Neutral Citation Number: [2025] EWHC 2131 (Admin)

Case No: AC-2024-LON-002499

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 12/08/2025

Before :
Mr Justice Dexter Dias

- -

Between:

THE KING
(ON THE APPLICATION OF FATHEYA ALI)

Claimant

-v-

HM ASSISTANT CORONER FOR INNER NORTH LONDON

Defendant

and

EAST LONDON NHS FOUNDATION TRUST

First Interested Party

and
HOMERTON HEALTHCARE NHS FOUNDATION TRUST

Second Interested Party

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Thalia Maragh (instructed by **Bhatt Murphy, Solicitors**) for the **Claimant**

Hearing dates: 5 August 2025
(*Judgment circulated in draft: 7 August 2025*)
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JUDGMENT

Remote hand-down: this judgment was handed down remotely at 10.30am on Tuesday 12 August 2025 by circulation to the parties or their representatives by e-mail and release to the National Archives.

Mr Justice Dexter Dias :

Introduction

1. This is a renewed application for permission to proceed in an application for judicial review. Permission was refused by Turner J on 8 May 2025. The core challenge is to the coroner's ruling dated 25 April 2024 that article 2 of the European Convention on Human Rights is not engaged.

2. The claimant is the sister of Mahamoud Ali ("M") who was born on 4 June 1980 and died on 26 August 2020. He went into cardiac arrest on 21 August 2020 in Lea Ward at Mile End Hospital, where he was an involuntary inpatient having been sectioned under section 2 of the Mental Health Act 1983 ("MHA 1983"). The claimant is represented by Ms Maragh of counsel.

3. The defendant is HM Assistant Coroner for Inner North London. The first interested party is the East London NHS Foundation Trust ("the Trust"). The second interested party is the Homerton Healthcare NHS Foundation Trust. The defendant's stance in the application is neutral as confirmed in her acknowledgement of service and in a subsequent confirmatory note. Her stance accords with that envisaged by Brooke LJ in *R (Davies) v HM Deputy Coroner for Birmingham* [2004] EWCA Civ 207, at paras 47-49. The interested persons indicated that they did not intend to attend nor make submissions, and they did not.

4. Given the importance of the case to those involved and the seriousness of the issues, I reserved judgment on permission for a short time to reflect on the submissions and review all the materials, rather than giving an ex tempore judgment in a busy list.

Facts

5. I take the facts from the Summary of Facts and Grounds ("SFG") and pay tribute to the claimant's legal team for the carefully crafted document.

6. On 14 January 2020, M was admitted to the Emergency Department of Royal London Hospital after he lost consciousness and collapsed in the street. The cause of the fall was never diagnosed and M was discharged from the hospital after a CT scan showed no intracranial pathology or haemorrhage.

7. On 19 August 2020, at approximately 06:56, M had another fall in the street following a loss of consciousness in similar circumstances to the incident on 14 January 2020. The London Ambulance Service ("LAS") records note that M had potentially suffered an alcohol withdrawal seizure. At approximately 07:55, M was admitted to the Accident and Emergency department at Homerton Hospital. He gave a history of walking back from the shops, his legs feeling shaky and blacking out. At 08:55, following a consultation with Dr Champion and then Dr Radford, M had a CT scan which indicated no intracranial haemorrhage. He was noted to have a large midline parietooccipital scalp haematoma which required cleaning only. It was noted in the records that this fall was likely "ETOH withdrawal seizure", that is ethanol (alcohol) withdrawal seizure.

8. At 09:37, M was discharged and left Homerton Hospital. At 10:19, paramedics attended M for a second time that day following a call from a member of the public who witnessed M fall again in the street. At 10:55, M was taken back to Homerton Hospital by LAS. M was noted to have been drinking: he was holding a can of open beer and was confused and unsteady on his feet. It was noted by Dr Radford that the wound on the back of his head was "now bleeding heavily" and required suturing. A further CT scan was conducted and it was reported by Dr Boavida that "comparison is made with the CT of 0855 19/08/2020. No interval change in the appearances. No intracranial haemorrhage."

9. M stayed in hospital overnight for observation, but on the morning of 20 August 2020, he absconded and went to his sister's house in his hospital gown. He was referred for psychiatric assessment. At 14:59, Dr Chloe Beale recommended that M be detained under the MHA 1983 following her assessment. Dr Beale stated in evidence that M was suffering from alcohol withdrawal symptoms at the time of this assessment and that she was concerned about this.

10. At 15:40, Dr Keyhani and Michael Jeggo conducted a second assessment of M and at 16:20, Dr Keyhani recommended he be detained under section 2 of the MHA 1983. Arrangements were made for his involuntary admission to Mile End Hospital which falls under the Trust. A copy of the discharge summary from Homerton Hospital, stated that the cause of M's fall was "likely ETOH withdrawal seizure."

