Neutral Citation Number: [2026] EWHC 810 (Admin)

Case No: AC-2024-MAN-000243

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

Manchester Civil Justice Centre
1 Bridge Street West
Manchester
M60 9DJ

Date: 02/04/2026

Before:

MRS JUSTICE HILL DBE

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Between:

THE KING (ON THE APPLICATION OF ELIZABETH OLABODE)	**Claimant**
- and –	
HIS MAJESTY'S AREA CORONER FOR MANCHESTER CITY	**Defendant**
- and –	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	**Interested Party**

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Christian Howells and **Lewis Harrison** (instructed by **Harding Evans Solicitors LLP**) for the **Claimant**
Bridget Dolan KC (instructed by Legal Services, Manchester City Council) for the **Defendant**
Sophie Cartwright KC (instructed by **Hempsons**) for the **Interested Party**

Hearing date: Tuesday 24 March 2026

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Approved Judgment

This judgment was handed down remotely at 10.30am on Thursday 2 April 2026 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

Mrs Justice Hill:

Introduction

1. By a claim form filed on 9 July 2024, the Claimant seeks judicial review of the Defendant's findings of fact and conclusion at the end of the inquest into the death of her 12-year-old daughter, Victoria, dated 10 April 2024. The Claimant proceeds with permission granted by Holgate LJ on 24 June 2025. Permission had been refused in the Administrative Court by HHJ Pearce and HHJ Sefton KC, sitting as Judges of the High Court, on 16 September 2024 and 12 November 2024 (as to the latter, see [2024] EWHC 3471 (Admin)).

2. The Interested Party to the claim is the Trust responsible for the Royal Manchester Children's Hospital ("the RMCH"), where Victoria died on 15 July 2019.

3. Although this claim has involved the consideration of incredibly detailed expert evidence, and certain legal principles, the context for the claim is the tragic death of a child. Victoria died, having suffered a sickle cell crisis, in circumstances where the RCMH has accepted that there were some failings in her care. I reiterate my condolences to the Claimant and Victoria's wider family. The protracted nature of the legal proceedings in which they have been involved since her death have plainly been very distressing for them.

4. The Claimant advanced three grounds of review. Ground 1 related to the Defendant's approach to the alleged failings in care by the RCMH. Ground 2 relating to his approach to causation. Ground 3 ultimately became an argument about the materiality of any errors identified under Grounds 1 or 2. The Claimant seeks a quashing of the Record of Inquest and the Defendant's written reasons, leading to a fresh inquest.

5. I have been greatly assisted by the comprehensive oral and written submissions from counsel for the Claimant and for the Interested Party. The Defendant adopted a neutral position.

The factual background

6. Victoria was born on 14 May 2007, one of twins. She had sickle cell disease and asthma. She lived with her parents and twin brother in the Brighton area. In October 2018, the family moved to Manchester. In July 2019, Victoria was in Year 7 at school. She was highly intelligent and wanted to be a doctor, politician or singer. She was also highly artistic and wanted to travel. Her mother said she wanted to be a star and had great aspirations.

7. On 1 July 2019 Victoria walked to school as usual with her twin brother. At around 10 am the school staff called her parents saying she was having an asthma attack and was struggling to breathe. They took her home. When her breathing did not improve with the use of her inhaler an ambulance was called and she was taken to a general hospital in north Manchester.

8. At around 4.25 am on 2 July 2019, Victoria was transferred to the RMCH. She had a cough, intermittent difficulty in breathing, chest pain and symptoms thought to be related to a sickle crisis and asthma. She was managed with inhalers, oxygen, pain relief and 120% maintenance fluids.

9. On 3 July 2019 Victoria was transferred to a haematology ward. She appeared to be responding well to the treatment. This continued into 4 July 2019.

10. At around 10.25 am on Friday 5 July 2019, Victoria's pain increased so her analgesia was changed from Oromorph (liquid oral morphine) to a morphine infusion.

11. At around 10.30 pm, while watching TV with her parents, Victoria suffered a sudden onset of nausea, vomiting and severe headache. She was screaming in pain and vomited four times. She had a period of reduced consciousness and hypoventilation with hypercapnia (a condition characterised by excessive carbon dioxide buildup in the blood).

12. At 11.10 pm she was reviewed by a speciality training doctor. On examination she was apyrexial with a heart rate of 86 beats per minute, respiratory rate of 20 breaths per minute and oxygen saturation of 100% in air. Her blood pressure was raised, above the 90th centile for a girl her age with sickle cell disease. She was asleep and not responding to voice with a Glasgow Coma Score of 9/15. The doctor spoke to a consultant haemato-oncologist, who suggested monitoring Victoria overnight and giving consideration to a CT scan the following day. This was documented in the notes as an action plan.

13. On the morning of Saturday 6 July 2019, Victoria was difficult to rouse but it was noted that she was normally a heavy sleeper. She had been vomiting and screaming in pain because of headache although she had then settled overnight, and had slept well. That morning, she walked to the toilet but very unsteadily, despite being held up by her mother. She seemed her normal self. She still complained of headache, but it was not as bad. The plan was to increase her morphine, continue intravenous fluids, transfuse and monitor. The headache stopped and the vomiting appeared to settle, but her blood pressure continued to be high.

14. At 7.30 pm Victoria was reviewed by another speciality training doctor. Victoria was still complaining of headaches and a low back pain. She was not really eating or drinking. Her mother asked that a CT scan be performed. The doctor did not consider that a CT scan was required and one was not performed. As Victoria's haemoglobin was low, she had a "simple" blood transfusion.

15. On the morning of Sunday 7 July 2019, Victoria was still in a lot of pain in her chest and back. She had a headache and had vomited during the night. She was reviewed by a speciality training doctor at 8.30 am, but it does not appear that she was seen by a doctor again that day. She remained apyrexial with high blood pressure and a headache, and slept most of the day.

16. Over the night of 7/8 July 2019 Victoria's symptoms got worse. At 2.00 am on 8 July 2019 she was examined by a senior house officer doctor. She was visibly in distress and had pain in her neck, head and body despite being on 20 ug per kilogram per hour of oxycodone. At 3.30am Victoria remained unsettled and was in increased pain. After

discussion with a specialty registrar, an intravenous infusion of ketamine was commenced at 3ug per kilogram per minute with oxycodone at 20ug per kilogram per hour.

17. At around 10.30 am on the morning of Monday 8 July 2019, Victoria had a seizure lasting 12-14 minutes and became unresponsive. She recovered consciousness but at around 1.10 pm had another seizure. Following the second seizure she obeyed commands and spoke single words. An emergency CT head scan without intubation was performed and an MRI scan was recommended.

18. During the evening of 8 July 2019, Victoria was intubated and ventilated and had an MRI head scan. Intracranial Magnetic Resonance Venography (further imaging) was also carried out. This showed convexity subarachnoid haemorrhage, cerebral infarction of the frontal, parietal and occipital lobes over the top of her head, cerebral oedema, and generalised attenuation of the intracranial vasculature with some likely focal narrowing of medium sized vessels.

19. At 8.30 pm Victoria was admitted to the Paediatric Intensive Care Unit. She was initially moving a lot, so she was sedated and paralysed for ventilation and continuous EEG was started. An exchange transfusion was carried out. This is a potentially life-saving procedure that is done to counteract the effects of serious jaundice or changes in the blood due to diseases such as sickle cell anaemia. The procedure involves slowly removing the patient's blood and replacing it with fresh donor blood or plasma. Sadly, over the next 12 hours Victoria deteriorated.

20. By 7.00 am 9 July 2019 her pupils were recorded as fixed and dilated. At 7.33 pm a CT scan revealed widespread cerebral infarction of the cerebral hemispheres, cerebral swelling and tonsillar herniation.

21. During 12 July 2019 the doctors concluded that the appearance of Victoria's brain was not compatible with life, and she fulfilled the criteria for brain stem death after appropriate testing.

