. Specifically, he suggests that the Coroner reached the conclusion that he did to protect the Trust against a finding of suicide. However, I have read all the correspondence and I see no evidence of collusion. I have read the transcript of the hearing carefully and I am satisfied that the Coroner's conclusion reflects his own judgment, based on the evidence before him. I have already explained my view that such a conclusion was

rational and permissible. That conclusion does not exclude the possibility that Zoe took her own life, and it does not exonerate the Trust if matters were to proceed, for example, by way of civil proceedings (which I would not encourage, and which the family told the Court they do not intend). All it means is that as things stood before the Coroner, he thought it was probable that Zoe had died from an excessive intake of drugs and that was as far as he could go. There is no evidence of any collusion or similar irregularity.

Grounds 5 and 7: Trust's witness evidence read

44. The Trust prepared statements from Ms McGlue and Dr Abdoola. Both were members of the Trust's mental health team and had been involved in Zoe's care. As discussed above, it appears that the family were not aware in advance of the inquest that the Coroner intended to read these statements. But the decision to read those statements, surprising and unwelcome as it may have been to the family, was consistent with the Coroner's decision on the limited scope of this inquest and was a decision the Coroner was entitled to make.

45. The Defendant had arranged for Ms Dougherty to attend in person in order to answer questions about the findings in the comprehensive review. Looking at the pre-inquest correspondence, I can see why the Coroner thought that the family would view her as a helpful witness, because the family wanted to challenge the findings in the comprehensive review. In the event, it seems the family may not have found Ms Dougherty particularly helpful, possibly because she did not answer the questions put to her in the way the family would have preferred. But there was nothing objectionable about the Coroner's decision to call Ms Dougherty as the sole "live" witness from the Trust.

Ground 6: late addition of evidence from Ms Dougherty

46. Ms Dougherty's witness statement was only provided to the family very shortly before the inquest started. That is very regrettable, especially for a family that lacked legal representation. But it was not the Coroner's fault, rather the late service was the product of delays at the Trust. The Coroner decided to proceed with the inquest anyway, which was a case management decision for him. I am satisfied that the Coroner was right to carry on: the family had received the comprehensive review two weeks earlier and had had plenty of time to consider it; the purpose of Ms Dougherty's statement was to summarise some key points arising out of that comprehensive review rather than to bring in new points which were not already discussed in the review; this inquest was scheduled to last a day and time was already set aside for it; Zoe had died around a year earlier and it was important for the inquest to take place as soon as possible. The interests of justice clearly lay in favour of proceeding with the inquest, rather than adjourning to another date.

Ground 9: lack of guidance on inquest procedure

47. The Claimant and his family complain that they had insufficient guidance on the inquest process. This is answered by Mr Illingworth who points to multiple communications between the Coroner's officers and the Claimant prior to the inquest, including an email dated 19 April 2021 when the coroner's officer (Victoria Rubbery) notes that she has spoken to the Claimant and "explained process" and an email from her to the Claimant dated 4 January 2022 enclosing a link to the "Short Guide to Coroners' Services and

Coroner Investigations" (published 4 January 2022) which offers families guidance on the process. The Claimant denied having received the email with the enclosed link to the Guide, even though he received and sent other emails at around the same time on the same email address.

48. The family were expecting the Family Liaison Officer from the Trust (Kate Bond) to be present at the inquest but she did not attend. It appears that Ms Bond subsequently told the family that the Trust had said she should not attend. However, Ms Bond's absence does not make the inquest unfair or unlawful.

49. The Claimant and his family found themselves in the same position as many families at an inquest into the death of a loved one, navigating the process without legal assistance. Having read the pre-inquest correspondence, I am satisfied that the Coroner's officers made reasonable efforts to help the family understand the process. I am also confident that the Claimant, who is articulate and capable, was able to put his points across clearly.

Conclusion

50. There appears to have been a mismatch between the family's expectations of what they could achieve at this inquest and the reality of the Coroner's investigation which was much more limited in its scope.

51. I am not persuaded that there is any reason to quash the Coroner's conclusion and substitute suicide. The evidence for suicide is not clear-cut and drug-related death was a rational conclusion. I am not persuaded that it is necessary or desirable in the interests of justice for a fresh inquest to be ordered. I have not identified any substantial defect in the first inquest and I am satisfied that the inquiry which took place was sufficient as a matter of law. I would refuse this application.

52. It remains open to the Claimant and his family to meet representatives of the Trust to discuss Zoe's treatment in the months leading to her death.

Mr Justice Goose:

53. I agree.