11. At Homerton, there was a partially conducted CIWA (alcohol withdrawal assessment tool) which resulted in a score of 26. The recognised weighting of this score suggests that M was in severe withdrawal. Dr Felinski's evidence was that a symptom or consequence of severe alcohol withdrawal could be seizures. Ms Olawale confirmed in her evidence that had M been able to engage fully with this assessment, his CIWA score could have been higher.

12. During the day, there was increasing concern about M's condition. Eventually, at 19:22 M was taken by ambulance to Royal London Hospital, arriving at 19:57. A CT scan performed at Royal London Hospital at 20:19. It showed that M had suffered an acute subdural haematoma, small volume subarachnoid and intraventricular haemorrhage. It was also noted that the haematoma at the back of M's head had expanded. Doctors concluded that M had suffered a brain injury that could not be survived.

13. On 26 August 2020, at 17:27, a formal brain stem test confirmed that M had suffered hypoxic ischemic encephalopathy resulting in an irreversible loss of brain stem function. His time of death was recorded as 17:27 on 26 August 2020.

Submissions

14. Four key factors are relied on by the claimant in respect of risk to life:

    (1) First, it was known to the Trust that M had fallen twice on 19 August between 36-48 hours prior to his admission to Mile End Hospital for psychiatric assessment. The likely cause of the falls was alcohol withdrawal seizure. In these falls he sustained head injuries. These injuries included a haematoma and a wound to the back of his head;

(2) Homerton instructed its staff to monitor him "closely" for signs of alcohol withdrawal.
(3) On 21 August 2020, the incomplete CIWA indicated that he was in severe alcohol withdrawal;
(4) Trust staff appreciated that one of the possible consequences of alcohol withdrawal is seizures.

15. In oral argument, Ms Maragh presented the court with a comprehensive factual history, commendably grounded in her command of detail. The essence of the submission is that one must combine the recent history of falling on 19 August with M's presentation of obviously being unwell due to his mental health. For example, he absconded from the hospital with a canula in his hand and dressed in a hospital gown. When he was involuntarily detained, he was sedated and observed to be awake all night. He was monitored every 15 minutes as a new patient. At 14:00 the next day, he was noted to have changed a position with his trousers down and being incontinent of urine. This is said to be "indicative of the possibility of a fall". It is submitted that the change of position provides some evidence of another fall. Sarah Thompson (lead nurse on Lea Ward) attended at 17:45 and saw him lying on the floor and non-responsive. He appeared to be bleeding to the back of the head. It is submitted that this suggests that somewhere between 14:00 and 18:00 he sustained another blow to the head from a fall. Evidence given at the inquest was to the effect that the haemorrhaging seen on 23 August was likely to have been caused by a fall after involuntary admission. Professor Thom's evidence was that the most common cause of a subdural haemorrhage was a fall or a head injury. Thus on the evidence, the injury to his head was sustained while he was under the management and care of the Trust. M was a vulnerable person. Had he had been properly observed and monitored, it is likely he would have been safeguarded against a fall. This is the harm that likely led to his death and it could have been avoided but for the Trust's collective failures. Therefore, there is sufficient evidence for the coroner to find that the test for the risk to life was met and clearly relevant operational failures in the *Morahan* sense (*R* (*Morahan) v West London Assistant Coroner* [2021] EWHC 1603 ("*Morahan*")).

16. As to operative failures to take reasonable protective or preventative steps, the claimant relies on those factors identified in her SFG at para 77:

> "It was also clearly arguable that there was a breach of the positive obligation given the hospital's failure to take reasonable measures which might have averted and / or substantially reduced the risk to Mahamoud's life, for the following non exhaustive reasons:
>
> (a) No risk assessment was undertaken on Mahamoud's admission to Lea Ward at 18.40 on 20 August 2020 and throughout his time as a patient on the ward until up to 18.00 on 21 August 2020 when he was found in cardiac arrest. As a consequence there were no assessment of risk in relation to his head injury, or that associated with his alcohol withdrawal, risk of falls and of seizures;
> (b) There was no care plan for Mahamoud during his detention on the Lea Ward, contrary to the hospital's own policy;