22. On 15 July 2019, treatment is withdrawn and Victoria died.

The Interested Party's investigation

23. After Victoria's death, the Interested Party commenced an investigation. On 21 November 2019 a Comprehensive Level 2 Investigation Report ("the Level 2 report"), was produced, authored by Dr Grainger, a Consultant Paediatric Haematologist. At section 6, the report identified a series of problems with the care given to Victoria, as follows:

> "**Problem 1**: Victoria's GCS of 9 was not raised during the telephone conversation with the Consultant on Friday 05/07/19 at 23:10. Therefore the plan for Victoria to have a CT scan in the morning if further headaches was made without this information…

> **Problem 2**: Plan for imaging if headaches persisted made at 23:10 on 05/07 was not implemented. This led to a 63 hour delay in undertaking imaging; when imaging was performed the damage was irreversible…
>
> **Problem 3**: There was a lack of escalation to and review by Consultant over the weekend so Victoria was not reviewed by a consultant for 58 hours despite increasing pain and drowsiness.
>
> Victoria's ongoing headaches were not escalated to the on-call Consultant over the weekend of 06/07/19 – 07/07/19 by the Junior Doctors.
>
> The Junior Doctors also did not discuss the headaches with Radiology or the on-call Anaesthetist (who are part of the pain management team). This led to a delay in Victoria's head scan and recognition of her stroke…
>
> **Problem 4**: The delay in undertaking imaging subsequently led to a delay in an exchange transfusion; had the imaging been undertaken over the weekend earlier exchange transfusion may have been undertaken (an exchange transfusion is the recognised treatment of stroke in sickle cell patients of up to 72 hours, diagnosis of stroke is achieved through MR scan, which was delayed as detailed under problem 2).
>
> **Problem 5:** Neurological observations were not documented as per policy (they were referred to as normal in the nursing notes but it cannot be verified if this was correct)".

24. The Level 2 report concluded at p.40 with the following:

> "We accept that as a result of the delay in carrying out the imaging, there was a delay in the exchange transfusion taking place, which contributed to Victoria's death from stroke and we are very sorry for this. There were a number of factors that contributed to these delays and the recommendations and actions [we have] outlined…are designed to address those factors".

25. This conclusion was the subject of internal review by the Interested Party. They then arranged for independent external review to take place. An addendum to the Level 2 report was prepared by Dr Grainger with Dr Ram (Consultant Paediatric Neurologist), Professor Stivaros (Consultant Paediatric Neuroradiologist) and Professor Kilday (Consultant Paediatric Neuro-oncologist). It took into account external reports from Dr Saunders (Consultant Neuroradiologist) dated 25 September 2020 and 18 October 2022; Dr Mankad (Consultant Paediatric Neuroradiologist, dated 18 October 2022); and a joint report written by Professor Kirkham (Professor of Paediatric Neurology), Dr Trompeter (Consultant Haematologist) and Dr Saunders, dated 17 November 2020.

26. The addendum is undated but must have been prepared at some point after 14 November 2022 when the final report which contributed to it (a response from the Professor Stivaros, Dr Grainger, Dr Ram and Professor Kilday to Dr Mankad's report) was

provided. It appears to have been prepared in anticipation of the inquest that was due to start on 7 December 2022.

27. The addendum made clear that the Interested Party continued to accept Problems 1-3 and 5 as identified in the Investigation Report. However, the addendum took a different view in relation to Problem 4 and added a Problem 6, as follows:

> "**Problem 4:** The delay in undertaking imaging identified as Problem 2 potentially led to a delay in appropriate clinical management. However, without neuroimaging it is not possible to describe what clinical management needed to occur. Further to the review of the additional information received by the Trust as outlined above, it is no longer the view of the clinicians that a significant stroke occurred over the weekend of 06/07/2019-07/07/2019 and therefore the conclusion that an exchange transfusion should have definitely occurred over this weekend is no longer held. For further information on the potential diagnoses please see the conclusion below…
>
> **Problem 6**: It is the opinion of the Trust that Victoria had a catastrophic stroke on Monday 08/07/2019, that presented initially with a seizure at 10:30 that morning with focal neurology subsequent to this. There were delays in managing Victoria's stroke. In particular a top up red blood cell transfusion should have occurred by 12:00 and an exchange transfusion by 17:00 on 08/07/2019 but neither occurred until 09/07/2019. It is not possible to determine if earlier intervention at this stage would have prevented the rapid progression of Victoria's neurological deterioration or her death. This is accepted by [the Interested Party]".

28. In effect, the further evidence obtained had led the Interested Party to change its view as to whether the failings in care identified had contributed to Victoria's death or not. Its position as set out in the addendum was that it was no longer possible to determine whether any earlier intervention would have prevented Victoria's death.

29. On 24 November 2022, the Interested Party provided an Action Plan and Learning Assurance document, setting out the steps taken to address the problems identified during the investigation.

The inquest

30. After Victoria's death an inquest was opened. Victoria's family and the Trust were Interested Persons in the coronial proceedings. There was no suggestion that the procedural obligations under Article 2 of the European Convention on Human Rights applied to the investigation. It was accepted that the scope of the inquest would include the issue of whether there had been any failure to provide timely and appropriate medical care to Victoria and the likely causative impact of any failure to provide her with appropriate treatment.

31. On 7 December 2022 the inquest began. Victoria's family were represented by counsel, but not Mr Howells or Mr Harrison. The Interested Party were represented by Ms Cartwright KC. Over 7-9 December 2022, the Coroner heard evidence from the

Claimant, Dr Grainger, Professor Stivaros, Professor Kirkham, Dr Trompeter and Dr Saunders.

32. During the course of the joint evidence of Professor Kirkham, Dr Trompeter and Dr Saunders, it became apparent that further evidence was required. The Coroner adjourned the hearing. A further report was obtained from Dr Saunders, responding to the evidence of Professor Stivaros, on 6 December 2023. In January 2024 the Interested Party provided an updated Learning Assurance report; followed by a further report from Dr Grainger dated 16 February 2024. Further reports were also obtained from Professor Kirkham, Dr Trompeter and Dr Saunders on 20 February 2024 and Dr Mankad on 26 February 2024.

33. On 26 February 2024 the inquest resumed. Over 26-27 February 2024, the Defendant heard further evidence from Professor Stivaros, Professor Kirkham, Dr Trompeter and Dr Saunders, Dr Mankad and Professor Kilday.

34. By agreement of Victoria's family and the Interested Party the Defendant also admitted a significant amount of evidence under Rule 23 of the Coroners (Inquests) Rules 2013.

35. At the end of the evidence, counsel for Victoria's family and for the Interested Party made brief submissions as to the permissible conclusions available to the Defendant. In effect, they agreed that it was open to the Defendant to return a "short form" conclusion of natural causes, but that if he identified any failings in Victoria's care which had contributed to her death a narrative conclusion would be preferable. Although the Defendant suggested that he might be assisted by submissions as to the "specific issues [on] which I need to make findings" neither counsel made such submissions.

36. In the course of this claim, Ms Cartwright KC rightly contended that the Defendant was required to consider Victoria's clinical management by personnel on behalf of the Interested Party in the period 5 to 8 July 2019; and that it was incumbent on him to seek to identify and have regard to those matters which contributed to Victoria's death. She identified the factual issues the Defendant had to determine as follows:

    (i) The manner in which Victoria had presented on 5 July 2019;

    (ii) The degree of clinical engagement and/or assessment which may or may not have been appropriate in the light of such presentation;

    (iii) The potential for CT (and I would add MRI) imaging to be required and/or commissioned on 6 July 2019;

    (iv) The potential identification of subarachnoid haemorrhage or other neurological insult being identified by means of imaging on 6 July 2019;

    (v) The nature, character and provenance of the seizures experienced by Victoria on 8 July 2019;

    (vi) The presence or absence of subarachnoid haemorrhage on the CT image conducted on 8 July 2019; and

(vii) The extent to which any or all of these matters might have altered the outcome which occurred on 8 July 2019 and Victoria's death.

37. The Defendant took time to consider the evidence and provided his findings of fact and conclusion on 10 April 2024.

The Defendant's findings of fact and conclusion

The Record of Inquest

38. The Defendant completed a Record of Inquest in relation to Victoria's death.

39. This recorded under section 2 the medical cause of her death as being "1a. Cerebrovascular Accident [due to] 1b. Arterial ischaemia [due to] 1c. Sickle cell disease". There is no challenge to this conclusion.

40. Under section 3, addressing "how, when and where…the deceased came by…her death", the Defendant recorded the following:

> "The Deceased, who suffered from sickle cell disease, was admitted to North Manchester General Hospital on 1st July 2019 and was thought to be in sickle crisis. On 2nd July 2019 she was transferred to Royal Manchester Children's Hospital for ongoing care.
>
> On 5th July 2019, the Deceased developed sudden onset of vomiting and severe headaches. The Deceased's headache persisted for three days, and on the morning of 8th July 2019 she suffered two seizures. Radiology confirmed ischaemic brain injury, and the Deceased was subsequently transferred to the Paediatric Intensive Care Unit. On 9th July the Deceased underwent an exchange transfusion, and a CT scan demonstrated widespread cerebral infarction.
>
> The Deceased met the criteria for brain stem death following testing on 12th July 2019, and she died at Royal Manchester Children's Hospital on 15th July 2019".

