CO/2992/2018

IN THE HIGH COURT OF JUSTICE

QUEEN'S BENCH DIVISION

ADMINISTRATIVE COURT

[2018] EWHC 3617 (Admin)

Royal Courts of Justice Wednesday, 5 December 2018

Before:

LORD JUSTICE HOLROYDE

MR JUSTICE NICOL

B E T W E E N :

BERYL JAMES Claimant

- and -

HER MAJESTY'S SENIOR CORONER FOR ESSEX Defendant

THE CLAIMANT was not represented and did not appear.

THE DEFENDANT was not represented and did not appear.

J U D G M E N T

LORD JUSTICE HOLROYDE:

Nicol J is not able to be present this morning but concurs in the judgment of court which I am about to deliver.

1 Dean Charles James was born on 26 September 1979 and was therefore only 17 years old when he did on 10 September 1997. The medical cause of his death was an overdose of methadone. At an inquest held on 6 November 1997, the then Assistant Deputy Coroner, now her Majesty's Senior Coroner for Essex, recorded a verdict of accidental death. Dean James's family thereafter continued to make enquiries into the circumstances of his death and, as a result, significant further information and evidence is now available.

2 Dean James's mother applies, under the authority of a fiat granted by Her Majesty's Attorney General on 18 June 2018, for an order pursuant to s.13 of the Coroner's Act 1988 quashing the inquest held on 6 November 1997 and directing a fresh investigation pursuant to part 1 of the Coroners and Justice Act 2009.

3 Section 13 of the 1988 Act gives this court the power to quash a finding made at an inquest and direct a further investigation into a death if the court is satisfied "that (whether by reason of fraud, rejection or evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise) it is necessary or desirable in the interests of justice that an investigation (or as the case may be, another investigation) should be held."

4 For some months prior to his death, Dean James had been a patient of a Dr Kawa, who had prescribed methadone and temazepam for him. His last visit to Dr Kawa's surgery was on 9 July 1997, and he subsequently presented to a pharmacist a prescription bearing that date for 500 millilitres of methadone and 50 temazepam tablets. Dean James's family believe, however, that Dr Kawa in fact gave him two identical prescriptions on that date, the second of which was post-dated 18 August 1997. It is entirely clear that Dean James did not attend Dr Kawa's surgery on 18 August 1997 because he was in custody at that time. He was released from custody a few days before he presented the second prescription to a pharmacist in early September 1997. That same night he consumed the fatal overdose of methadone.

5 In the years which have elapsed since the original inquest, Dean James's mother and other members of the family have pursued their attempts to establish more about the circumstances in which he was able to, and did, take that overdose. Through no fault of theirs, it has been a long process. In 1998, an independent review established by the North Essex Health Authority made findings of negligence against Dr Kawa in relation to his professional judgment and his record keeping. It emerged that two other patients under his care, each of them, like Dean James, a young drug user, died of methadone overdoses in January 1996 and February 1997 respectively. There was a police investigation. Dr Kawa stood trial on a charge of the manslaughter of Dean James by gross negligence, a charge of which he was acquitted in March 2001. Later in 2001, a panel of the General Medical Council found Dr Kawa guilty of serious professional misconduct, including in failing to equip himself with available information before prescribing dangerous drugs to Dean James, and ordered that his name be erased from the register of medical practitioners.

6 Throughout this series of investigations, Dr Kawa has given inconsistent explanations of the second prescription. In the criminal trial, he gave evidence that Dean James had told him

that he had attended a team at the North Essex Mental Health Partnership, who had authorised the prescription of methadone. Evidence is now available that Dean James did not in fact ever attend that team.

7 Her Majesty's Senior Coroner acknowledges that further evidence is now available. She indicates that it is extremely difficult to say whether her verdict would have been different if all that information had been available to her at the time of the inquest, but she does not resist this application.

8 The Deputy Assistant Coroner reached her verdict on the basis of information and evidence which can now be seen to have been incomplete. A fresh inquest may come to a different verdict; but whether it does or not, and notwithstanding the passage of time, it will serve an important purpose by allowing an investigation on a much fuller basis into the circumstances of Dean James's death.

9 In our judgment, the discovery of new facts and evidence makes it necessary in the interests of justice that a fresh inquest be held. We therefore make an order in the terms which have helpfully been agreed between the parties as follows:

(1) the verdict of the inquest of 6 November 1997 relating to the death of Mr Dean Charles James be quashed;

(2) the defendant shall hold a fresh inquest of the death of Mr Dean Charles James and shall have regard to the new evidence and information before her when reaching her decision.

(3) there be no order as to costs.

Transcribed by ***Opus 2 International Ltd.***
(Incorporating Beverley F. Nunnery & Co.)
Official Court Reporters and Audio Transcribers
5 New Street Square, London EC4A 3BF
Tel: 020 7831 5627 Fax: 020 7831 7737 admin@opus2.digital

This transcript has been approved by the Judge.