> (c) There was a failure to closely monitor Mahamoud following his restraint and the administration of rapid tranquilisation, contrary to the hospital's policy;
> (d) There was a failure to follow the hospital's policy on de-escalation in the first instance before restraint and in restraining him at 00:30 20 August placing him at risk of further head injury;
> (e) There was a failure to conduct any CIWA assessment between 18.40 on 20 August 2020 and 00.30 on 21 August 2020 despite the instructions on handover from Homerton Hospital and a further failure to follow up the partially completed CIWA assessment at 00.30 on 21 August 2020 despite the instructions of Dr Felinski and Dr Sessay. This left Mahamoud without any assessment or management of his alcohol withdrawal for approximately 18 hours when he was found in cardiac arrest;
> (f) Given Mahamoud's history of falls and presenting head injury, there was a failure to assess whether he had sustained any further physical injuries or whether he suffered a fall when he was observed at 14.15 incontinent of urine with his trousers down to his ankles;
> (g) There was a failure to reassess Mahamoud's physical condition and vital signs after 14.30 on 21 August 2020, taking in to account the possibility he had suffered a further fall and/or a seizure leading to a further fall;
> (h) There was a failure to conduct any observations at all between 16.45 and 17.45 which meant that there was no monitoring of his physical health during this time;
> (i) There were delays in providing Mahamoud with appropriate care at 17.45 on 21 August 2020
> (j) There was a failure to ensure that all staff were adequately trained in the relevant policies, including in particular the hospital's observation policy; and
> (k) There as a failure to ensure adequate and safe staffing levels at Mile End Hospital."

Discussion

17. The analysis of the claim can be usefully divided into two parts (1) the failure to take reasonable measures; (2) the risk to life.

18. The starting-point is that the coroner found that there was an assumption of responsibility. Thus, following Popplewell LJ in *Morahan* at para 38 (as approved by the Supreme Court in *R* (*Maguire) v HM Senior Coroner for Blackpool & Fylde & Anor.* [2021] UKSC 38 at paras 4 and 13), the sole question is whether it is arguable that the positive operational duty to protect life is engaged.

19. For the risk to life, the operational duty requires consideration of the arguability of a refined question: whether or not it is arguable that there was a foreseeable significant or substantial present and continuing risk to the deceased's life ("the risk to life"). The answer to the arguability question turns on a more detailed examination of the key constituent terms of the test. The relevant risk must be to life rather than of harm, even serious harm (*G4S Care and Justices Services Ltd v Kent County Council* [2019]

EWHC 1648 (QB), paras 74-75 and *R (Kent County Council) v HM Coroner for the county of Kent* [2012] EWHC 2768 (Admin) at paras 44-47).

(1) Failure to take reasonable measures

20. The claimant relies on para 138 of *Van Colle v Chief Constable of Hertfordshire Police* [2009] 1 AC 225 ("*Van Colle*"). There Lord Brown of Eaton-under-Heywood said:

> "As Lord Bingham pointed out in *R (Greenfield) v Secretary of State for the Home Department* [2005] 1 WLR 673, Convention claims have very different objectives from civil actions. Where civil actions are designed essentially to compensate claimants for their losses, Convention claims are intended rather to uphold minimum human rights standards and to vindicate those rights. That is why time limits are markedly shorter— the one year (albeit extendable) limitation period under section 7(5) of the Human Rights Act comparable to the one year permitted for defamation claims intended, analogously, to vindicate a claimant's reputation. It is also why section 8(3) of the Act provides that no damages are to be awarded unless necessary for just satisfaction. It also seems to me to explain why a looser approach to causation is adopted under the Convention than in English tort law. Whereas the latter requires the claimant to establish on the balance of probabilities that, but for the defendant's negligence, he would not have suffered his claimed loss—and so establish under Lord Bingham's proposed liability principle that appropriate police action would probably have kept the victim safe—under the Convention it appears sufficient generally to establish merely that he lost a substantial chance of this."

21. The question, repeated in *Savage* [2009] 1 AC 661 at para 82, is whether the deceased "lost a substantial chance" of avoiding the risk. There is a danger here of hindsight. To review the position: no witness saw any fall by M in the hospital. It is possible that he fell, but it is speculative to attribute his "change of position" to a fall. It must be remembered, as I was reminded at the oral hearing, that he was very mentally unwell. To pinpoint the injury to a further fall in the absence of anyone witnessing it and given the lack of clarity about its origins from the medical witnesses raises obvious problems. The injury might have been from a fall, despite no one witnessing it, but it might not have been.

22. The list of alleged failures levelled at the Trust needs to be connected, in the *Van Colle* sense, to the loss of a substantial chance of avoiding death. The difficulty is in attributing these defective or suboptimal practices to depriving M of a substantial chance of avoiding death by preventing a fall (not seen or witnessed) that may or may not have caused the fatal injury to his head (unproven). The difficulty arises as the injury can only "possibly" be attributed to the unwitnessed fall. The speculative nature of this argument emerges from para 79(a) of the SFG. There it is confirmed that Mr Thakur's evidence was that it is "possible" that the subdural hematoma which caused Mahamoud's death was a result of a further head injury sustained by M at Mile End Hospital. This is supported by Professor Thom. See also para 81d., where it is said:

> "Mr Thakur's evidence that Mahamoud's state of incontinence of urine could have been a sign of a seizure, and that he could have sustained a head injury as a result of this."