41. Under section 4, the conclusion as to the cause of death, he recorded a short-form conclusion of "natural causes".

Findings of Fact and Conclusion

42. The Defendant set out his reasons for completing the Record of Inquest in this way in a detailed written document entitled "Findings of Fact and Conclusion" ("FFC").

43. He began with an appropriate self-direction that he need not make reference to or findings on each part of the evidence, but was instead required to focus on "the central issues", citing *R (Lewis) v HMC for Mid and North Shropshire* [2009] EWCA Civ 1403 at [26]: FFC at [2]. There, Sedley LJ had quoted counsel's submissions to the effect that the inquest process can be "visualised as a funnel: wide at its opening but narrowing as the evidence passes down it so as to exclude non-causative factors from the eventual [conclusion]. The Defendant observed that the evidence then passes through a "sieving"

process, leaving the relevant evidence for consideration at the final stage. The Claimant did not take issue with any part of this direction.

44. The Defendant set out the background to Victoria's admission to the RMCH and the events up to the evening of 5 July 2019, none of which are controversial for the purposes of this claim: FFC at [4]-[5]. He then made the following findings:

> "6. At or around 10:30pm on 5th July 2019, following the sudden onset of severe headache, nausea, and vomiting, and thereafter following the review at 11:10pm by Dr D'Souza, a CT scan (in the first instance) was clinically indicated. I find that it was a failure that a CT scan did not take place overnight on 5th July 2019 and into the early hours on 6th July 2019.
>
> 7. Victoria was in sickle crisis and, it was imperative for a neurological event to be excluded by neurological examination and imaging. A CT scan was warranted, and whilst it was appropriate for the clinicians to address Victoria's pain, her pain and a potential neurological event were not mutually exclusive. Moving into 6th July 2019, the severity and duration of Victoria's headache suggested an intracranial event, and thus a CT scan was required.
>
> 8. In relation to 7th July 2019, Victoria's headache and vomiting remained clinically inexplicable. Whilst I find that appropriate steps were taken in relation to Victoria's pain management, a CT scan remained clinically indicated".

45. He summarised the events beginning with Victoria's first seizure on 8 July 2019 up to her death on 15 July 2019: FFC at [9]-[11].

46. The Defendant then turned to the issue of what the CT and MRI scans on 8 July 2019 showed. This was a central issue because the experts had used their opinions on what the scans on 8 July 2019 showed to inform their assessment of what scans, had they been carried out earlier, over 5-7 July 2019, would have showed. On this issue, the Defendant made the following findings:

> "12. As to the reporting of the CT head scan on the 8th July 2019, I find that there was a possibility of subarachnoid blood, as reported by Dr Dixon. Dr Saunders went further, opining that the high density in the subarachnoid space was likely to be subarachnoid blood. Dr Mankad, more nuanced, opined that it was possible, but did not commit on the balance of probabilities. Professor Stivaros stated there may have been blood, but there were other possibilities for these findings, including ischaemia. I am not satisfied, on the balance of the evidence, that it is more likely than not that there was subarachnoid blood at the time of the CT scan in 8th July 2019.
>
> 13. Moving on to the reporting of the MRI scan on 8th July 2019, the range of opinion was also broad. The reporting radiologists, Dr Stephens and Professor Stivaros, made no reference to subarachnoid blood in their joint report. Professor Stivaros' evidence to the Inquest

> was that there was no evidence. Dr Saunders disagreed; whilst the necessary sequencing was not requested, the fluid-attenuated inversion recover (or FLAIR) signal indicated subarachnoid blood and the distribution over the frontal lobe was concordant with the sequence. Again, Dr Mankad was more nuanced. He agreed with the local report; however, he also noted that the report was silent on the issue of subarachnoid blood. He was not fully singing from Dr Saunders' song sheet on the issue of the FLAIR signal, although he opined that subarachnoid blood could not be excluded.
>
> 14. I find that the protocol of the MRI scan on the 8th July 2019 was suboptimal, and that appropriate sequencing should have been used to determine whether there was subarachnoid blood, particularly as this was the purpose of the MRI scan following the CT scan. The report says nothing about subarachnoid blood, and this too was a failure in the care. As to the findings of the scan, I prefer the evidence of Dr Mankad and find that subarachnoid blood cannot be confirmed, nor ruled out".

47. He then turned to the hypothetical question of what a scan on the morning of 6 July 2019, at the latest, would have shown, making the following findings:

> "15. Based on my findings that a CT scan should have been requested by the morning of 6th July 2019 at the latest, I must therefore consider and make findings, on a hypothetical basis, what a scan (or, to be clear, scans, as it was accepted that a CT and MRI would both have been required) would have likely shown. Dr Trompeter opined that such scans would have confirmed subarachnoid blood. This opinion was supported by Dr Saunders and Professor Kirkham. Professor Stivaros' evidence was that a CT scan would not have been added anything at that time, and an MRI scan may have shown evidence of neurovascular collapse but would not have shown subarachnoid blood. Dr Mankad was unequivocal: a scan (on balance, an MRI scan) would have shown abnormalities on the morning of 6th July 2019 if the optimisation of the scan protocol was done properly with susceptibility weighted imaging (or SWI) sequencing. On balance of probabilities, this would have picked up early ischaemic changes and haemorrhage.
>
> 16. This evidence, in my judgment, represents a conflict with an inadequacy of reasoning. The balance of the evidence of Dr Mankad is that the CT and MRI scans on 8th July 2019 did not exclude subarachnoid blood; however, there were no positive findings of it. However, his opinion on the hypothetical scenario for what CT and MRI scans would have shown had they been undertaken on 6th July 2019 is that subarachnoid blood would have been shown. In my judgment, it does not withstand logical analysis to state with that level of certainty that a scan performed two days prior would likely have shown subarachnoid blood, when the scans themselves on 8th July 2019 did not definitively do so. Whilst Dr Mankad did also refer to the onset of Victoria's headache and vomiting as the starting point of abnormalities, this appears inconsistent with his evidence of Dr

> Grainger and Professor Stivaros, who both states that they did not think earlier scans would likely have revealed subarachnoid blood".

48. He continued:

> "17…The corollary of my assessment of the evidence is that I cannot find, on the balance of probabilities, that scans on 6th July 2019 would have led to subarachnoid blood being found. I must therefore consider whether any other radiological findings would have led to steps being taken to treat Victoria from 6th July 2019 onwards. In the absence of a finding of subarachnoid blood, I cannot find that other steps would have been necessary".

49. The Defendant then turned, "for completeness", to the issue of "what steps would likely have been taken had [he] found that scans on 6th July 2019 would have shown subarachnoid blood. He did so "in order to make further findings relating to whether Victoria's death was avoidable" but "with the clear caveat that I do not accept that scans on 6th July 2019 would have led to a significant escalation in Victoria's care". On this issue the Defendant's findings were as follows:

> "19. Dr Trompeter's evidence on the hypothetical scenario following earlier scans which revealed subarachnoid blood was for an exchange transfusion to take place on 6th July 2019. She added that she was unable to say whether this would have altered the eventual outcome as there was no clear evidence on the role of an exchange transfusion as treatment for a cerebral haemorrhage. Professor Kirkham, who deferred to Dr Trompeter on the issue of an exchange transfusion, opined that a finding of subarachnoid blood was a serious neurological condition. Moreover, had the diagnosis been made between 5th and 8th July 2019, appropriate preventative measures could have been taken, and Victoria's death would have been avoided. This evidence must be analysed against the evidence of Dr Grainger and Professor Stivaros, who both opined that it would be speculative to say that Victoria would not have died when she did due to the delays in imaging. Of note, Dr Grainger pointed to the severity of the stroke that Victoria suffered on 8th July 2019.
>
> 20. On the balance of the evidence following my analysis, I find that there is insufficient evidence to cross the threshold beyond speculation that Victoria's death would have been avoidable with earlier imaging on 6th July 2019. I do not accept Professor Trompeter's evidence, which although was provided with relative robustness, does not, in my judgment, withstand logical analysis, nor did she provide sufficient reasoning for it. Professor Trompeter's opinion appears to cut through the complexity of the issues without logic or structure. It reaches its final destination with too much ease, and thus on its analysis I cannot accept it when balanced with the evidence of Dr Grainger and Professor Stivaros".

50. He concluded the FFC as follows:

> "21. In summary, my findings are as follows:
>
> a. There was a failure in Victora's care on the evening of 5th July 2019 and morning of 6th July 2019 is not processing to imaging (CT and MRI scans) when it was clear that Victoria was suffering serious neurological symptomatology;
>
> b. Had imaging been undertaken on 6th July 2019, this would not have conclusively confirmed the presence of subarachnoid blood;
>
> c. Thus, save for a change in the course of Victoria's care with imaging on 6th July 2019, no other substantive changes would have been implemented;
>
> d. Imaging that was undertaken on 8th July 2019 did not reveal evidence of subarachnoid blood on the balance of probabilities, although the appropriate sequencing for the MRI scan was not requested;
>
> e. On the balance of probabilities, there is insufficient evidence to state that Victoria would have avoided the terminal event on 8th July 2019 which caused her death on 15th July 2019.
>
> 22. Flowing from my findings, in my judgment Victoria has died from a naturally occurring illness, which sadly reached its natural end on 15th July 2019. Whilst I have found failures in her care, none of these failures more than minimally contributed to her death on the balance of probabilities. As a matter of law, the factual circumstances of Victoria's death fits squarely within the legal definition of 'Natural Causes', and therefore I will return this as a short-form conclusion".

The legal framework

The Defendant's functions and responsibilities

51. An inquest is a fact-finding inquiry with the statutory purpose of determining who the deceased was and when, where and how they came by their death. The Coroners and Justice Act 2009 ("CJA") provides at section 5 in material part (where Article 2 is not engaged) that:

> **"5 Matters to be ascertained**
>
> (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…

> (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)".

52. Accordingly, section 5(3) requires that the proceedings and evidence at an inquest are directly solely to ascertaining the identity of the deceased person and when, where and how they came by their death. It expressly prohibits any expression of opinion on any other matter.

53. Section 10(2) provides that a determination under section 5:

> "…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".

54. Causation in the coronial jurisdiction is not limited to the "but for" test found in civil law: rather, a matter can be considered causative if it "more than minimally, negligibly or trivially" contributed to the death or "made a material contribution to death": *R (Khan) v HM Coroner for West Hertfordshire* [2002] EWHC 302 (Admin) at [25] and [43]. It has also been said that in clinical cases the "touchstone" is "the opportunity of rendering care ... which would have prevented death": *R v HM Coroner for Coventry ex parte Chief Constable of Staffordshire* (2000) 164 JP 665, [2000] Inquest LR 35.

55. Coroners are encouraged, "where possible", to use one of the "short form" conclusions listed in the Schedule to the Coroners (Inquests) Rules 2013, as this has "the advantage of being simple, accessible, and clear for statistical purposes". It is recognised that in most cases, "using a conclusion from this list in combination with the answer to 'how' in Part 3, will be sufficient to 'seek out and record' as many of the facts concerning the death as the public interest requires": Chief Coroner's Guidance for Coroners on the Bench, Chapter 15, paragraphs 40 and 41.

The approach of this court

56. A judicial review challenge based on alleged irrationality, even where proportionality considerations are in issue, "cannot partake of the nature of an appeal". Rather, the "classic judicial review investigation" involves:

> "…studying the reasons the alleged discriminator acted in the way that she or he did and deciding whether that lay within the range of reasonable responses which a person or body in the position of the alleged discriminator might have had": *GMC v Michalak* [2017] UKSC 71 at [21].

57. Accordingly, the fact that another Coroner may have reached a different conclusion on much the same material, or that this court might, does not entitle the Claimant to relief:

rather, the question is whether the Defendant reached a conclusion that was open to him as a reasonable Coroner.

58. As to the quality of reasons provided by a decision-maker:

> "The reasons for a decision must be intelligible and they must be adequate. They must enable the reader to understand why the matter was decided as it was and what conclusions were reached on the "principal important controversial issues", disclosing how any issue of law or fact was resolved. Reasons can be briefly stated, the degree of particularity required depending entirely on the nature of the issues falling for decision. The reasoning must not give rise to a substantial doubt as to whether the decision-maker erred in law, for example by misunderstanding some relevant policy or some other important matter or by failing to reach a rational decision on relevant grounds. But such adverse inference will not readily be drawn. The reasons need refer only to the main issues in the dispute, not to every material consideration": *South Bucks District Council v Porter (No 2)* [2004] UKHL 33, [2004] 4 All ER 775 at [36].

59. Where a court or tribunal is faced with competing expert evidence, "it is important that the tribunal should state which expert evidence (if any) it accepts and which it rejects" and "must at least indicate the reasoning process by which they have decided to accept some and reject other evidence": *R (H) v Ashworth Hospital* [2002] EWCA Civ 923, [2003] 1 WLR 127 at [80].

60. It is also necessary to bear in mind that a decision of this kind is provided to "an informed audience". Accordingly:

> "Those who receive it and who are concerned with it will be familiar with the essential documents in the case, as here with the reports on the applicant. They will be familiar with what has been said at the tribunal by way of oral evidence and what the issues there were which had been argued. Given that necessary familiarity, if there was a case in which it could still be said that the parties simply were not told why the tribunal arrived at the decision it did, then no doubt there would be a sound basis for a legal challenge": *Mental Health Review Tribunal ex p Booth* [1997] EWHC Admin 816 at [29].

61. In assessing the adequacy of reasons, a decision should be looked at "in the round"; the court should not be "invited…to apply a very fine tooth comb to the evidence given at the inquest and to the statement of reasons and to go through a minute analysis of each and every point in order to see whether she referred to it explicitly or implicitly": *R (Evans) v HM Coroner for Cardiff and Vale of Glamorgan* [2010] EWHC 3478 at [63]. The need to give adequate reasons should not impose an unrealistic burden upon the decision-maker: *R (TZA) v Secondary School* [2025] EWCA Civ 200, [2025] PTSR 1503 at [88] and [108].

62. However, an absence of analysis may found the basis of a judicial review challenge: see, for example, *R (O'Connor) v Police Misconduct Panel* [2025] EWCA Civ 27, [2025] ICR 1137 at [24] and [54].

The issues

63. The parties agreed that the issues for determination, arising from the Claimant's grounds, were as follows:

> Ground 1: Did the Defendant unreasonably leave the opinion evidence of Dr Kirkham out of consideration in finding that because it could not be established on the balance of probabilities that a scan on 6 July 2019 would have shown subarachnoid bleeding, he could not find that any course of treatment would have been implemented over the weekend?
>
> Ground 2: Did the Defendant unreasonably discount the evidence of Dr Kirkham in respect of causation on the basis that it was inconsistent with the evidence of Professor Stivaros and Dr Grainger?
>
> Ground 3: (a) Did the Defendant misdirect himself in law in finding that there was insufficient evidence that Victoria's death 'would have been avoided'? (b) Should the Defendant have asked whether the failure to implement a care plan on the correct differential diagnosis of increased intracranial pressure contributed to the catastrophic event on 8 July 2019 in a more than minimal, trivial or negligible way?

Ground 1

The parties' positions in outline

(i): The Claimant's submissions

64. Under Ground 1 the Claimant contended that when finding in the FFC at [17] and [21](c) (see [48] and [50] above) that, because it could not be established on the balance of probabilities that a scan on 6 July 2019 would have shown subarachnoid bleeding, the Defendant could not find that any course of treatment would be implemented over the weekend of 6/7 July 2019, he had irrationally left out of account the evidence of Professor Kirkham.

65. Professor Kirkham was a neurologist who gave evidence from a clinical perspective. The crux of Ground 1 was the argument that the Defendant had fallen into error by excluding her clinical evidence, instead treating the neuroradiology evidence as the sole and decisive evidence as to whether there was a neurological event over the weekend and/or the sole basis upon which treatment decisions could be made.

66. Professor Kirkham had described what she considered to be the appropriate treatment plan for Victoria over the weekend. It was common ground that there was a failure to recognise the importance of Victoria's headaches and ensure a review by a consultant neurologist over the weekend of 6/7 July 2019[1]. In addition, Professor Kirkham had

[1] This had been accepted by the Interested Party as far back as the Level 2 Report on 21 November 2019; it was maintained in Dr Kilday's 13 May 2021 report, the addendum and updated Learning Assurance report; and it was confirmed by Dr Grainger in his oral evidence on 7 December 2012: Supplementary Bundle, pages 513-514 ("SB/513-514").

said that posterior reversible encephalopathy syndrome ("PRES") should have been suspected in Victoria and treated appropriately by the clinicians. This was relied on by Mr Howells as another potential failing in Victoria's care which may have contributed to her death, over and above the accepted failings with respect to scanning.