23. However, while Mr Thakur's opinion that a hospital fall was far likelier than previous falls to be responsible for the subdural hematoma, the high-point of his evidence remained that it was only "possible" that a hospital fall caused the fatal injury. To the extent that the evidence of Dr Boavida is supportive, it is that (as summarised at SFG, para 81c.):

> "the presence of an enlarged parieto-occipital extra calvarial haematoma and an additional right temporal haematoma upon Mahamoud's admission to Royal London Hospital is supportive of the possibility that Mahamoud sustained a further fall / head injury."

24. One sees the repetition of the theme: that of possibility. Therefore, the state of the medical evidence on causation does not rise above a possible causal contribution from a fall that was unwitnessed and thus essentially conjectural. Turning back to the necessary arguability question, the limitations of Mr Thakur's evidence count against the real prospect of success on this ground. There is a strong element of speculation about the mechanism of death and this is directly connected to the question of the loss of a substantial chance in *Van Colle/Savage* terms.

25. I judge that this ground is not arguable.

(2) Risk to life

26. It is also clear from *Van Colle* that the operational test is a "stringent one" (per Lord Brown of Eaton-under Heywood at para 15). As said in *Rabone v Pennine Care NHS Foundation Trust* [2012] 2 AC 72 at paras 36-37, and noted in her ruling by the coroner:

> "It will be harder to establish than mere negligence, but that is not because reasonableness here has a different quality to that involved in establishing negligence; rather it is because it is sufficient for negligence that the risk of damage be reasonably foreseeable, whereas the operational duty requires the risk to be real and immediate."

27. As Lord Carswell stated in *Re Officers L* [2007] 1 WLR 2136 at para 20, an "immediate" risk is one that is "present and continuing". In her ruling, the coroner noted, with factual accuracy, that following the two falls, "neither CT scan showed any intracranial bleeding, he had been under a period of observation having been admitted at Homerton Hospital with no evidence of risk to his life and he had been 'medically cleared' before being transferred to Mile End Hospital." The fact that the CIWA score "might" have been higher if M had been able to cooperate adds little of substance. It is speculative whether it is likely or probable that the score would have been higher. The Trust's in-patient alcohol detoxification guidelines (v.3.0) indicate that "scores of twenty or more indicate severe alcohol withdrawal and a risk of Delirium Tremens and seizures." However, the fact that M was at risk of seizures does not equate with a significant or substantial risk to life that is immediate in the sense of being "present and continuing".

28. While it is arguable that there was a risk of serious injury to M, I cannot detect an arguable evidential basis to establish the necessary risk of death. A risk of serious injury is insufficient to meet the operational test. Further, counsel's argument may have force as a possible explanation of the mechanism of death through an additional fall at some point while M was not being observed. But one must return to the applicable test: whether there was a risk of death in the recognised sense. Even if it is possible that death was causally contributed to by the additional fall in the hospital (if there was one), the question is whether the possibility of a further fall meets the risk test: once M was detained involuntarily in the hospital was there a foreseeable significant or substantial present and continuing risk to his life? As counsel recognised, the previous CT scans following the falls were neurologically and medically "unremarkable". In this medical context, it is not arguable that the risk was elevated to a substantial risk to life. Therefore, crystallising the risk question after M was being observed, there was a need for it to be foreseeable that there was a substantial risk to his life. I cannot find that this is arguable.

29. I note that Turner J ruled that the coroner was "in the best position to determine" the arguability of the risk to life. This must be true. However, and as a crosscheck, I have sought to examine everything presented to me, not to make the ultimate decision myself, but to assess whether there is an arguable basis that there was indeed here a real and immediate risk to life. I find no arguable basis that there was. Accordingly, there is no arguable basis that the coroner's decision was "irrational" or "unlawful", as submitted.

Conclusion

30. As permission must be refused in respect of the challenge to the unlawfulness of the coroner's conclusion on article 2, necessarily, the narrative conclusion grounds fall away, not surviving the unarguability of the operational duty ground.

31. To the extent that the other grounds challenge the coroner's findings of fact, these are matters classically for the coroner. She presided over an extended inquest with live evidence and extensive documentation (the supplementary renewal bundle runs to 1132 pages). Her factual conclusions do not reach the threshold of arguable irrationality.

32. Permission is refused. The court is grateful to Ms Maragh for her first-class submissions. No one could have said more.