67. PRES, also known as reversible posterior leukoencephalopathy syndrome, presents with a rapid onset of symptoms including headache, seizures, loss of consciousness and visual disturbance. It is often associated with hypertension and is recognised to occur in patients with sickle cell disease in the absence of the normal triggers such as immunosuppressive therapy: see paragraph 7.7 of Dr Saunders' 25 September 2020 report.

68. Mr Howells relied on the fact that as the neuroradiologists could not rule out PRES or subarachnoid haemorrhage, they had deferred to the evidence of clinicians as to the differential diagnosis.

69. Although at [19] the Defendant had made reference to Professor Kirkham's evidence, this was in the context of causation and the Defendant made no prior findings on whether he accepted that there should have been consultant input and an appropriate management plan put in place. Mr Howells argued that the PRES issue was so obviously relevant to the Defendant's determination that no reasonable Coroner could have left it out of account; and that the Defendant's failure to consider it was a fatal flaw in his approach.

70. The pathological significance of PRES and/or subarachnoid haemorrhage was, Mr Howells contended, that it is a potential contributing factor to cerebral ischaemia (not the sole cause).

(ii): The Interested Party's submissions

71. Ms Cartwright KC highlighted the thorough approach the Defendant had taken. This was a case conducted over many days: far from excluding any issue from his consideration he had adjourned the hearing in December 2022 for the purposes of obtaining more evidence.

72. She relied on the totality of the expert evidence from different disciplines that was before the Defendant. She noted that the experts had generally given evidence within their areas of expertise, but deferred to each other where appropriate. The evidence had to be seen as a composite whole, because to varying degrees each of the experts' evidence interacted with that of the others. There was not one single narrative that emerged from the expert evidence, but a range of such narratives, that required granular assessment. Professor Kirkham's evidence was not and could not be considered to be determinative of any of the issues the Defendant was required to resolve.

73. The Defendant's FFC made clear that he had given all of the evidence anxious consideration and had correctly focussed on the central issues. The findings he made were within the scope of the inquest and were the product of proper legal and evidential assessment. The Defendant had properly discharged his obligations under the CJA to determine how had Victoria died.

74. Ms Cartwright KC submitted that the Defendant had eliminated the prospect of subarachnoid haemorrhage being detected on 6 July 2019; and as a result had concluded that the scans would not have caused an escalation of Victoria's care. As to the potential for an alternative treatment path by which the ultimate outcome could have been averted, he had properly contextualised the evidence and sought to resolve the medical evidence. Having done so, he had concluded that there was insufficient evidence to migrate him from the threshold of speculation. These were entirely sound conclusions.

75. She contended that the Claimant was engaging in "cherry picking" of the evidence, which was inappropriate. It was said that where the Claimant was presenting aspects of the evidence as "common ground", this was an over-simplification.

76. Taken at its highest, the expert evidence advocated the formulation of a differential diagnosis of PRES. She contended that PRES was relied on before the Defendant as a factor which might inform two matters: (i) the conduct of further imaging on 6 July 2019; and/or (ii) the interpretation of the imaging as a resource in the formulation of the care plan to be adopted.

77. It was wrong to suggest that the accommodation of a differential diagnosis of PRES would per se have led to the adoption of treatment which could have pre-empted the significant neurological injury which Victoria experienced on 8 July 2019. However, there was consensus between the experts that the irreversible harm caused to Victoria was an ischaemic event which occurred after the first seizure on 8 July 2019.

The relevant evidence

78. Ms Cartwright KC submitted that it was necessary for me to review all the expert evidence, not only to see how it had developed before the Coroner, but also to see the extracts relied on by Mr Howells in their full context. The various reports, transcripts and notes of evidence ran to around 850 pages. Both counsel provided me with lists of page references within the bundle of evidence. I have not referred below to every one of these references, but only to those parts of the evidence which I consider particularly relevant to the determination of Ground 1.

(i): The neuroradiology evidence

79. The Defendant had adduced considerable evidence from the neuroradiologists. Their evidence was focussed on ascertaining (i) what the 8 July 2019 CT scan showed and whether that provided an explanation for the symptoms which started on 5 July 2019 or not; (ii) what a scan conducted on 6 July 2019 would have shown, in particular whether any such scan would have shown subarachnoid bleeding; and (iii) whether the failure to carry out scanning earlier contributed to Victoria's death. The Claimant did not challenge any of the Defendant's findings on these issues, as set out in the FFC at [6]-[8] and [12]-[17]: [44] and [46]-[47] above.

80. Mr Howells relied on the further neuroradiology evidence before the Defendant to the effect that (i) there was a clear neurological event on 5 July 2019 which could not be explained by the 8 July 2019 CT scan[2]; (ii) the absence of obvious ischaemia on the 8 July CT scan could not rule out ischaemia over the weekend, essentially because of the

[2] See Professor Stivaros at SB/588 and Professor Kirkham, Dr Saunders and Dr Trompeter at SB/372

inadequacy of CT scans for that purpose[3]; and (iii) the neuroradiologists deferred to neurology evidence to explain the underlying clinical diagnosis of the cause of the headaches on 5 July 2019[4]. As to (iii), Professor Kirkham, Dr Trompeter and Dr Saunders also agreed that as imaging (scanning) occurred "rather late" in Victoria's clinical presentation, "whether she may have had PRES / hypertensive encephalopathy was a clinical decision" SB/390.

(ii): The joint reports from Professor Kirkham, Dr Trompeter and Dr Saunders

81. The only neurologist called to give evidence was Professor Kirkham. Accordingly, Mr Howells submitted, hers was crucial evidence.

82. Professor Kirkham provided three lengthy reports jointly with Dr Trompeter and Dr Saunders: on 13 November 2020, on another date in 2023/early 2024[5]; and on 26 February 2024. On each occasion rather than provide an addendum report they produced a fresh version of their original report, with amendments.

83. In their 13 November 2020 report they raised PRES as one of the diagnoses for Victoria that should have been considered and set out how they considered this should have been treated. They then provided more detail on this issue in their further reports.

84. In Appendix 1 to their 26 February 2024 report, Professor Kirkham, Dr Trompeter and Dr Saunders answered a series of questions the Defendant had put to them in his letter of instruction dated 16 February 2023: SB/369-395; and a further series of questions put to them by the Interested Party: SB/395-405.

85. In answer to question 3, the joint experts gave their view that (i) the probability of a serious central nervous system ("CNS") event should have been recognised with the sudden onset of acute headaches on the late evening of the 5 July 2019; and (ii) paediatric neurology should have been involved as the management of an acute CNS event in sickle cell disease is different from the management of an acute painful or chest crisis: SB/370-1. In answer to a question from the Interested Party about whether there were any missed opportunities for earlier intervention in Victoria's case they reiterated that the onset of severe headache in a child with sickle cell disease should have triggered a neurology consultation. They confirmed that paediatric neurology cover is available in Manchester including at the weekend and there is paediatric neurovascular expertise there: SB/400.

86. The experts opined that Victoria's headache at around 11 pm on 5 July 2019 was likely to have been caused by a neurological event and a number of potential causes for that should have been explored. The differential diagnoses included PRES, as well as intracranial haemorrhage, including subarachnoid haemorrhage and haemorrhage into an area of her previous ischaemic stroke, reversible cerebral vasoconstriction syndrome, recurrent arterial ischemic stroke and venous sinus thrombosis. They noted that headache is not typical of an acute painful crisis in sickle cell disease: SB/372.

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[3] See Professor Stivaros at SB/576 and SB/583

[4] See Professor Stivaros at SB/95, SB/580 and 608

[5] The second report is undated but must have been between 16 February 2023 (the date of the Defendant's letter of instruction to the experts, which was referred to in it) and 26 February 2024 (the date of their third report).

87. They expressed their view that there should have been a multi-disciplinary team ("MDT") review following Victoria's sudden onset of severe headache, ideally with one 1-2 hours and certainly on 6 July 2019. This should have included a haematology consultant, a paediatric neurology registrar, a paediatric neurosurgical registrar or consultant and a paediatric High Dependency Unit ("HDU") or Paediatric Intensive Care Unit ("PICU") consultant. The MDT should have considered or obtained details of Victoria's Glasgow Coma Score, pupil responses, respiratory pattern and blood pressure, the results of a full neurological examination as well as CT and MRI scanning: SB/373.

88. They described the appropriate management and treatment of Victoria as transfer to [HDU] or PICU for monitoring of Glasgow Coma Score, pupils, blood pressure, fluid balance etc; regular measurement and gradual reduction of blood pressure; careful management of fluid input and output to reduce the positive balance; and consideration of an exchange transfusion rather than a simple "top up" transfusion, as well as neuroimaging (scanning): SB/65.

89. As to causation, they said that:

> "Multidisciplinary involvement would, on the balance of probabilities, have led to stabilisation of the clinical situation, reducing the risk of destabilisation with fluid shifts during exchange, which, on the balance of probabilities, would have enabled a safe exchange at some point over the weekend, reducing the sickle percentage and the risk of cerebral hypoxic ischaemic brain damage": SB/376.

90. They observed that haematologists usually initiate transfusions before neuroimaging is undertaken and expressed the view that exchange transfusion should ideally have taken place before 6 pm on 6 July 2019 or during the day on 7 July 2019: SB/376.

91. The experts identified the possibility that the subarachnoid haemorrhage would not have been diagnosed on the CT on 6 July 2019. However, they contended that:

> "[i]f a neurology consultation had been requested
>
> - the hypertension and positive fluid balance would have been taken into account,
>
> - the possibility of PRES as well as sub arachnoid haemorrhage would have been recognised,
>
> - an MRI would have been requested over the weekend, probably including a gradient ECHO / susceptibility-weighted sequence in view of the very sudden onset of headache and
>
> - any cerebral oedema would have reversed with careful management, including fluid restriction and the possibility of a carefully considered and slow manual... or automated exchange transfusion": SB/400.

(iii): Dr Kilday and Dr Grainger

92. Dr Kilday, in his 13 May 2021 report, accepted that there had been no consultant review of Victoria from the evening of Friday 5 July 2019 until her first seizure at around 10.30 am on Monday 8 July 2019. He said that the reasons why this did not happen were "multifactorial" and included "handover communication between consultants, prioritisation at handover, escalation regarding the patient's clinical status and medical staffing [and] staff: patient ratios / weekend working volume": SB/109.

93. Dr Kilday accepted that there had been "[s]everal inadequacies in the clinical management given to Victoria between 5th - 7th July 2019". However, he said that on the balance of probabilities, "rectifying them during this time period would sadly have been unlikely to have resulted in a difference to Victoria's survival". He deferred to his haematology, neurosurgical and neurology colleagues on the issues of (i) whether there were delays in establishing an exchange transfusion following the acute event on 8 July 2019; and (ii) if so, whether Victoria's chances of both survival and quality of life could have been altered by earlier transfusional and/or neurosurgical / neuroprotective intervention following her first seizure": SB/113-138.

94. Dr Grainger, in his 16 August 2021 report, addressed the issues of (i) the appropriate treatment plan following Victoria's first seizure at around 10.30 am on 8 July 2019; (ii) whether there were delays in organising a transfusion for her and if so the rationale for those delays; (iii) her prognosis from the neuroimaging; and (iv) whether earlier intervention would have made any difference to the outcome. However, "earlier" in this context meant "earlier on 8 July 2019": SB/117.

95. Dr Grainger explained that there are no published clinical studies exploring survival with the timing of exchange transfusion in patients with sickle cell disease and stroke. He also said that Victoria's case was unusual because she was not at high risk of stroke, was on prophylactic therapy which has been shown to reduce the risk of stroke and had no signs of stroke during her initial admission. An overwhelming event of the kind Victoria suffered and the speed of her clinical deterioration were very unusual. He concluded that it was not possible to say, on the balance of probabilities, that if an earlier red cell exchange transfusion had taken place during 8 July 2019, Victoria would have survived: SB/117.

(iv): The response of Professor Stivaros, Dr Grainger, Dr Ram and Professor Kilday to Dr Mankad's evidence

96. Dr Mankad provided further radiology evidence in a report dated 27 May 2022. In responding to it in a joint report dated 14 November 2022, Professor Stivaros, Dr Grainger, Dr Ram and Professor Kilday accepted the following:

> "2.21. The clinical features are consistent with either raised intracranial pressure or posterior reversible encephalopathy syndrome (PRES).
> …
> 2.23. PRES is linked to high blood pressure and the symptoms of headache and altered levels of consciousness are reversible if the blood pressure is controlled.
>
> 2.24. It is accepted that neuroimaging should have been undertaken earlier to exclude raised intracranial pressure.
> …

> 2.26…Dr Mankad opines that there were clinical signs of raised intracranial pressure, overnight on the 5 July, which we agree": SB/142.

(v): Key parts of the oral evidence

97. Dr Grainger, in his oral evidence on 7 December 2022, expressed the view that PRES was the most likely of possibilities but not more probable than not. He agreed that where a patient with sickle cell anaemia has high blood pressure and impaired neurological consciousness, they would be moved to a critical care unit, to better monitor fluid intake and manage blood pressure. If there was a suspicion of PRES, then there would have been "an implementation of a very tight fluid monitoring", because an excess of fluid can contribute to high blood pressure which can contribute to the development of PRES: SB/522 and 525. When invited to comment upon the efficacy of treatment to contribute to Victoria's survival, Dr Grainger confirmed that he was unable to respond since it was outside his expertise: SB/537-538, 547 and 556-557.

98. Professor Stivaros said in evidence on 8 December 2022 that a scan on 5 July 2019 would have been the same as a scan on 8 July 2019; and that the distribution of ischaemia visible on the scan was not what he would expect to see in someone with PRES. He said that certain previous infarcts Victoria had suffered increased the probability that she did not have PRES; and for PRES to translate into a global hypoxic ischaemic event and global ischaemia of the sort present here was very, very rare and not something he had seen previously: SB/586, 608-609 and 612.

99. In the first part of her oral evidence on 9 December 2022, Professor Kirkham agreed that "it was hard to know what was going on…on 6 July 2019 and an investigation was required". She said she would "want to discuss with the haematologist and I would…want to be considering the possibility of [PRES]": SB/618. She expressed the view that "on the balance [of] probabilities…there would have been some white matter oedema consistent with PRES": SB/623. She explained that she was "very used to dealing with debate amongst other professionals trying to assist in the management of an acutely sick child". She said "we have neuroradiology joint meetings and there is often debate between the neuroradiologists…as a clinician you can press quite a lot but in the end you have to take clinical responsibility and that acute headache is what would have been worrying": SB/623.

100. Dr Saunders considered that it was possible but not probable that scanning over the weekend would have shown PRES: SB/621.

101. In the second part of her evidence on 26 February 2024 Professor Kirkham said that the severity of the headache, its duration, and its association with vomiting, were worrying signs that there was an intracranial event. On the balance of probabilities, there was a spike of intracranial pressure on the evening of 5 July 2019. A CT, or at bare minimum a paediatric neurology opinion, was indicated. PRES probably develops when blood pressure increases beyond the compensatory limits of autoregulation and this causes oedema. If the blood pressure is gradually reduced, the oedema will gradually be taken away but if the high blood pressure remains, fluid enters the brain. Management of suspected subarachnoid haemorrhage is "really high-quality neuroprotection", typically in a HDU or PICU, trying to keep everything stable and appropriately managing the fluids and then making neurological decisions on treatment: SB/668, 678 and 695.

102. She said that even if imaging did not show a clear neurological cause for Victoria's headache, she would still be concerned that there was a "neurological driver" to it. The "key thing" would be to have "very careful monitoring" and "do everything extremely slowly and hope that the patient is gradually going to improve from the neurological point of view". She said it was "more important not to drop the blood pressure too quickly than to get it down": SB/696.

103. Further, she said that:

> "…if Victoria had been very carefully managed in terms of fluid balance and other monitoring, over the weekend, she would, on the balance of probabilities, not [have] had a seizure on Monday morning and that includes not having ketamine, which I think put her into cranial pressure up and therefore reduced the profusion pressure": SB/698.

104. She confirmed her view that on the above scenario, on the balance of probabilities the deterioration on Monday 8 July 2019 "simply would not have occurred": SB/698.

105. She stated that if a scan had been undertaken on 5/6 July 2019 which evidenced a subarachnoid haemorrhage, such that the diagnosis of a bleed had been made earlier, appropriate preventive strategies would, on the balance of probabilities, have meant that Victoria would not have died: SB/683-884 and 746-747.

106. On 26 February 2024, Dr Trompeter said that Victoria's signs and symptoms late on the evening of 5 July 2019 would have caused any clinician to be concerned about intracranial pressure, which would be a differential diagnosis. She agreed with Professor Kirkham that if there was a concern that a child had had an intracranial haemorrhage, support would be sought from the intensive care team, even if they decided not to admit the child. There should have been an MDT meeting on 6 July 2019. If a scan did not explain the current symptoms she would go back to the MDT and ask what should be done as the symptoms were significantly worrying: SB/682, 686 and 690-691. She described PRES as an "MRI appearance that can just about be detected on CT scan"; and confirmed that there was no mention of PRES in Victoria's medical history: SB/662 and 701.

107. Dr Saunders confirmed that there was no evidence of PRES on the MRI scan of 8 July 2019: "[I]nfarction can be a manifestation of PRES but not in the distribution that we see are seeing on this scan": SB/788.

108. On 27 February 2024, Dr Mankad said that it was impossible to exclude or include the possibility of PRES at the time of the CT Scan on 8 July 2019: SB/806.

Initial observations on Ground 1

109. The procedural history set out above makes clear that the Defendant conducted the inquest in a very thorough manner. This was reflected in, for example, his further instruction of experts initially engaged by the Interested Party, his decision to adjourn the inquest to obtain further evidence and the comprehensive way in which he questioned the witnesses. It is clear he was seeking to test the evidence with which he was being provided, in order to discharge his duty of inquiry.

110. Overall, the Defendant received a significant body of highly complex, multi-faceted expert evidence. The experts gave evidence from a range of disciplines. In various respects, they quite rightly deferred to the views of others, given their respective areas of expertise. There was no single expert able to give a definitive view of whether there had been any failings in Victoria's care and whether any such failings contributed to Victoria's death. There were conflicts in the expert evidence on some of the key issues.

111. Given that background, it was not possible nor was it evidentially appropriate for the Defendant to consider any aspect of that evidence in the abstract or as a separate and discrete matter divorced from the opinion of others. Rather, it was necessary for him to look at the expert evidence "in the round". He also had to weigh up the conflicts in the evidence between the experts and resolve them where necessary to determine the key issues.

112. In my judgement this was a challenging exercise. This was particularly so, given the volume of written reports, oral evidence, and the gap in time between the first and second phases of the inquest; the nuanced nature of much of the evidence; and the fact that the experts were required to express opinions and conclusions by reference to a series of hypotheses.

113. In my view it is regrettable that in approaching the task of reaching his conclusion the Defendant was not doing so with the benefit of an agreed list of the issues he needed to address. He had indicated that he would be assisted by such a list and such a list could, with care, have been prepared without transgressing the Coroners (Inquests) Rules 2013, Rule 27, which precludes addresses to the Coroner on the facts. Counsel did not provide such a list; nor did the Defendant direct them to do so.

114. In all those circumstances, I consider that the Defendant is to be commended for producing such a concise but detailed judgement which on any view engaged with the key issue of whether scanning should have been ordered in Victoria's case and whether the failure to do so contributed to her death. The Defendant logically moved through the analysis, finding the failure in relation to the scanning, then addressing what the consequences of that were, before turning to the hypothetical scenario of whether the failure to conduct an exchange transfusion on 6 July 2019 made a more than minimal contribution to Victoria's death.

115. I confess I found the task asked of me by the Interested Party – simply to review all the evidence myself – an unusual one, in the context of a judicial review. Such claims are, by definition, focussed on identifying public law errors in an underlying decision rather than re-assessing the facts. I was initially concerned that I was being asked to do the "very fine tooth comb" exercise what had been discouraged in *Evans* at [63] (see [61] above). However, as the public law error at the heart of Ground 1 was an alleged failure to deal with a key issue, in the final analysis the exercise proved necessary for the reasons given by counsel at [78] above.

116. I make these observations not by way of criticism: it is clear that very significant efforts have been expended by the medical and legal professionals in trying to assess how Victoria died. I merely make them to underscore the complexity of the task before the Defendant and by extension before me.

Discussion and conclusion

117. Mr Howells advanced Ground 1 with an elegant clarity. On its face, he advocated for a key issue which the Defendant had simply left out of account. Such an absence of analysis may indicate a public law failing: see *O'Connor* at [24] and [54], at [62] above.

118. In my judgement some of the "building blocks" of his Ground 1 are sound.

119. The Interested Party had accepted as far back as the Level 2 report on 21 November 2019 that there had been a failure to recognise the importance of Victoria's headaches and ensure a review by a consultant neurologist over the weekend of 6/7 July 2019; and a failure to conduct scanning that was clinically indicated until 8 July 2019.

120. The lack of challenge to the Defendant's findings on the scanning issues means that Ground 1 needs to proceed on the basis that if scanning had been conducted on the morning of 6 July 2019, it cannot be assumed that subarachnoid blood would have been found: see the [FFC at [17], at [48] above.

121. Professor Stivaros and Professor Kirkham agreed that where radiological evidence is inconclusive, differential diagnosis and treatment was a clinical decision: see [68], [80(ii)] and [99] above.

122. It was common ground between the experts that PRES was clinically indicated on 5 July 2019; and this was a differential diagnosis that should have been considered: see [86] and [96]-[-97] above.

123. It was agreed that the appropriate clinical monitoring of suspected PRES is transfer to HDU / PICU, monitoring and careful management of blood pressure and fluids, as well as consideration of an exchange transfusion: see [88] and [97] above.

124. It is also clear on the face of the FFC that the Defendant did not give explicit consideration to the issue of whether the failure to follow this management plan, irrespective of the scanning or exchange transfusion issues which he did address, more than minimally contributed to Victoria's death.

125. However, beyond these matters I cannot accept the analysis advanced by Mr Howells for the following reasons.

126. *First*, although there was agreement that PRES was clinically indicated, there was no clear agreement among the experts as to whether Victoria was actually suffering from it: Professor Stivaros did not support a differential diagnosis of PRES; Dr Mankad said it was impossible to include or exclude PRES from the 8 July 2019 scan; Dr Saunders had confirmed that there was no evidence of PRES on the scan on 8 July 2019: see [98] and [107]-[108] above. If Victoria was not in fact suffering from PRES, any failure to treat it properly could not have contributed to her death.

127. *Second*, it remained unclear whether Mr Howells' case on Ground 1 was being advanced on the hypothetical scenario that scanning had taken place over the weekend of 6/7 April 2019 and was inconclusive; or on the actual scenario that no scanning had taken place. There appeared to me at least the possibility that the two scenarios could have led to different treatment plans: at a conceptual level it seems to me that a clinician

who calls for a scan and does not see, for example, clear evidence of a bleed, might adopt a different treatment plan to the clinician who does not call for a scan at all. Whether or not I am right in this analysis, I was not entirely convinced that the experts had set out a clear "roadmap" for the consequences of both of these scenarios.

128. *Third*, Professor Kirkham's evidence as to the appropriate treatment plan for suspected PRES needs to be looked at as a whole. Her initial written evidence, set out at [91] above, was the one she maintained throughout her evidence. This was posited on the basis that a neurology consultation would have been requested, as well as a properly conducted MRI. These were additional hypotheticals that needed to be accommodated for.

129. Even if it can be assumed that any reasonable neurology consultant would have advised the treatment plan outlined by Professor Kirkham, the Defendant has specifically found that he could not be satisfied that an MRI conducted on 6 July 2019 would have shown subarachnoid blood: see the FFC at [17], at [48] above. Again, linking back to the concern expressed in the preceding paragraph, I was not entirely convinced that Professor Kirkham and the other experts had given clear evidence which accommodated this potential finding, which now stands.

130. *Fourth*, Professor Kirkham's proposed treatment plan had always included the idea that the clinicians would be working towards an exchange transfusion: see, for example, the reference to a treatment plan that "would have enabled a safe exchange at some point over the weekend" at [89] above; and the observation that any cerebral oedema would have been reversed with careful management, including fluid restriction and "the possibility of a carefully considered and slow manual... or automated exchange transfusion" at [91] above.

131. However, as the Defendant explained in his FFC at [19] (see [49] above) even Dr Trompeter had said that she was unable to say whether this would have altered the eventual outcome as there was no clear evidence on the role of an exchange transfusion as treatment for a cerebral haemorrhage. There was no challenge to this finding.

132. Professor Kirkham was clearly also concerned about the role of ketamine, which she thought increased Victoria's cranial pressure and therefore reduced the "profusion pressure": see [103] above. I was not taken to detailed evidence on the role of ketamine, but Professor Kirkham's evidence on its face appeared to be offering no more than a possible variation to the treatment plan – ie. stopping the ketamine – that might have made a difference.

133. *Fifth*, and perhaps most crucially, when looked at in its full context, Professor Kirkham's oral evidence to the effect that on the balance of probabilities, Victoria would not have had a seizure on Monday morning was not given in an entirely unqualified way, in accordance with the Claimant's case on Ground 1.

134. When Professor Kirkham touched on the causation issue on the basis that imaging did not show a clear neurological cause for Victoria's headache, all she said was that monitoring, and an extremely slow attempt to reduce the blood pressure was important. The "hope" would be that Victoria would "gradually …improve from the neurological point of view": see [102] above. This was speculative: she did not go as far as to say this treatment plan would, on the balance of probabilities, have reduced the blood

pressure, let alone that the failure to do this more than minimally contributed to the catastrophic event on 8 July 2019. This evidence also did not appear to factor in the transfusion or ketamine variables referred to above.

135. Professor Kirkham's evidence that appropriate preventive strategies would, on the balance of probabilities, have meant that Victoria would not have died, was advanced on the specific hypothetical that a scan undertaken on 5/6 July 2019 had evidenced a subarachnoid haemorrhage: see [105] above. The Defendant's unchallenged finding is that the evidence did not satisfy such a proposition: see the FFC at [17], at [48] above.

136. *Sixth*, even if Victoria was suffering from PRES, the link between this and the catastrophic event on 8 July 2019 that led to her death was far from clear.

137. Although Mr Howells contended that the pathological significance of PRES is that it is a potential contributing factor to cerebral ischaemia (albeit not the sole cause), the evidence on which he relied for this proposition did not appear to be bear the weight he sought to attach to it.

138. He took me to SB/160, part of Dr Saunders' 25 September 2020 report. At paragraph 6.6 thereof, she had opined that the cerebral infarction visible on the MRI scan conducted on the evening of 8 September 2019 indicated that "[Victoria's] cerebral perfusion was already compromised at the time of her second seizure either from hypertension (possible PRES), or ketamine infusion; the latter is known to increase intracranial pressure and decreased perfusion pressure". The reference to "the latter" was surely a reference to the role of ketamine, not PRES. Dr Saunders was referring to the view also expressed by Professor Kirkham that ketamine infusion increased intracranial pressure and decreased perfusion pressure: see [103] above. She did not appear to be saying that PRES contributes to cerebral ischaemia.

139. He also took me to SB/166, part of Dr Saunders' written response to the evidence Professor Stivaros had given in the first phase of the inquest, dated 6 December 2022. She responded to Professor Stivaros' evidence that he considered it very unlikely that PRES would have developed into what was seen in Victoria (see [98] above). She addressed the evidence on PRES in conjunction with a related condition, Reversible Cerebral Vasoconstriction Syndrome ("RCVS"). Indeed, the heading of her report which gave this evidence was "RCVS and outcome". Dr Saunders agreed that PRES alone was "not likely to explain the outcome of generalised cerebral ischaemia leading to death". However, she pointed to some evidence of RCVS being so severe as to result in death. This appeared to amount to an acceptance that there was relatively limited scientific support for the proposition that PRES was a contributing factor to the cerebral ischaemia here.

140. *Seventh*, as Ms Cartwright KC highlighted, there was evidence from Professors Stivaros, Kilday and Grainger that the terminal event occurred after the first seizure on 8 July 2019. Dr Grainger's view in this regard appeared to have been advanced even on the hypothetical basis that a fluid management regime would have been applied. This perspective was consistent with the "waxing and waning" of the symptoms described by Dr Mankad and accepted by Professor Kirkham. This adds yet further uncertainty to the causative potency of any failures in the clinical treatment plan over the 6/7 July 2019 weekend.

141. Overall, therefore, I conclude that in this very difficult evidential exercise the Defendant did not err in leaving out of account the neurological evidence of an appropriate treatment plan as alleged under Ground 1. He considered the potential for an alternative treatment path by which the ultimate outcome could have been avoided. He properly contextualised the evidence and brought an appropriate focus to bear on the key issues that most clearly, on evidence, might have contributed to Victoria's death, namely the delays in scanning and the timing of the exchange transfusion.

142. Despite the attractive way in which it was presented, Ground 1 is therefore dismissed.

Ground 2

143. Ground 2 contended that in his FFC at [19] (see [49] above) the Defendant has unreasonably discounted the evidence of Dr Kirkham in respect of causation on the basis that it was inconsistent with the evidence of Professor Stivaros and Dr Grainger.

144. Mr Howells submitted that the Defendant had failed to compare "like with like" in that Professor Kirkham's causation evidence related to the treatment plan over the weekend of 6/7 July 2019, whereas Dr Grainger and Professor Stivaros were only concerned with the events of 8 July 2019.

145. Dr Grainger's evidence was that following the seizures on 8 July 2019, whilst interventions could have taken place, such as an exchange transfusion, they were unlikely to change the outcome: SB/520 and 553. Professor Stivaros' evidence was that by 8 July 2019 there had been a significant ischaemic insult which was not survivable: SB/597 and 602. Neither expert said that a management plan over the weekend of 6/7 July 2019 would have made no difference and that following the neurological event on 5 July 2019 Victoria's death was inevitable.

146. However, the Defendant's conclusions at [18]-[20] were addressing the hypothetical situation of whether the delays in scanning more than minimally contributed to Victoria's death. Where the Defendant was referring to Professor Kirkham's evidence on causation, it was in this context.

147. I do not consider, therefore, that it would be fair to read [19] as a rejection of Professor Kirkham's evidence on causation outright - the Defendant was simply not addressing in this part of the FFC whether any failures of care separate from those relating to scanning contributed to Victoria's death.

148. If the sentence in relation to Professor Kirkham were excised from the FFC at [19], the conclusions at [18]-[20] would still stand, and Mr Howells advanced no challenge to them. He did not say, for example, that the Defendant was not entitled to accept the evidence of Dr Grainger and Professor Stivaros and to reject that of Dr Trompeter.

149. Accordingly, even if there was an error by the Defendant in [19] – and I do not consider that there was - it was not material to the overall conclusion in this section.

150. It may have been that the real purpose of Ground 2 was to keep open the argument that Professor Kirkham's evidence could be relied on at any fresh inquest ordered as a result of Ground 1 succeeding, on the basis that it had not been fatally undermined by the

Defendant already. I do not believe it has been, for the reasons given at [146]-[147] above.

151. Ultimately, I did not understand Mr Howells to seek to pursue the claim solely on the basis of Ground 2. If I am right in that analysis, as Ground 1 has been dismissed, then Ground 2 has become largely academic. However, to the extent that it is pursued, I dismiss it for the reasons set out above.

Ground 3 / Materiality

152. The shape of Ground 3 developed during the course of the claim.

153. Initially, it was said that the Defendant had misdirected himself in law in finding that there was insufficient evidence that Victoria's death "would have been avoided" rather than applying the "more than minimal" test derived from *Khan*, set out at [54] above. The Defendant had correctly directed himself to the *Khan* test in the FFC at [22]: see at [50] above. Ground 3 as initially advanced was not pursued by Mr Howells in oral submissions. To the extent that issue 3(a) (see [63] above) remains live, I find in the Defendant's favour. There was no legal misdirection.

154. Issue 3(b) – should the Defendant have asked whether the failure to implement a care plan on the correct differential diagnosis of increased intracranial pressure contributed to the catastrophic event on 8 July 2019 in a more than minimal, trivial or negligible way – has been answered in the negative by my findings on Ground 1. In summary, the Defendant was justified in focussing on the key, potentially causative issues in the way that he did, and this was not one of them.

155. In its final presentation Mr Howells contended that Ground 3 was really an argument about materiality. The crux of his argument was that if he succeeded on Ground 1, he was entitled to relief, because if the Defendant had in fact left out of his consideration a key issue of an alleged failing in care, his findings of fact and conclusion of natural causes might have been different. I accept that proposition, reflecting as it does the agreed legal position before the Defendant that if failings in care were identified, which more than minimally contributed to Victoria's death, a narrative conclusion rather than a natural causes conclusion was appropriate.

156. Accordingly had Ground 1 succeeded, I would have accepted that there had been a material error in the Defendant's reasoning, such that the Claimant was entitled to relief. However, as Ground 1 has been dismissed, this argument has become academic.

Conclusion

157. Accordingly, for all these reasons, the claim is dismissed. I reiterate my thanks to all counsel for their assistance in this very complex and sad case.